STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675132	A. Building B. Wing	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremond Nursing and Rehabilitation Center	211 N Main Bremond, TX 76629

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview, and record review, the facility failed to treat each resident with dignity and respect and care for residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for three of four residents (Resident #16, Resident #5, and Resident #10) reviewed for dignity. 1. Resident #16's door and curtain were left open while he received wound care to his ankle. 2. Resident #5's wound care was performed with the door to the hallway open and the privacy curtain was not pulled. 3. Resident #10's wound care was performed with the privacy curtain partially closed, exposing his buttock and leg to anyone passing by in the hallway. These failures placed residents at risk for an undignified existence due to exposure of body parts during medical treatments. Findings include: 1. Record review of Resident #16's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of need for assistance with personal care, Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), non-pressure chronic ulcer (sore) of lower leg. Record review of Resident #16's Care Plan dated 04/25/2023 reflected he had a pressure ulcer located on his left lateral ankle and he was to receive treatments as ordered. Record review of Resident #16's Quarterly MDS dated [DATE] reflected he had a BIMS score of 14 indicating intact cognitive status. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/25/2023 at 10:06 AM of LVN A performing wound care to Resident #16's left ankle revealed the door to the hallway was left wide open during entire wound care procedure and the curtain was not closed. Numerous staff and residents passed though the hallway during the procedure. 2. Record review of Resident #5's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Vascular Dementia (brain damage caused by multiple strokes), Type 2 Diabetes Mellitus with other circulatory complications (a chronic condition that affects the way the body processes blood sugar, if high blood sugar is too high it damages blood vessels), unspecified sequelae (a condition which is the consequence of a previous illness or injury) of Cerebral Infarction (brain stroke), and Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #5's Physician orders dated 04/14/2023 reflected to non-pressure wound right posterior (bask) ankle full thickness. Float heels in bed and off load wound. [keep heels off bed to reduce pressure to wound]. Record review of Resident #5's Quarterly MDS dated [DATE] reflected she had a BIMS score of 15 indicating intact cognitive status. Observation on 04/26/2023 at 9:55 AM of LVN A performing wound care for Resident #5 revealed the door to the hallway was left open and the curtain was not closed during the entire procedure. Numerous staff and residents passed though the hallway during the procedure. 3. Record review of Resident #10's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of age-related physical debility (state of general weakness), and unspecified open wound of right buttock. Record review of Resident #10's Care Plan dated 12/13/2022 reflected he had a pressure ulcer/injury to the right gluteus (buttock). Record review of Resident #10's Quarterly MDS dated [DATE] reflected he had a BIMS score of 15 indicating intact cognitive status. Observation on 04/26/2023 at 10:26 AM of LVN A performing wound care for Resident #10's right buttock revealed the curtain was partially pulled back. Surveyor walked to door and was able to observe the residents exposed buttock and leg. Interview on 04/26/2023 at 10:44 AM LVN A stated regarding Resident #16, #5, and #10's wound care, leaving the curtains and doors open during wound care was a HIPAA violation and violated the resident's privacy. Interview on 04/27/2023 at 9:15 AM CNA B stated the curtains and door should be closed for respect and dignity for the residents while providing care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/27/2023 at 9:32 AM CNA C stated staff should always pull the curtains and close the doors for resident privacy. She stated not closing the curtains and doors was a dignity issue. Interview on 04/27/2023 at 10:00 AM the IDON stated, Staff should always provide privacy while giving care and no one should have visual access to their naked bodies at any time and it was a dignity issue. Interview on 04/27/2023 at 10:15 AM the ADM stated his expectations would be for all staff to close doors during patient care. He stated leaving the leaving the doors open during care could be embarrassing to the residents. Review of a facility Policy and Procedure dated 10/01/2023 and titled Patient/Resident Rights reflected The facility treats each resident with respect and dignity. 38073

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for one of two smoking areas (Smoking Area 1)observed for hazards The facility Smoking Area 1 had a plastic trash can in use and no useable metal trash cans, and there was a splintered board on the seat of one of the porch swings in the area. These failures placed residents at risk of burns and lacerations to the skin. Findings included: Observation on 04/25/23 at 04:10 PM revealed six residents in Smoking Area 1 smoking under the supervision of the AD. There was a tall plastic trashcan with a push door on the lid in the center of the smoking area. There were multiple spots indicating the size and shape of the lit end of cigarettes and some burn marks on the lip of the lid in front of the push door. One resident put his cigarette out on the lip in front of the push door. This did not create a melted area, but it did create a small burn mark. There was a red, push lidded, metal wastebasket against a fence several feet from the resident smoking area with a long broom handle sitting in it. Within the bin of the wastebasket was visible a large clump of [NAME] seeds, some fungus which had grown there, and the rusted-out metal bottom of the can. Further observation revealed two freestanding wooden porch swings in this smoking area, and one of them had a cracked slat with sharp splintered wood sticking out in the area where the back of an average-sized person's knee would rest if she/he were seated in the swing. During an interview on 04/26/23 at 03:50 PM, the MAINT stated he had not set up the smoking area but did build the porch swings and did not know one had a cracked slat. He stated he could fix it right away. The MAINT stated the cracked slat on the porch swing could have injured a resident. During an observation and interview on 04/26/23 at 04:02 PM, the ADM stated he was not aware the trashcan used in the smoking area was plastic. After observing the smoking area and the melt and burn marks in the trash can lid, he stated that was a fire and burn hazard and could be corrected immediately. The ADM observed the cracked wooden slat on the porch swing and stated that was an injury hazard. When asked how he monitored for safety in the smoking area, he stated he did rounds on the building but could not remember when he had last observed the smoking area. The ADM stated the AD was primarily responsible for the resident smoking area. During an interview on 04/27/23 at 02:59 PM, the AD stated she did not know who had brought the plastic trash can into the smoking area, but it was not her. The AD stated the ADM had taken the trash can away and told her there were burn marks on it. The AD stated she had not received training on what was required in the resident smoking area. She stated she did not notice the broken seat board on the porch swing. The AD stated people occasionally use that swing, but nearly all the residents were in wheelchairs, and she could not think of any residents who used it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the National Fire Prevention Association 101 federal tag 702 reflected the following: (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for one of one residents (Resident #2) reviewed for respiratory care. The facility failed to ensure Resident #2's oxygen tubing was dated with the date it was changed. This failure could place all residents who use respiratory equipment at risk for respiratory infections. Findings included: Record review of Resident #2's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (a group of lung disease that block airflow and make it difficult to breathe), and Shortness of breath, and Conduct Disorder (group of behavioral and emotional problems characterized by a disregard for others). Record review of Resident #2's Quarterly MDS dated [DATE] reflected she had a BIMS score of 3 indicating severe cognitive impairment. Observation on 04/25/2023 at 9:19 AM of Resident #2's oxygen tubing revealed it was not dated. Observation and Interview on 04/25/2023 at 9:30 AM LVN A observed Resident #2's oxygen tubing and stated it was supposed to be changed out every Tuesday. She stated, I'm not sure what the policy is but I date it [tubing]. Interview on 04/27/2023 at 1:18 PM the IDON stated the company wide practice was to change the oxygen tubing weekly and by not changing the tubing weekly it could grow bacteria and the resident could end up with an infection. Interview on 04/2720/23 at 10:15 AM the ADM stated oxygen tubing should be dated so they would know it was clean and not contaminated. He stated did not know potential outcome to the resident if the oxygen was not changed out weekly. Record review of a facility's Policy and Procedure dated 04/01/2022 and titled Oxygen Therapy General Policy reflected label tubing and humidifier with date, time and practitioner initials.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for one of one medication carts and one of one loose pill reviewed for medication storage. 1. The facility failed to ensure the medications for Resident #2 were placed inside of the medication cart when the nurse left the cart for 12 minutes. 2. The facility failed to secure Resident #16's Oxcarbazepine after it fell on the floor. This failure could place residents at risk of ingesting unprescribed medications resulting in adverse health consequences. Findings included: 1. Record review of Resident #2's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors), Chronic Obstructive Pulmonary Disease (a group of lung disease that block airflow and make it difficult to breathe), Type 2 Diabetes Mellitus without complications (a chronic condition that affects the way the body processes blood sugar), Anorexia (an eating disorder causing people to obsess about weight and what they eat), Shortness of breath, and Conduct Disorder (group of behavioral and emotional problems characterized by a disregard for others). Observation on 04/26/2023 at 7:03 AM of a medication pass for Resident #2 by LVN A revealed she left a bottle of Vitamin D3, and inhalers Incuse Ellipta and Breo Ellipta on top of the medication cart while she went to retrieve additional medications out of the medication storage room. LVN A returned to the medication cart at 7:15 AM. LVN A then went into Resident #2's room to administer medications and left the bottle of Vitamin D3 on top of the medication cart. Interview on 04/26/2023 07.26 AM LVN A stated by leaving medications on top of the cart, someone could have come by and taken or ingested them. She stated the potential side effect of ingesting the medications could be an allergic reaction. She stated the inhalers could burn their mouth. Interview on 04/27/2023 at 10:00 AM the IDON stated medications should always be locked inside of the carts and if left out, anyone could get ahold of them and take them. Interview on 04/27/2023 at 10:15 AM the ADM his expectations would be for the nurse to place mediations inside of the cart and lock it. He stated it was a big problem as the residents could come along and ingest the meds. I'm not a clinician so I do not know the potential risk of taking them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Policy and Procedure dated 07/13/2021 titled Medication Management Programs reflected medications, chemicals or other dangerous articles are not to be left on top of the cart. 2. Record review of Resident #16's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), need for assistance with personal care, Nightmare Disorder (pattern of repeated frightening and vivid dreams that affects quality of life) Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) Schizoaffective Disorder (chronic mental health disorder characterized by hallucinations or delusions and symptoms of a mood disorder such as mania [highs] or depression [lows]), non-pressure chronic ulcer (sore) of lower leg, and Neuromuscular dysfunction of bladder (lack of bladder control due to a brain, spinal cord or nerve problem). Record review of Resident #16's Care Plan dated 04/25/2023 reflected he had a pressure ulcer located on his left lateral ankle and he was to receive treatments as ordered. Record review of Resident #16's Quarterly MDS dated [DATE] reflected he had a BIMS score of 14 indicating intact cognitive status. Record review of the physician orders for Resident #16 reflected an order dated 01/13/23 for Oxcarbazepine/oxcarbazepine 300 mg one time per day. Observation on 04/27/23 at 09:08 AM revealed a yellow medication tablet on the floor outside the dining room door. The DON was notified and retrieved the tablet. During an interview on 04/27/23 at 10:00 AM, the IDON stated she had investigated the yellow tablet and discovered it was Oxcarbazepine prescribed to Resident #16. The IDON stated she had spoken to LVN A, who had administered Resident #16's medication that morning, and she stated she did not know what happened or how the pill ended up on the floor. The IDON stated LVN A claimed to have administered Oxcarbazepine to Resident #16 that morning as ordered. The IDON stated Resident #16 had told her immediately without her sharing any details that LVN A had dropped the pill during his medication administration that morning and had given him another one. During an interview on 04/27/23 at 12:38 PM, LVN A stated she administered Resident #16's Oxcarbazepine as ordered and did not know what had happened with the tablet that had been found on the floor. She denied dropping a tablet or any other occurrence that could have resulted in an unsecured medication. She stated Resident #16 was taking the Oxcarbazepine for his depression and had no mood swings or adverse effects, because he had received his medication. When asked how she could be sure he received his Oxcarbazepine if it was found on the floor, she stated she did not know, but he had received it. LVN A stated she had watched him take his medications and had not walked away. LVN A stated a potential negative impact of the Oxcarbazepine being on the floor was that another resident could have picked it up and ingested it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Mayo Clinic webpage found at Oxcarbazepine (Oral Route) Side Effects - Mayo Clinic and titled Oxcarbazepine (Oral Route) Side Effects reflected the following: More common Change in vision change in walking or balance clumsiness or unsteadiness cough crying dizziness double vision false sense of well-being feeling of constant movement of self or surroundings fever mental depression sensation of spinning sneezing sore throat uncontrolled back-and-forth or rolling eye movements Less common Agitation awkwardness bloody or cloudy urine blurred vision bruising confusion about identity, place, and time (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decreased urination difficulty with focusing the eyes dizziness, faintness, or lightheadedness when getting up suddenly from a lying or sitting position fast or irregular heartbeat frequent falls frequent urge to urinate headache hoarseness increased thirst loss of consciousness memory loss muscle cramps pain or burning while urinating pain or tenderness around the eyes or cheekbones problems with coordination shaking or trembling of the arms, legs, hands, and feet seizures skin rash stuffy or runny nose tightness in the chest trouble with walking troubled breathing unusual feelings unusual tiredness or weakness

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 38073 Based on observation, interview, and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for one of two kitchen staff (CK/DM) reviewed for sufficient staff. The dietary manager (CK/DM) at the facility did not have a dietary manager certificate. This failure placed residents at risk of unsatisfying food and food borne illness. Findings included: Observations on 04/25/23 at 9:30 AM, 04/25/23 at 11:04 AM, 04/26/23 at 12:40 PM, and 04/27/23 at 08:30 AM revealed CK/DM was working in the kitchen preparing the noon meal. DA D went in and out of the kitchen, retrieving and washing breakfast dishes. During an interview on 04/27/23 at 08:44 AM, the LD stated she did not work fuill time at the facility and only visited onsite once a month. The LD stated she was aware the CK/DM was not certified, and that the CK/DM had stepped into the dietary manager role when the previous dietary manager quit. During an interview on 04/27/23 at 01:52 PM, the CK/DM stated she had worked at the facility in the kitchen since 2017, and when the previous dietary manager quit, she took over the job of kitchen manager. The CK/DM stated she was the only daytime cook and acted as a dietary aide as well. She stated she was not certified, because she worked too much to finish the classes. She stated she was still planning to finish certification but had not been able to. The CK/DM stated the ADM had not provided any training for her about what to do in the kitchen, but the LD did provide some training. During an interview on 04/27/23 at 02:15 PM, the ADM stated he had not known until that day (04/27/23) the CK/DM was not a certified dietary manager. The ADM stated he had started in his position the week before Christmas (December 2022) and had not been told the CK/DM was still uncertified and had not asked. He stated the CK/DM had started the class to become certified, and prior to the ADM taking his position, the previous administrator had cut staff in the kitchen. The ADM stated that resulted in the CK/DM having to take over the kitchen. The ADM stated he had the CK/DM call the certification school the day prior (04/26/23), and she learned she would have to start the classes over again. The ADM stated failures identified in the kitchen could be related to the CK/DM not having her full education, and these could result in food borne illness for the residents. Policy on certified dietary manager was requested but not provided prior to exit.

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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** 38073 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for food storage, preparation, and service. 1. The facility dishwasher was out of sanitizer and still being used to wash dishes. 2. The CK/DM failed to sanitize the puree bowl between puree dishes and used unsanitized tongs to handle sausage during the puree process. 3. There was no system in place to accurately monitor holding temperatures for the pureed foods. These failures placed residents at risk of food-borne illness. Findings included: 1. Observation on 04/26/23 at 12:26 PM revealed an Autochlor A5 Water Saver dishwasher (chemically sanitizing dishwasher) in the facility kitchen. When a wash/rinse cycle of the machine was conducted with a plastic coffee cup, the available chemical test strips did not indicate any presence of chlorine or other disinfecting fluid. DA D ran the dishwasher again and tried detecting chemical in the water on the surface of the coffee cup again, and no presence of chemical resulted. During an interview on 04/26/23 at 12:30 PM, DA A stated he tested the chemical content of the dishwasher daily and had done so earlier that morning before breakfast. DA A stated he logged the results of his tests on a paper form hanging on the wall behind the dishwasher. DA A stated the chemical must have run out on the dishwasher. He stated the chemical content should have registered at 50 ppm. During an interview on 04/26/23 at 12:40 PM, the ADM stated the chemical sanitizer had run out in the dishwasher, and he had just ensured an order was put in for more. He stated the facility would revert to disposable dishes until the chemical sanitizer was restored to the dishes. The ADM stated the residents had already been served lunch and were eating, and there was no way to guarantee they did not eat on dishes that had not been properly sanitized. Review of the log hanging behind the dishwasher reflected an entry for 04/26/23 with a checkmark next to it and no further information. Review of the 2022 FDA Food Code reflected the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4-204.117 Warewashing Machines, Automatic Dispensing of Detergents and Sanitizers. The presence of adequate detergents and sanitizers is necessary to effect clean and sanitized utensils and equipment. The automatic dispensing of these chemical agents, plus a method such as a flow indicator, flashing light, buzzer, or visible open air delivery system that alerts the operator that the chemicals are no longer being dispensed, ensures that utensils are subjected to an efficacious cleaning and sanitizing regimen. 2. Observation on 04/25/23 at 11:04 AM revealed the CK/DM pureed one scoopful of broccoli in a food processor, rinsed the processor bowl under running water in a sink next to the preparation area without using any soap or sanitizing solution, poured the pureed broccoli into a small chafing dish, and pureed rice with milk in the food processor bowl. She then rinsed the food processor bowl in the nearby sink without using soap or sanitizer, poured the pureed rice into a small chafing dish, and pureed whole pinto beans. The CK/DM then poured the pinto beans into a small chafing dish and rinsed the food processor bowl in the same sink. There were still beans visible on the inside of the food processor. She then retrieved a chafing dish filled with Polish sausage from the cook area and pulled a pair of metal tongs out of the bottom of the sink where she had been pouring and rinsing the food processor bowl and retrieved a sausage link with the tongs. She proceeded to puree the sausage in the food processor bowl. During an interview on 04/25/23 at 11:10 AM, CK/DM stated her last supervisor said she did not even have to rinse the food processor bowl in between pureeing different food items, but she did not like to leave food in there, so she rinsed some of it out. The CK/DM stated she was not a certified dietary manager and had been going to school to become certified, but she had to take over the dietary manager position when the last one quit, and she had not been able to attend her classes, because she was working so hard as the CK and DM. The CK/DM stated the town the facility was in was very small, and there were no options for dietary manager or cook applying for the jobs. Review of the 2022 FDA Food Code reflected the following: The 3 compartment requirement allows for proper execution of the 3-step manual warewashing procedure. If properly used, the 3 compartments reduce the chance of contaminating the sanitizing water and therefore diluting the strength and efficacy of the chemical sanitizer that may be used. Alternative manual warewashing equipment, allowed under certain circumstances and conditions, must provide for accomplishment of the same 3 steps: 1. Application of cleaners and the removal of soil; 2. Removal of any abrasive and removal or dilution of cleaning chemicals; and 3. Sanitization. Refer also to the public health reason for S 4-603.16. 3. Observation on 04/25/23 at 11:48 AM revealed the CK/DM attempted to take the temperature of the pureed sausage, but there was too little food depth to measure with only one serving of each dish in each chafing dish. The CK/DM stated she did not have a way to measure the temperature of the pureed food and did not know she needed to do so. When asked if she did not regularly or daily take the holding temperature of the pureed foods, she stated she normally did that later on but did not clarify what that meant. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675132	A. Building B. Wing	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremond Nursing and Rehabilitation Center	211 N Main Bremond, TX 76629

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 2022 FDA Food Code reflected the following: Hot Holding In a January 2001 report, the National Advisory Committee on Microbiological Criteria for Foods (NACMCF) recommended that the minimum hot holding temperature specified in the Food Code: FDA believes that maintaining food at a temperature of 57 C (135 F) or greater during hot holding is sufficient to prevent the growth of pathogens and is therefore an effective measure in the prevention of foodborne illness. During an interview and record review on 04/27/23 at 08:44 AM, the LD stated she came to the facility in person once a month, and all her other duties were remote. The LD stated the company that owns the facility placed the responsibility for most of the kitchen inspections/sanitation reports with the dietary manager and administrator positions, but she did conduct her own kitchen inspection when she came to the building from a brief checklist. The LD stated the ADM did a weekly kitchen inspection, and the CK/DM was in there daily, so they were primarily responsible for any issues with kitchen sanitation. The LD stated some of the checklist items were marked N/A because the facility was so small and old they did not have the items. The checklist she worked from had the following items listed that were applicable to the facility: -pot washing and dishwashing -food temperature log -no cross contamination during cooking -clean dishes air drying with no wet items in racks. The LD stated she did not routinely check the chemical dishwasher but left that up to the CK/DM, who needed to be ensuring it was done daily. The LD stated she would usually watch the CK/DM make the puree to make sure she was using the right thinner, but she had not noticed anything [NAME] with sanitation during purees. The LD stated the facility just had one small food processor and only one resident on a puree diet, so they did not cook food in big batches. The LD stated this made it difficult to measure the temperatures on the steam table. The LD stated she did not really know how to solve that problem, because the pureed foods did have to be maintained at the same 135 degrees as the other foods. The LD stated the food processor bowl should have been washed and sanitized in between dishes. The LD stated, since they prepared these foods in such small batches, they could not send the bowl through the dishwasher, but needed to wash it in soapy water by hands and sanitize in the approved sanitizing sink with a chlorine bleach component. The LD stated she did not know the protocol they had developed, but the food processor bowl needed to be washed and sanitized. The LD stated when the previous dietary manager left, the facility promoted the CK/DM while she was still working on her dietary manager certificate. The LD stated some of the instances of noncompliance in the kitchen were probably due to the CK/DM not having her full education as a food and nutrition services manager. The LD stated the CK/DM was not a certified dietary manager and had not worked more than two years as a food and nutrition services manager. The dietitian stated the potential result for all the identified failures in the kitchen could have been an outbreak of food-borne illness among the resident population. A copy of the most recent kitchen sanitation checklist was requested from the LD but not received prior to the end of survey. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/27/23 at 02:15 PM, the ADM stated he monitored the kitchen by conducting weekly kitchen inspections and documented them on a checklist. The ADM stated he had not observed any of the issues noted during his inspections. The ADM stated the CK/DM was not a certified dietary manager. He stated she had started the class to become certified, and prior to the ADM taking his position, the previous administrator had cut staff in the kitchen. The ADM stated that resulted in the CK/DM having to take over the kitchen. The ADM stated he had the CK/DM call the certification school the day prior, and she learned she would have to start the classes over again. The ADM stated the failures identified in the kitchen could result in food borne illness for the residents. The ADM stated he would provide his completed kitchen inspection sheets but had not provided them prior to exit. Review of facility's policy, titled Food Safety, and dated 08/01/20 did not include any policy related to holding temperatures, dishwasher operation, or cookware sanitization.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 28689 Based on observation, interview, and record review, the facility failed to 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 one of one staff (LVN A) observed for infection control practices. 1. LVN A used a contaminated glove to touch and administer Resident #10's medications. 2. LVN A failed to sanitize her hands and replace her gloves prior to performing wound care for Resident #5. These failures could place residents who require assistance with medication administration and wound care at risk for healthcare associated cross-contamination and infections. Findings include: 1. Observation on 04/26/2023 at 7:35 AM of a medication pass for Resident #10 by LVN A who placed gloves on her hands then touched the medication administration record, keys, and medication cart drawers. LVN A then picked up a pill cup and her contaminated gloved finger was placed inside the cup it. She placed Prozac 20 Tizanidine 2mg, Divalproex DR 125 mg, and Zinc 50 mg in the cup with her contaminated gloves. She wiped her sweaty brow with her gloved right hand then administered the medications to Resident #10. Interview on 04/26/2023 at 7:52 AM, LVN A stated it was an infection control issue for her to touch Resident #10's medications with her unclean gloved hand. 2 Observation on 04/26/2023 at 9:55 AM LVN A washed her hands, gloved, then went into Resident #5's room to perform wound care. LVN A then went back to the treatment cart in the hall, opened a drawer with her gloved hands and retrieved items. Without cleaning her hands or changing gloves, LVN A cleansed Resident #5's wound with gauze and wound cleanser, placed hydrogel dry dressings and wrapped the wound with a gauze wrap. Interview on 04/26/2023 at 10:10 AM LVN A stated not washing her hands and changing her gloves prior to performing wound care was an infection control issue. Interview on 04/27/2023 at 10:00 AM the IDON stated if contaminated gloves that have touched other surfaces touch the medications, then they are transferring bacteria to the medications and contaminating them. She stated if the residents ingest the contaminated medications, it could make them sick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/27/2023 at 10:15 AM the ADM stated his expectations would be contaminated gloves should not touch the pills or the inside of the pill cup. He stated the pills could be contaminated and it could cause an illness. Record review of a facility's Policy and Procedure dated 07/13/2021 titled Medication Management Programs reflected Administering the Medication pass 1. Wash hands.