

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2025
NAME OF PROVIDER OR SUPPLIER Marshall Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 S Washington Ave Marshall, TX 75670	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for 1 of 6 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to ensure Resident #1 did not experience physical abuse by Resident #2 on 4/5/25.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 4/5/25 and ended on 4/6/25. The facility had corrected the noncompliance before the investigation began on 4/15/25.</p> <p>This failure could place residents at risk for emotional distress and further abuse.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet dated 4/15/25 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including metabolic encephalopathy (is a change in how your brain works due to an underlying condition), altered mental status, and legal blindness.</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was rarely/never understood and rarely/never had the ability to understand others. Resident #1 had a BIMS score of 00 which indicated severe cognitive impairment.</p> <p>Record review of Resident #1's care plan dated 3/18/25 indicated:</p> <p>*Resident #1 had impaired vision due to macular degeneration (an eye disease that causes vision loss). Intervention included attempt to provide a safe and obstacle free environment.</p> <p>*Resident #1 had impaired cognitive and decision-making abilities. Intervention included monitor facial expressions and body language for signs and symptoms of distress.</p> <p>Record review of Resident #1's nurses note by LVN B, dated 4/5/25 indicated, . [CNA A] reported that [Resident #2] kicked [Resident #1] on her left leg just below the knee .may have x-ray .no signs/symptoms of pain noted at this time .</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Incident/Accident Report by LVN B, dated 4/5/25 indicated, . [Resident #1] was in hall talking to . [Resident #2] was trying to tell [Resident #1] what to do . [CNA A] said "[Resident #2] just kicked [Resident #1]" .assessed [Resident #1] .no apparent injury .</p> <p>Record review of Resident #1's Left tibia and fibula (are the two bones that form your lower leg), 2 view x-ray results dated 4/6/25 indicated, .no evidence of acute fracture or dislocation of the tibia or fibula .</p> <p>Record review of Resident #1's social service progress notes by the Social Service Designee (SSD), dated 4/7/25 indicated, .Spoke with [Responsible Party of Resident #1] and offered [local provider] referral related to incident that happened over the weekend between [Resident #1] and [Resident #2] .[RP of Resident #1] did not think [Resident #1] needs a referral at this time . [RP of Resident #1] said they visited with [Resident #1] over the weekend and [Resident #1] didn't remember anything about the incident .I [SSD] also spoke with [Resident #1] and she was in a pleasant mood and did not remember incident .</p> <p>During an interview and observation on 4/15/25 at 3:45 p.m., Resident #1 said no one had kicked her that she could remember. Resident #1 had disorganized thoughts and appeared confused about the questions asked. Resident #1 appeared without distress or pain.</p> <p>2. Record review of Resident #2's face sheet dated 4/15/25 indicated Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses including moderate intellectual disability (is defined as observable developmental delays, which may be accompanied by physical impairments), generalized anxiety disorder (excessive, ongoing anxiety and worry that are difficult to control and interfere with day-to-day activities), and mood affective disorder (is a mental health condition that primarily affects your emotional state). Resident #2 had been discharged on [DATE] to psychiatric hospital.</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2 was understood and had the ability to understand others. Resident #2 had clear speech, moderate difficulty hearing, and moderately impaired vision with correctives lenses. Resident #2 had a BIMS score of 09 which indicated moderate cognitive impairment. Resident #2 had not displayed behaviors during the assessment period. Resident #2 had no functional limitation in range of motion and did not use a mobility device. Resident #2 required setup for oral hygiene, dressing, and putting on/taking off footwear, supervision for toileting and personal hygiene, and moderate assistance for shower/bathe self.</p> <p>Record review of Resident #2's care plan with target date of 6/15/25 indicated:</p> <p>*Resident #2 had specific preferences, wants, needs, and likes. Interventions included Resident #2 talked loud and times and many need reminders to lower voice and to honor others personal space. Resident #2 did not like to be told what to do and had tendency to become defensive and say, You are not my momma you can't tell me what to do. Approach [Resident #2] with a calm friendly tone to prevent upsetting. Resident #2 could become argumentative with the staff at times when they were only trying to help.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Resident #2 had exhibited behavior symptoms. Resident #2 had poor impulse control, intellectual disabilities with episodes of poor social judgement and reasoning skills. Resident #2 had episodes of invading others personal space. Resident #2 had episodes of agitation and yelling. Resident #2 had difficulty regulating emotions and behaviors. Resident #2 had episodes of making fun of others and calling them ugly names and thinking they were talking about me or telling me what to do. Intervention included calmly redirect when exhibiting an inappropriate behavior.</p> <p>Record review of Resident #2's nurse's notes dated 4/5/25 by LVN B, indicated, . [CNA A] said [Resident #2] kicked [Resident #1] just below her left knee . [Resident #2] apologized .</p> <p>Record review of Resident #2's Incident/Accident Report dated 4/5/25 by LVN B, indicated, . 4/5/25 .1:45pm . hallway near nursing station .normal resident's condition before incident/accident . [Resident #1] and another resident talking while in their wheelchairs . [Resident #2] was telling [Resident #1] what to do . [Resident #1] ignored [Resident #2] .when I [LVN B] was not looking [CNA A] said '[Resident #2] kick [Resident #1]' . assessed [Resident #1] .no signs/symptoms of an injury noted .no apparent injury .awake, alert, and oriented to person, place or time .</p> <p>Record review of CNA A's witness statement dated 4/5/25 indicated, . I [CNA A] was down the hall and I [CNA A] saw [Resident #2] kicked [Resident #1] on her left leg below her kneecap .</p> <p>Record review of MA D statement dated 4/5/25 indicated, . I [MA D] didn't see the incident when it happened, but after they asked [Resident #2] why she did it, [Resident #2] went and apologized to [Resident #1] and said 'I [Resident #2] am sorry for kicking you' .</p> <p>Record review of the facility's Provider Investigation Summary and Findings dated 4/10/25 indicated, .at around 1:45pm on Saturday April 5th on the C wing hallway .[CNA A] was coming out of a resident's room when she looked down the hall and observed [Resident #2], as she was standing kick [Resident #1], in her left shin as she was sitting in her wheelchair . [CNA A] called out to [Resident #2] and who then went down the hall to her room . [Resident #2] did not voice any complaints of pain but was upset . Charge nurse did an assessment of [Resident #1] and determined she may have a mark on her left shin but wasn't sure if it was varicose veins or bruising . [Resident #2] could not verbalize why she did what she did but was apologetic . [Resident #2] was moved off the wing that [Resident #1] resides on and a sitter was placed with her til she was transferred to [local behavioral center] .what happened preceding the incident is unknown as the why [Resident #2] did what she did . [Resident #2] did not deny it and there is an eyewitness .</p> <p>During an interview on 4/15/25 at 10:00 a.m., the DON said Resident #2 was still at an inpatient behavioral hospital. Unable to interview Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/15/25 at 1:43 p.m., MA D said Resident #2 had behaviors and was hard to redirect at times. She said Resident #2 was bossy and had a history of hitting other residents. She said Resident #2 got loud when staff tried to redirect her and refused to follow directions. She said sometimes if staff left Resident #2 alone or explained to her why something needed to be done, she was more agreeable. She said in the past, Resident #2 told her when she had done something wrong. She said sometimes Resident #2 would tell her the reason she did something was because she got mad. She said Resident #2 said she did not think about the action before she did it. She said Resident #2 was normally apologetic. She said she did not witness the incident on 4/5/25 but was Resident #2's sitter on 4/6/25 and 4/7/25. She said Resident #2 was still on the C wing when she was her sitter. She said she asked Resident #2 about the incident. She said Resident #2 told her; Resident #1 pushed her against the wall so she kicked her. She said Resident #2 was stressing about the incident and told her she would not do it again. She said this incident was the first incident between Resident #1 and Resident #2. She said Resident #2 wandered the halls and visited other residents. She said Resident #2 knew hitting people was wrong but could not control herself.</p> <p>During an interview on 4/15/25 at 2:52 p.m., CNA A said before she went into another resident's room on 4/5/25, she saw Resident #1 and another resident sitting at the nursing station holding hands. She said as she was coming out of the resident's room, she saw Resident #2 walk up to Resident #1. She said Resident #2 kicked Resident #1 on her left leg near the knee. She said she did not see Resident #1 do anything to Resident #2. She said after the incident, Resident #2 ran away to the lobby area. She said she hollered out for LVN B and him came to the nursing station. She said she asked Resident #2 why she kicked Resident #1. She said Resident #2 just said she was sorry and apologized to Resident #1. She said Resident #2 did not mention if Resident #1 did something to her first. She said Resident #2 picked on everybody especially those who could not defend themselves. She said this incident was the second time she had heard Resident #2 hitting another resident. She said Resident #2 had behaviors at times but was easy to redirect. She said Resident #2 was ambulatory and walked around the facility. She said Resident #2 was placed on 1:1 monitoring until she was transferred to a behavioral hospital. She said immediately after the incident on 4/5/25, Resident #1 kept saying, she kicked me. She said Resident #2 understood she kicked Resident #1. She said Resident #2 kicked her with intention. She said Resident #2 pulled her leg back like when you ball up your fist before you hit someone. She said Resident #2 apologized to Resident #1 and told her we're friends now. She said Resident #1 eventually had a bruise on her leg. She said Resident #1 had not mentioned the incident since it happened on 4/5/25. She said no residents had reported to her being afraid of Resident #2.</p> <p>During an interview on 4/15/25 at 3:07 p.m., LVN B said the incident between Resident #1 and Resident #2 happened on 4/5/25. He said before he left the nursing station on 4/5/25, he overheard Resident #2 trying to tell Resident #1 what to do. He said Resident #1 was trying to console another resident. He said CNA A reported to him that Resident #2 had kicked Resident #1. He said the residents were immediately separated. He said Resident #2 was placed on 1:1 monitoring and family, medical doctor, and the DON were notified. He said a bruise was not noted on Resident #1 over the weekend. He said he had initially thought a dark arear on her left leg was a bruise but it was varicose veins. He said Resident #2 was bossy and liked to argue with everyone. He said Resident #2 wandered the halls and went to different floors. He said Resident #2 was usually easy redirect. He said Resident #2 apologized so it was not like she did not know what she was doing. He said he did not know if Resident #2 intent was to hurt Resident #1. He said Resident #1 did not appear upset after the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/15/25 at 3:58 p.m., the DON said Resident #2 had a similar incident in January 2025. She said Resident #2 hit a male resident. She said after the incident in January 2025, Resident #2 had a sitter with 1:1 monitoring, psych consult, and medication changes. She said when the 1:1 monitoring was discontinued, Resident #2 was placed on every 15 minutes visual checks. She said after the incident on 4/5/25, she had a sitter until she was transferred out on 4/7/25. She said Resident #2 did not have any behavioral changes leading up to the incident on 4/5/25. She said Resident #2 wandered and visited residents and staff everywhere. She said Resident #2 was moved from C wing to A wing. She said Resident #1 did not develop a bruise after the incident. She said the darkened area on Resident #1's leg was a varicose vein. She said the facility ordered the x-ray to error on the cautionary side. She said Resident #2, said she knew what she had done was wrong and should not had done it. She said Resident #2 said she would not do it anymore. She said according to the facility's abuse policy, Resident #2 physically abused Resident #1. She said the facility tried to prevent resident to resident altercations by noticing behavior changes, notifying the physician of behavior changes, and getting psych consults. She said depending on the resident's behaviors, the resident could be placed on every 15-minute checks or 1:1 monitoring. She said the family was also involved to see if they noticed any changes and what worked to help with the behaviors. She said when a resident was abused, they could become fearful, anxious, sleeping problems, depressed, or scared all the time.</p> <p>During an interview on 4/15/25 at 4:44 p.m., the corporate administrator said from what he knew of the incident on 4/5/25, Resident #2 had kicked Resident #1. He said Resident #2 was transferred to a behavioral hospital and her room changed to another floor. He said Resident #2 had an intellectual disability and was childlike. He said he felt Resident #2's actions were not intentional but impulsive. He said Resident #2's actions on 4/5/25 was not willful intent so he did not consider it abuse.</p> <p>Record review of a facility's Abuse Prevention Program revised on 12/2016 indicated, .our resident have the right to be free from abuse, neglect .this includes but is not limited to .physical abuse .protect our residents from abuse by anyone including, but not necessarily limited to .other residents .</p> <p>The facility took the following actions to correct the non-compliance:</p> <p>Record review of Resident #1 and Resident #2's Incident/Accident Report dated 4/5/25 indicated the family members/responsible parties, nurse practitioner, and/or medical doctor had been notified on the incident.</p> <p>Record review of safe survey interview form dated 4/5/25 indicated 5 residents who resided on C hall with Resident #2 were interviewed. All 5 residents indicated no one had been hurtful, physically, or verbally, did not have any problems with another resident in the facility, felt safe and free from any harm or abuse, and felt they were free to voice a complaint with fear of retaliation.</p> <p>Record review of Resident #2's visual every 15-minute check dated 4/6/25 and 4/7/25 were completed.</p> <p>Record review of Resident #2's nurse's notes dated 4/7/25 at 1:05 a.m., indicated urinalysis (is a medical test that analyzes a urine sample to assess kidney function, identify potential infections, and detect other health issues) was collected via in and out catheter.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's nurse's notes dated 4/7/25 at 1:00 p.m., indicated Resident #2 was transferred to room A20-A.</p> <p>Record review of Resident #2's nurse's notes dated 4/7/25 at 5:00 p.m., indicated Resident left the facility via facility transportation to go to a behavioral hospital.</p> <p>Record review of a local behavioral hospital referral dated 4/7/25 indicated Resident #2 needed evaluation for inpatient treatment.</p> <p>Record review of the PIR dated 4/10/25 indicated the facility had reported the incident within the regulated timeframe. The PIR reflected a thorough investigation had been conducted with witness/involved person statements obtained and the resident was protected during the investigation.</p> <p>Record review of a facility's resident roster dated 4/15/25 indicated Resident #2 was out of the facility and would return to room A20-A.</p> <p>Record review of Resident #2's urinalysis results dated 4/7/25, reviewed on 4/15/25, did not reflected a urinary tract infection that could have contributed to Resident #2's behavior.</p> <p>Record review of a facility conducted in-service, Abuse, Neglect, and Exploitation; Resident to Resident abuse dated 4/6/25, was conducted by the DON indicated, fifty-six staff members across all shifts had been in-serviced.</p> <p>Interviews of sampled resident during the investigation on 4/15/25 reflected no residents complained of resident abuse/neglect. The sampled residents verified they did not fear any residents and knew who to report abuse/neglect allegation to.</p> <p>Interviews of sampled staff members during the investigation on 4/15/25 reflected they had been in-serviced on abuse/neglect and resident to resident altercation on 4/6/25. The sampled staff members, across all shifts indicated they were not aware of any abuse/neglect in the facility and knew to immediately report alleged abuse/neglect allegations to the DON and Assistant Administrator (Abuse Coordinator).</p> <p>Record review of facility incident/accident reports for the past three (3) months revealed no concerns in the area(s) of Resident Abuse (Resident to Resident Altercation), Resident Neglect. Appropriate facility responses and investigations were done as necessary. Incident report for Resident-to-Resident altercation was addressed with appropriate facility response and investigation. Resident #2 was placed with sitter and 15-minute visual checks. Resident #2 was transferred to a local behavioral hospital. Resident #1 was assessed for injuries and x-ray obtained for precautionary measures. Resident #1 responsible party was offered a psych consult which was declined. Resident #1 and Resident #2 no longer resided on the same floor.</p> <p>Record review of facility complaints for the past three (3) months revealed no concerns in the area(s) of Resident Abuse or Resident Neglect. The monthly grievance logs did not reflect any complaints related to Resident #2.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 4/5/25 and ended on 4/6/25. The facility had corrected the noncompliance before the investigation began on 4/15/25.</p>		