STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455646	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Manor Nursing & Rehabilitation Center	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)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain physician orders for the resident's' immediate care for 1 (Resident #1) of 5 residents reviewed for admission physician orders. 1.The facility failed to obtain physician orders for the immediate care of Resident #1's surgical wound and pressure ulcer. These failures could affect residents who were admitted or readmitted to the facility by placing them at risk for not receiving the appropriate care, medication, and treatment services. Findings included: 1.Record review of an undated face sheet revealed Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of gangrene of wound (the death of body tissue caused by a loss of blood supply or a severe bacterial infection), Diabetes type II (a chronic metabolic condition where the body resists insulin or cannot produce enough of it), and osteomyelitis (a serious infection and inflammation of the bone, primarily caused by bacteria or fungi). Record reviews of the electronic health record on 06/24/2026 revealed Resident #1 admitted on [DATE] at 05:15 p.m. It revealed the following:Resident #1 had a recent amputation of all of the toes on his right foot. He had a surgical wound from the amputation.Resident #1 had no orders for wound care for his surgical wound to his right foot after amputation of his toes, from 04/03/2026 to 04/06/2026.Resident #1 had a stage II pressure ulcer to left sacrum noted on his admission assessment 04/03/2026.Resident #1 had no orders for wound care for his stage II pressure ulcer to his sacrum from 04/03/2026 to 04/06/2026. Record review of the MD orders for Resident #1 on 04/06/2026 revealed the following orders:Right Transmetatarsal: Cleanse with NS or Wound Cleanser, Pat dry, apply Betadine damped gauze to incision line then nonadherent dressing, then wrapwith rolled gauze secure with tape, then wrap with ace wrap.Sacrum: Cleanse with Soap and H2O, Pat dry, apply Zinc Ointment 20% to wound bed, then Leave Open to Air. Record review of Resident #1's MAR/TAR for April 2026 indicated Resident #1 did not receive any wound care from 04/03/2026 through 04/06/2026. During an interview on 06/23/2026 at 10:30 a.m., LVN A stated she was the nurse that admitted Resident #1. She stated he came in late on a Friday and all of the department head nurses, including the treatment nurse, were gone for the day. She stated there was more than one admit that evening and she had forgotten to contact the MD regarding the wounds and was off on Saturday and Sunday. She stated the resident not having wound for 2 days could have caused complications with his wounds by causing them to worsen. She stated Resident #1's wounds were evaluated by the treatment nurse and the wounds had not worsened on Monday. LVN A stated the treatment nurse initiated wound care on 04/06/2026. During an interview on 06/24/2026 at 1:00 p.m., the treatment nurse stated it was the job of the admitting nurse to do the initial evaluation of all wounds and call the MD for orders for the wounds if they had not come from the hospital with wounds. She stated the treatment nurse would assess the wounds the next weekday and stage the wounds and review the orders for treatment for each wound. The treatment nurse stated Resident #1 had no wound care orders when she came in on 04/06/2026 to evaluate his wounds. She stated she immediately notified the MD and obtained orders and started wound care for him. During an interview on 06/24/2026 at 11:00 a.m., the DON stated the admission process for new residents was that the admitting nurse completes the admission assessment, enter all MD orders from the hospital discharge information, start the baseline care plan, (continued on next page)

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clarify all orders with the physician and administer the initial dose of medications ordered on their shift and begin treatments for wounds. The DON stated it was the expectation that documentation would include vital signs, a full body assessment to include pain and skin issues that need to be addressed. The DON stated not ensuring initial MD orders are in the EHR for all residents and not ensuring their assessments are completed can cause delay in care for the residents. She stated the department head nurses always check the orders and assessments for completion and accuracy on the first business day after the resident admits. During an interview on 06/24/2026 at 2:15 p.m., the Administrator stated it was the responsibility of the admitting nurse to ensure that the resident had all orders in the EHR and that the pharmacy was aware of the orders and was sending the medication. He stated it was the admitting nurse's responsibility to complete the admission assessment and notify the MD of the arrival of the resident and clarify any orders needed after assessing the resident. He stated she he was unaware this process was not being followed. He stated it was the responsibility of the DON and administrative nurses to ensure the residents have all the orders they need and all assessments are completed correctly. He stated the failure to do so could lead to the residents feeling ignored and unimportant. An undated policy titled ?Admitting a Resident' indicated the following: .6. Assist resident into bed. Observe carefully for any open or draining areas, dressings, rashes, bruises or reddened areas and report these to the charge nurse.7. The licensed nurse interviews resident/family member and initiates the admission Nursing data Collection.The drug regimen review is to be completed.12. The licensed nurse notifies the attending physician of his/her arrival and orders.13. Complete and record resident's height, weight, temperature, blood pressure, pulse and respirations on the admission Nursing Assessment and other daily documentation per policy.