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	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Manor Nursing & Rehabilitation Center	1007 S Washington Ave Marshall, TX 75670

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screening for 1 of 5 residents (Resident #73) reviewed for PASRR. The facility failed to review Resident #73's PASRR level 1 assessment for accuracy. Resident #73 had a diagnosed of bipolar disorder not reflected on PASRR Level 1. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of a face sheet printed 04/09/24 indicated Resident #73 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), autistic disorder (problems with social communication and interaction, and restricted or repetitive behaviors or interests), epilepsy (a brain condition that causes recurring seizures), intellectual disability (limits to a person's ability to learn at an expected level and function in daily life) and attention deficit hyperactivity disorder (a chronic condition including attention difficulty, hyperactivity, and impulsiveness). Record review of an admission MDS assessment dated [DATE] indicated Resident #73 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability. The MDS indicated Resident #73 had condition related to ID/DD status of autism and epilepsy. The MDS indicated Resident #73 was sometimes understood and rarely/never had the ability to understand others. The MDS indicated Resident #73 had adequate hearing, no speech, and adequate vision. The MDS indicated Resident #73 was unable to complete the BIMS assessment due to being rarely/never understood. The MDS indicated Resident #73 had short-and-long term memory problem and severely impaired cognitive skills for daily decision making. Record review of a care plan dated 07/05/23, revised on 04/02/24, indicated Resident #73 had potential to feel depressed due to nursing home placement and had a diagnosis of bipolar and autism. Intervention included assess for the need for additional counseling and refer to social/psych/activity services as needed. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a care plan dated 07/26/23, revised on 04/02/24, indicated Resident #73 had a level II PASRR assessment completed by Local Authority on 07/25/23. Resident #73 was eligible for specialized services and benefits related to intellectual and development disability. Resident #73 had a diagnosis of autism, attention deficit hyperactivity disorder with seizure disorder. Resident #73 care needs are greater than support available in community at this time and best served in long term care settings. Intervention included conduct PASRR comprehensive service plan meetings as required, review and revise care plan as needed. Record review of Resident #73's PASRR level 1 screening dated 06/22/23, completed by the RN case manager at a local hospital, indicated .mental illness .is there evidence or an indicator this is an individual that has a mental illness .No . During an interview on 04/10/24 at 10:00 a.m., MDS Coordinator H said she was responsible for PASRR residents. She said Resident #73 was PASRR positive for DD and ID due to diagnoses of autism and epilepsy. She said Resident #73 had a diagnosis of bipolar disorder. She said she did not know why the PASRR Level 1 done at the hospital did not mention Resident #73 having a bipolar diagnosis. She said she was the MDS Coordinator who submitted the PASRR Level 1 to the portal. She said she normally tried to ensure the referring entity completed the PASRR Level 1 correctly. She said somehow no one caught the error. She said during care plan meetings and IDT meetings with the LA, no one realized the error. She said it was important for the PASRR Level 1 to be accurately completed so residents did not miss specialized services. During an interview on 04/10/24 at 3:40 p.m., the DON said if Resident #73 had a diagnosis of bipolar disorder, then mental illness should have been marked on the PASRR Level 1. She said then the LA decided if the resident qualified. She said the MDS coordinator was responsible for PASRR Level 1s. She said if a PASRR Level 1 was not done correctly resident, specialized services were not received. During an interview on 04/10/24 at 4:00 p.m., the ADM said mental illnesses should be on the PASRR Level 1. He said the MDS Coordinator was responsible for PASRR being completed correctly. He said when the PASRR Level 1 assessments were not correct, residents lost out on services available to them. Record review of the facility's undated Preadmission Screening and Resident Review (PASRR) policy indicated .all persons needing admission to a nursing facility must have a preadmission screening for possible mental illness and or mental retardation (DD/ID) (Level 1) .all persons who reside in a nursing facility are subject to resident review . The policy did not address accuracy of the PASRR Level 1.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 ased on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 3 of 19 residents reviewed for care plans. (Resident# 13, Resident #47, Resident #73) 1. The facility failed to develop a care plan for Resident #13 and Resident #47's use of a transfer bar. 2. The facility failed to implement Resident #73's care plan intervention to wear a seizure safety helmet while out of bed on 04/09/24. These failures could place residents at risk of not having individual needs met and cause residents not to receive needed services. Findings included: 1. Record review of a face sheet printed 04/09/24 indicated Resident #13 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including fracture of shaft of left fibula (a long bone in the lower extremity that is positioned on the lateral side of the tibia), fracture of lower end tibia (the shinbone; the larger of the two bones in the lower leg), acquired absence of right leg below knee, muscle weakness, and history of falling. Record review of an annual MDS assessment dated [DATE] indicated Resident #13 was understood and understood others. The MDS indicated Resident #13 had minimal difficulty hearing, clear speech, and moderately impaired vision with corrective lenses. The MDS indicated Resident #13 had a BIMS score of 13 which indicated intact cognition. The MDS indicated Resident #13 required moderate assistance for toilet hygiene, shower/bathe self, dressing, and personal hygiene and independent for oral hygiene. The MDS indicated Resident #13 required substantial assistance for rolling left and right and sitting to lying, and moderate assistance for lying to sitting on side of bed. Record review of a care plan dated 05/12/23, revised on 02/05/24, indicated Resident #13 required weight bearing support from staff during ADL care due to right and left below the knee amputation, impaired mobility, and legal blindness. An intervention included encouraging the resident to increase participation in all aspects of ADLs. There was no care plan or intervention for the use of transfer bar. During an observation and interview on 04/08/24 at 11:02 a.m., Resident #13 was sitting up in bed with a transfer bar on both sides of her bed. Resident #13 said she was able to turn side to side with assistance using the rails. During an observation on 04/10/24 at 12:00 p.m., Resident #13 was sitting in her wheelchair at the bedside. Resident #13 had a transfer bar on both sides of her bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of a face sheet printed on 04/10/24 indicated Resident #47 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), history and repeated falls, displaced intertrochanteric fracture of left femur (is a type of hip fracture or broken hip), and muscle weakness. Record review of a significant change of status MDS assessment dated [DATE] indicated Resident #47 was rarely/never understood and rarely/never understood others. The MDS indicated Resident #47 had minimal hearing difficulty, clear speech, and adequate vision. The MDS indicated Resident #47 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The MDS indicated Resident #47 required maximal assistance for putting on footwear and personal hygiene, moderate assistance for eating, oral and toilet hygiene, dressing, and showering or bathing herself. The MDS indicated Resident #47 required moderate assistance for rolling left and right, sitting to lying, and lying to sitting on side of bed. Record review of a care plan dated 04/05/24 indicated Resident #47 needed assistance with all aspects of ADL care. Resident #47 had vascular dementia (brain damage caused by multiple strokes) with malnutrition requiring feeding tube placement (soft, flexible plastic tubes through which liquid nutrition travels through your gastrointestinal (GI) tract). Intervention included required weight bearing assistance with transfer. No care plan or intervention for use of transfer bar. During an observation on 04/08/24 at 10:24 a.m., Resident #47 was lying down in bed with a transfer bar on the right side of the bed. Resident #47 did not react or respond to greeting. During an observation on 04/09/24 at 07:50 a.m., Resident #47 was lying down in bed asleep with a transfer bar on the right side of the bed. 3. Record review of a face sheet printed 04/09/24 indicated Resident #73 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), autistic disorder (problems with social communication and interaction, and restricted or repetitive behaviors or interests), epilepsy (ia brain condition that causes recurring seizures), intellectual disability (limits to a person's ability to learn at an expected level and function in daily life) and attention deficit hyperactivity disorder (a chronic condition including attention difficulty, hyperactivity, and impulsiveness). Record review of Resident #73's consolidated physician order dated 04/08/24 indicated may have seizure helmet in place while out of bed for preventative measure and seizure precautions. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #73 was sometimes understood and sometimes had the ability to understand others. The MDS indicated Resident #73 had adequate hearing, unclear speech, and adequate vision. The MDS indicated Resident #73 was unable to complete the BIMS assessment due to being rarely/never understood. The MDS indicated Resident #73 had short-and-long term memory problem and severely impaired cognitive skills for daily decision making. The MDS indicated Resident #73 was dependent for shower/bathe self, substantial assistance for eating and oral hygiene, and partial assistance for toileting hygiene, body dressing, putting on/off footwear, and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a care plan dated 07/05/23, revised on 04/02/24, indicated Resident #73 had a seizure which placed her at risk to have injuries during the episode. Resident #73 had the potential to have more seizures. An intervention included that the resident may have seizure safety helmet in place while out of bed for preventative measures/seizure precautions. During an observation on 04/09/24 at 7:50 a.m., Resident #73 was in her wheelchair on the hall A community room. Resident #73 was leaning sideways in her wheelchair with no seizure safety helmet in place. During an observation on 04/09/24 at 11:02 a.m., Resident #73 was in her wheelchair in the community room. She was then pushed into her room with no seizure safety helmet in place. During an interview on 04/10/24 at 1:52 p.m., CNA F said she worked prn, on all the halls. She said she had worked at the facility off and on for 6-7 years. CNA F said Resident #73 had seizures and was supposed to wear the seizure helmet when out of the bed. She said she felt liked Resident #73 should wear the helmet in bed too. She said honestly, Resident #73 should have the seizure helmet on all the time. She said the seizure helmet was in case she had a seizure. She stated it protected Resident #73's head. She said if Resident #73 did not wear her seizure helmet, she could hurt herself during a seizure. She said Resident #47 no longer followed commands, so she did not use the bar on the bed anymore. During an interview on 04/10/24 at 2:30 p.m., LVN G said Resident #73 was supposed to have on the seizure helmet when she was out of the bed. She said she felt like Resident #73 should have the helmet on all the time for seizure precaution. She said if Resident #73 did not have the seizure helmet on during an active seizure, she could injury her head. She said it was the CNAs and LVNs, but primarily the LVN's responsibility to ensure Resident #73 had the seizure helmet on when she was out of the bed. She said she did notice later in the afternoon on 04/09/24, Resident #73 was out of the bed without her helmet on. She said Resident #13 and Resident #47 had mobility rails. She said she knew if the rails were not to help with transferring, then it was considered a restraint. She said the facility did not have an assessment for transfer bars. She said the transfer bars should be care planned so it was clear what the rails were for. She said Resident #47 used the bar to transfer but after her recent hospital admission she had declined. She said Resident #13 used her transfer bar to transfer herself. During an interview on 04/10/24 at 3:37 p.m., the ADON D said Resident #73 should have had her seizure helmet on when out of the bed. She said the CNA should put the helmet on when they got her out of the bed. She said the LVNs should have made sure the CNAs placed the helmet on when she was out of the bed. She said it was important to follow the care plan intervention to keep the resident safe. She said Resident #13 and Resident #47 had mobility bars on their bed. She said Resident #13 and Resident #47 should have had a care plan problem for the mobility bars. She said nursing staff should have informed the MDS coordinator that the residents had mobility bars on their beds. She said it was important to have a care plan for the bars to know it was for mobility not a restraint. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/24 at 3:40 p.m., the DON said the mobility bars were usually care planned. She said the mobility bars were needed to help resident to turn. She said Resident #47 had good and bad days and assisted with turning on some days. She said Resident #47 still used the mobility bars when she was more alert. She said because the mobility bars were not care planned, staff, especially new staff, may not have known why they were needed and if the resident was safe to use them. She said Resident #73 was supposed to have the seizure helmet when she was out of the bed. She said the helmet was for seizure precaution intervention on the care plan. She said Resident #73 not wearing the seizure helmet when she fell on the floor during a seizure risked a head injury, contusion, and subdural hematoma. She said the CNAs and LVNs should have ensured Resident #73 had the seizure helmet on but ultimately it was the LVNs responsibility. During an interview on 04/10/24 at 4:00 p.m., the ADM said he expected staff to follow the resident's care plans. He said Resident #73 not wearing her seizure helmet placed her at risk for injury. He said all staff were responsible to ensure Resident #73 had the helmet on when out of bed. He said the mobility bars should have been care planned. He said the charge nurse and MDS coordinator were responsible for developing care plans with interventions. He said it was important to follow or develop a care plan because it was the resident's plan of care and set the tone of how care was going to be provided. Record review of a facility Care Plans, Comprehensive Person-Centered policy revised 12/16 indicated .a comprehensive, person centered care plan .meet the resident's physical, psychosocial and functional needs is developed and implemented .the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive .care plan for each resident .the comprehensive, person-centered care plan will .describe the services that are to be furnished .incorporate identified problem areas .aid in preventing or reducing decline in the resident's functional status .reflect currently recognized standards of practice for problems areas and conditions .the IDT must review and update the care plan .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45643 ased on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 5 of 20 residents (Resident #32, Resident #19, Resident #47, Resident #62, and Resident # 73) reviewed for quality of care. 1. The facility failed to keep Resident #32's smoking materials locked up at the nurse's station. Resident #32's cigarette and lighter was on his bedside table in his room. 2. The facility failed to ensure Resident #19, Resident #47, Resident #62, and Resident #73 did not have objects on top of their overhead light fixtures. These failures could place residents at risk for injury, harm, and impairment or death. Findings included: 1. Record review of Resident #32's Admission Record indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Polymyositis (an uncommon inflammatory disease that causes muscle weakness affecting both sides of your body), Hypokalemia (a lower-than-normal potassium level in your bloodstream), and Bacteremia (viable bacteria in the blood). Record review of Resident #32's Quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 13 which indicated he was cognitively intact. The MDS also revealed, Resident #32, required substantial assistance with transfer and ADLs. Record review of Resident #32's Care Plan revealed a problem initiated on 2/1/2024 for smoking. It stated Resident # 32 would be compliant with facility policies regarding smoking. Resident # 32 was care planned for leaving his smoking materials at the nurse's station and that he was unable to keep smoking materials in his bedroom. During an observation on 04/08/24 at 3:43 p.m., Resident #32 bedside table had a pack of cigarettes that was open. A cigarette lighter was observed inside the pack of cigarettes. Resident #32 was not in the room during the observation. Resident #32's roommate said that the cigarettes belonged to Resident #32. During an interview on 04/08/24 at 3:48 p.m., CNA A said she was supposed to lock up resident's smoking materials when they were finished smoking. She said Resident #32 had just finished smoking. She said his package of cigarettes and the lighter were in Resident #32's room. She said facility policy required residents to leave their smoking materials at the nurse's station. During an interview on 04/09/24 at 10:06 a.m., Resident #32 said he smoked cigarettes. He said he had left earlier to go to the doctor. He said he left his cigarettes in the room. He said sometimes he would go to the nurse's station to get cigarettes and sometimes he had them in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/09/24 at 11:00 a.m., The DON said she expected all residents to follow the facility's smoking policy and leave their smoking materials in the nurse's office. She said that facility staff should follow facility policies and ensure that residents did not have their smoking materials in their rooms. She said a risk of residents having their smoking materials in their room was that they could start a fire or harm themselves or others. During an interview on 04/09/24 at 11:15 a.m., The Administrator said he expected all residents follow the facility smoking policy which is to leave their smoking materials in the nurse's office. He said that facility staff should follow facility policy and ensure that resident's do not have their smoking materials in their rooms. He said that residents can be placed at risk for fire if a resident kept their smoking materials in their room. 2. During an observation on 04/08/24 at 9:38 a.m., Resident #73 was sitting up in her bed. Above Resident #73's bed, on the overhead light fixture was a stuffed animal. The overhead light fixture was on. Resident #62 was also sitting up in her bed. Above Resident #62's bed, on the overhead light fixture was a clear picture frame. The overhead light fixture was on. During an observation on 04/08/24 at 10:24 a.m., Resident #47 was lying down in her bed. Above Resident #47's bed, on the overhead light fixture, was a stuffed animal and picture frame. During an observation on 04/08/24 at 10:48 a.m., Resident #19 was sitting up in her bed. In Resident #19's room, the privacy curtain was draped over the on, overhead light fixture near the bedroom door. During an observation 04/08/24 at 12:43 p.m., Resident #73 was sitting up in her bed. Above Resident #73's bed, on the overhead light fixture, was a stuffed animal. The overhead light fixture was on. Resident #62 was also sitting up in her bed. Above Resident #62's bed, on the overhead light fixture was a clear picture frame. The overhead light fixture was on. During an observation on 04/09/24 at 7:50 a.m., Resident #47 was lying down in her bed. Above Resident #47's bed, on the overhead light fixture, was a stuffed animal and picture frame. During an interview on 04/10/24 at 1:52 p.m., CNA F said she worked prn, on all the halls. She said she had worked at the facility off and on for 6-7 years. She said she preferred things not be on the overhead light because pictures could fall. She said stuff animals on the overhead lights could be a fire hazard. She said sometimes family members visited and put things on the overhead light. She said having items on the overhead light could hurt the resident. During an interview on 04/10/24 at 2:30 p.m., LVN G said having items on the overhead lights was a safety hazard. She said she preferred items not be on the overhead lights. She said privacy curtains should not be draped on the overhead light either. She said she tried to keep Resident #73's stuff animals in her bed not on the overhead light. She said picture frames on the overhead lights could fall and hit a resident on the head. She said family did put things on the overhead light and she had to call family to let them know she took it down. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/24 at 3:27 p.m., ADON D said items should not be on the overhead light. She said things such as privacy curtains and stuffed animals could become flammable sitting on the overhead light. She said it was the unit managers and maintenance responsible to make sure items were not on the overhead light. During an interview on 04/10/24 at 3:40 p.m., the DON said stuffed animals, picture frames, and privacy curtains were not allowed on the overhead light. She said items on the overhead lights were a fire and safety hazards. She said picture frames could fall and cause injuries. She said all staff members were responsible to ensure items were not stored on top of the overhead light. She said staff members needed to be educated to take things off the overhead lights and family members not to place things on it. During an interview on 04/10/24 at 4:00 p.m., the ADM said items were not supposed to be stored on the overhead lights. He said items stored on the overhead light was a fire hazard. He said all staff were responsible to make sure things were not stored on top of the overhead lights. Record review of a facility policy revised on July 2017 entitled [Facility] Smoking Policy revealed, Provide maximum safety to all residents at all times. It is the intent of the facility to provide an environment to allow those residents who wish to smoke the opportunity to do so in a safe environment, with optimal safety themselves, other residents, volunteers, visitors, staff members and non-smokers . Residents will be informed of the written smoking policy prior or at the time of admission . Smoking materials will be kept in a designated area accessible to staff. Safe smokers will request these items from their nurse or staff member. At no time will residents be allowed to keep any smoking materials in their room. Record review of a facility's Fire Safety and Prevention policy revised on 05/11 indicated .all personnel must learn methods of fire prevention and must report condition(s) that could result in a potential fire hazard .fire prevention is the responsibility of all personnel, residents, visitors, and the general public . 44933

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 1 (Resident # 25) of 5 residents whose medications were reviewed for pharmacy services in that: 1. The facility failed to ensure Resident #25 had behavior monitoring for Haloperidol (a first-generation typical antipsychotic; is used to treat nervous, emotional, and mental conditions). 2.The facility failed to ensure Resident #25 had side effect monitoring for Haloperidol. 3. The facility failed to ensure Resident #25 had documented behaviors to justify administration of Haloperidol and effectiveness of administration. These failures could place residents at risk of possible medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Record review of a face sheet printed on 04/09/24 indicated Resident #25 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including senile degeneration of brain (the mental deterioration (loss of intellectual ability) that is associated with or the characteristics of old age), depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act), and anxiety disorder (feelings of fear, dread, and uneasiness). Record review of a Medicare Part A 5-day schedule MDS assessment dated [DATE] indicated Resident #25 was sometimes understood and sometimes had the ability to understand others. The MDS indicated Resident #25 had a BIMS score of 04 which indicated severe cognitive impairment. The MDS indicated Resident #25 did not have psychosis but had other behavioral symptoms not directed toward others. The MDS indicated Resident #25 was dependent on staff for toileting, hygiene, showering or bathing herself, required moderate assistance for oral hygiene, and supervision for eating. Record review of a care plan dated 04/05/24 indicated Resident #25 was at risk for the development of complications related to receiving psychotropic medications. Interventions included assess the reason to need the medication and reevaluate as needed, monitor, and document all behaviors, and observe for side effects and adverse reactions of medications. Record review of Resident #25's consolidated physician orders dated 04/08/24 indicated Haloperidol 5mg, give 1 tablet orally every 4 hours as needed for anxiety with agitation related to senile degeneration of brain for 14 days. The consolidated physician orders did not reveal an order for behavioral monitoring of Resident #25for signs and symptoms of anxiety or agitation or monitoring for sign and symptoms of antipsychotic side effects. (continued on next page)

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	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Manor Nursing & Rehabilitation Center	1007 S Washington Ave Marshall, TX 75670

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's MAR dated 04/01/24-04/30/24 indicated Haloperidol 5mg, give 1 tablet orally every 4 hours as needed for anxiety with agitation related to senile degeneration of brain for 14 days. The MAR indicated dose given 04/08/24 at 3:20 p.m. by RN E. The MAR did not reveal monitoring for signs and symptoms of anxiety or agitation or monitor for sign and symptoms of antipsychotic side effects. Record review of Resident #25's nurse's notes dated 04/01/24-04/10/24 did not reveal behaviors, non-pharmacological intervention used, or effectiveness of administration of Haloperidol 5mg on 04/08/24 at 3:20 p.m. During an interview on 04/10/24 at 2:20 p.m., RN E said she was assigned to Resident #25 on 04/08/24. She said on 04/08/24, Resident #25 was yelling out and about to fall in her room. She said she thought CNA F was with her when Resident #25 was acting out. She said Resident #25 attempted to fight her and CNA F. She said Resident #25 was combative which she had never acted like that. She said she may not have documented why she gave the prn Haloperidol and interventions she tried before administering the medication. She said she did not put Resident #25's prn administration on the 24-hour report either. She said she thought she told the unit manager of Resident #25's behavior and that she gave her prn Haloperidol. She said she was new to Unit A but believed she was supposed to document in a nurse's note why she gave it. She said it was important to document why a prn medication was given to know why it was given, intervention used before it was given, and keep track if the resident had adverse reaction. During an interview on 04/10/24 at 2:30 p.m., LVN G said the admission nurse was responsible to put orders in for behavior and side effects monitoring. She said when a prn medication was given nonpharmacological interventions should be done then medicate the resident. She said Resident #25 was placed on hospice services and was cold turkey some of her psychotropic medications. She said Resident #25 was refusing food and being combative. She said when residents had behaviors, she documented on a nurse's note only because the behavior was not continuous, and Resident #25 was able to redirect. She said when prn medication was given it was supposed to documented why it was given on a nurse's not, on the MAR, and TAR behavior monitoring. She said it was important to document behaviors and side effect monitoring to know if it was effective and observe for adverse reactions. During an interview on 04/10/24 at 3:27 p.m., ADON D said there was one staff member who input orders. She said she did not know if certain medications triggered behavior and side effect monitoring orders. She said nursing staff were supposed to monitor and document behavior and side effect monitoring ever shift. She said monitoring was important in case of adverse reaction and know why the medication was given. She said when prn medications were given, behavior monitoring should have been completed and nurse's note written. She said the nurse should have documented nonpharmacological interventions tried and if it was effective. She said it was important to know why the prn medication was given. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Manor Nursing & Rehabilitation Center	1007 S Washington Ave Marshall, TX 75670

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 3:40 p.m., the DON said certain medication needed behavior and side effect monitoring. She said the admitting nurse or the nurse who received the medication, should input behavior and side effect monitoring. She said nurse staff were supposed to monitor and document behavior and side effect monitoring ever shift. She said monitoring was important to monitor drug effectiveness, adverse reactions, and for prn medications to know if it helped. She said when prn medications were given, nurses should document behaviors, interventions, and whether the medication was effective. She said nurses should be documenting on the MAR, TAR, nurse's note, and 24-hour report. During an interview on 04/10/24 at 4:00 p.m., the ADM said behavior and side effect monitoring should be done for psychotropic medications. He said during chart audits and care plan meeting if orders did not have monitoring. He said he expected nursing to document behavior and intervention when prn medication was given. He said it was important because it was to track if the medication is needed and if it worked. Record review of a facility's Antipsychotic Medication Use policy revised 12/2016 indicated .antipsychotic medications may be considered for residents with dementia .the attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition .will identify, evaluate and document .symptoms that may warrant the use of antipsychotic medications .the staff will observe, document, and report to the attending physician information regarding effectiveness of any interventions, including antipsychotic medications .nursing staff shall monitor for and report any of the following side effects and adverse consequences .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 ased on observation, interview, and record review, the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #3, Resident #70) of 19 residents reviewed for infection control. The facility failed to ensure CNA F performed hand hygiene between going back and forth, several times, feeding Resident #3 and Resident #70 lunch on 04/08/24. This failure could place residents at risk for cross-contamination and the spread of infection. Findings included: 1. Record review of a face sheet printed 04/10/24 indicated Resident #3 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), muscle weakness, and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #3 was understood and understood others. The MDS indicated Resident #3 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS indicated Resident #3 had impairment on both sides of the upper and lower extremities with functional limitation in range of motion. The MDS indicated Resident #3 was dependent on staff for assistance with eating. Record review of a care plan dated 09/21/20, revised on 02/05/24, indicated Resident #3 had self-care deficit and needed assistance with all aspects of ADL. Resident #3 had dementia, late effects of cerebral palsy with intellectual disability and head trauma. Resident #3 had contractures and poor insight to care needs. Resident #3 needed care as well as feeding due to impaired mobility and had no use of upper extremities. Interventions included provide physical assistance with all meals and fluid intake. 2. Record review of a face sheet printed on 04/10/24 indicated Resident #70 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke), contracture (a fixed tightening of muscle, tendons, ligaments, or skin that prevents normal movement of the associated body part) of right hand, feeding difficulties, muscle weakness, and need for assistance with personal care. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #70 was usually understood and usually had the ability to understand others. The MDS indicated Resident #70 had adequate hearing, unclear speech, and moderately impaired vision with corrective lenses. The MDS indicated Resident #70 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #70 had impairment on both sides if the upper and lower extremities with functional limitation in range of motion. The MDS indicated Resident #70 required setup or clean-up assistance for eating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of care plan dated 06/21/22, revised 01/23/24, indicated Resident #70 had self-care deficit and needed assistance with all aspects of ADL. Resident #70 had late effects of CVA (stroke) with hemiplegia (a symptom that involves one-sided paralysis), essential tremors, contractures, and decreased vision with abnormal eye movement. Intervention included provide physical assistance with all meals and fluid intake. During an observation on 04/08/24 at 12:25 p.m., Resident #3 and Resident #70 were in the television room for lunch service. Resident #70 was sitting in a Broda (is a full-positioning chair used for people who need long-term assistance) chair and a plate with a metal plate boundary attached. Resident #70 was not feeding herself. CNA F was sitting down assisting Resident #3 with lunch. CNA F stopped feeding Resident #3, went to Resident #70's side and fed her a few bites without washing hands or using hand gel. CNA F left Resident #70's side and sat back down with Resident #3. CNA F restarted feeding Resident #3 without washing her hands or using hand gel. CNA F finished feeding Resident #3 then went back to Resident #70's side and restarted feeding her without hand gel or handwashing. During an interview on 04/10/24 at 1:52 p.m., CNA F said she worked prn, on all the halls. She said she had worked at the facility off and on for 6-7 years. CNA F said she worked Unit A on 04/08/24 and assisted Resident #3 and Resident #70 with lunch. She said she remembered feeding the residents but did not remember going in between Resident #3 and Resident #70 without washing her hands or using hand gel. She said if she did feed one resident then went to the next resident without proper handwashing it should not be done because of cleanliness. She said it was not good for infection control. During an interview on 04/10/24 at 2:30 p.m., LVN G said it was not okay for a CNA to assist two residents with eating at the same time without handwashing or hand gel in between interactions. She said that practice was not allowed, and CNAs knew not to do that. She said it was not allowed due to the potential for cross contamination. She said she worked that day but did not see CNA F go between the residents without proper hand hygiene. During an interview on 04/10/24 at 3:40 p.m., the DON said CNAs should feed one resident at a time. She said CNA F should have called for help to feed the other resident. She said feeding two residents was not allowed because of cross contamination. She said the other resident could have gotten sick or been given the wrong diet when staff fed residents at the same time. She said CNAs were aware they could not feed two residents without using hand gel or washing hands between assistance. During an interview on 04/10/24 at 4:00 p.m., the ADM said staff should hand gel between residents when assisting with meals. He said it was an infection control issue. Record review of a facility's Handwashing/Hand Hygiene policy revised 08/2015 indicated .the facility considers hand hygiene the primary means to prevent the spread of infections .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .use an alcohol-based hand rub .or alternatively soap and water for .before and after assisting a resident with meals .