

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/29/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide a safe, clean, sanitary, comfortable, and homelike environment for 3 of 22 resident rooms. (Residents # 56, #95, #103) 1. The facility failed to provide Resident #56 with intact window coverings with no broken/damaged areas. 2. The facility failed to provide Resident #95 with a safe toilet that had an appropriate lid on the tank of the toilet. 3. The facility failed to maintain a leaking air vent affecting Resident #103. These failures could place residents at risk of an unsafe, unsanitary, uncomfortable environment, embarrassment due to rooms not appearing homelike, and a decrease in quality of life and self-worth. Findings included: 1. Record review of Resident #56's undated face sheet revealed he was an [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #56 had diagnoses which included traumatic subdural hemorrhage (a serious condition where blood collects between the brain and its outer covering) and cerebral infarction (the death of brain tissue caused by a blocked blood vessel that cuts off blood flow, oxygen, and nutrients). Record review of Resident # 56's admission MDS assessment dated [DATE] indicated he was unable to make self-understood and understood others. Resident #56 had a BIMS score of 00 indicating severe cognitive impairment. Resident #56 required substantial assistance with toileting, bathing, and dressing lower body. Record review of Resident #56's care plan, revised on 7/17/2026 indicated Resident #56 had self-care performance deficits related to muscle weakness, unsteadiness on feet, lack of coordination, reduced mobility, and muscle wasting. During an observation on 07/27/2026 9:35 a.m., Resident #56's blinds were noted to have 2 slats with large missing gaps to the left bottom edge that let sunlight into the room hitting Resident #56 in the eyes. During an observation on 07/28/2029 at 10:00 a.m., Resident #56's blinds had tissue paper taped over the missing section of the blinds. During an observation on 07/29/2029 at 11:00 a.m., Resident #56's blinds continued to have tissue (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paper taped over the missing section of blinds. 2. Record review of Resident #103's undated face sheet revealed she was an [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #103 had diagnoses which included type II diabetes (a chronic condition that occurs when the body cannot properly use blood sugar, leading to high blood sugar levels), hypertensive heart and chronic kidney disease with heart failure (a complex, interrelated condition in which long-standing, uncontrolled high pressure damages both the heart and kidneys, leading to heart failure and chronic kidney disease). Record review of Resident # 103's quarterly MDS dated [DATE] indicated she was able to make self-understood and understood others. Resident #103 had a BIMS score of 11 indicating moderate cognitive impairment. Resident #103 required substantial assistance with toileting, bathing, and dressing lower body. The quarterly MDS indicated Resident #103 used a wheelchair. Record review of Resident #103's Care plan, revised on 6/17/2026 indicated Resident #103 had self-care performance deficits related to muscle weakness, unsteadiness on feet, lack of coordination, reduced mobility, and muscle wasting. During an observation and interview on 07/27/2026 at 9:20 a.m., Resident #103 stated her only concern about her stay at the facility was that her air conditioner vent leaked down the wall onto her sheets and it would leave a cold wet spot on her sheets. Several dark wet streaks were noted to be trailing down the wall from the air conditioner vent, and a dirty wet spot was noted to her sheets about mid-calf. She stated it was just not good housekeeping, and it made her uncomfortable to sleep in a cold wet bed. During an observation on 07/27/2026 at 2:10 p.m., revealed Resident #103 was in bed and a dinner plate sized wet spot was noted on her sheets mid-calf. Streaks of water were dripping down the wall onto her sheet from the A/C vent located near the ceiling on the wall parallel to Resident #103's bed. During an interview on 07/28/2026 at 10:12 a.m., CNA A stated many rooms had vents that leaked condensation from the air vent down the wall. She stated most people did not have their bed up against the wall like Resident #103'ss. She stated Resident #103 would let her know the bed was wet when she came in the room and she would get a new sheet when it happened. She stated maintenance knew about the condensation from the vents and he told her there was nothing that could be done to prevent condensation from forming when the air ran constantly because of the heat. Record review of the A wing maintenance log dated July 2026 revealed no requests for new blinds or a leaky air vent and no requests for Resident #56 or Resident #103. During an interview on 07/29/2026 at 11:40 a.m., the Maintenance Supervisor stated he had not been made aware of the missing blinds for Resident #56 nor the dripping A/C condensation for Resident #103. He stated he did walking rounds each day and looked in resident rooms for potential problems. He stated it had not been put on the maintenance request log. During an interview on 7/29/2026 at 12:52 p.m., the DON said she expected the staff to alert the (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had been that way for months. Record review of a Maintenance Request Log notebook at the nurse's station indicated maintenance request dated 06/25/26 &ndash; 07/29/26. There were no requests for the repair of Resident #95's toilet. During an interview on 07/29/26 at 10:38 a.m., CNA B said she had never noticed problems with Resident 95's toilet. She said he had never reported any issues to her. She said any time maintenance issues were noticed or reported they were supposed to enter the issue into maintenance book at the nurses' station or tell the nurse. She said then maintenance made the repairs. During an interview on 07/29/26 at 10:55 a.m., Housekeeper D said he was responsible for cleaning Resident 95's room. He said he had never noticed the toilet. He said the resident had not complained to him about the toilet. He said if he had noticed he would have reported it to his supervisor and verbally reported it to the Maintenance Supervisor. During an observation and interview on 07/29/2026 at 11:00 a.m., RN E said she had never noticed Resident #95's toilet. She said staff assisted him to the toilet. She said he had never reported the problems with the toilet to her. She said she needed to enter it into the maintenance request book that was kept at the nurse's station. She then wrote the repair request into the maintenance log. She said she thought Resident #95 would have reported the issue. She said it was important for the toilet to be stable at the base because it was a safety risk and increased the risk of accidents. During an interview on 07/29/26 at 12:51 p.m., the Maintenance Supervisor said he had been in Resident #95's room a few times over the last month to repair the filler valve that had kept running in the toilet. He said he had pulled the toilet two weeks ago and did not know it was not stable. He said he could tell the lid to that toilet did not fit the tank. He said Resident #95 had only told him that the toilet had been running but nothing else. He said staff should have noticed the lid. He said staff might have known the toilet was loose if they were helping him get on or off the toilet. He said work request should go into the maintenance log. He said he checked the maintenance logs several times a day. He said he also received work request through an app or verbally by residents. During an interview on 07/29/26 at 1:01 p.m., the DON said she felt like staff should have noticed the toilet in Resident #95's room and a repair request should have been placed in the maintenance book. She said he could have had a fall or be uncomfortable when he went to the restroom or it could have caused him not to go to the restroom and he could have become constipated. During an interview on 07/29/26 at 1:25 p.m., the Administrator said he would have expected staff to have noticed Resident #95's toilet even if he did not say anything to them. He said if he told someone it should have been put in the maintenance repair book. He said the toilet should have been bolted to the floor, or replaced, and the accurate lid placed on the tank. He said it was an opportunity for someone to get hurt. Record review of a facility policy titled Homelike Environment dated February 2021 indicated, .Residents are provided with a safe, clean, and comfortable and homelike environment and (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation.1. Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.a. clean, sanitary and orderly environment.b. comfortable, yet adequate lighting.c. inviting colors and décor.d. personalized furniture and room arrangements.e. clean bed and bath linens that are in good condition.3. The facility staff and management minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting.a. overhead paging.institutional odors.institutional signage.medication carts.chair and bed.4. Comfortable and adequate lighting is provided.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident's drug regimen was free from PRN orders for psychotropic drugs and are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days and documents their rationale in the resident's medical record and indicate the duration for the PRN for 1 of 6 residents reviewed for unnecessary psychotropic drugs (Resident #56). 1. The facility failed to ensure Resident #56 did not have a PRN order for lorazepam 0.5 mg (a prescription medication used to treat anxiety disorders-feelings of fear, dread, and uneasiness) after 14 days without an evaluation by the physician for continued treatment with a rationale in the resident's medical record and a duration for the PRN order. This failure could put residents at risk of possible psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Record review of Resident #56's undated face sheet revealed he was an [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #56 had diagnoses which included traumatic subdural hemorrhage (a serious condition where blood collects between the brain and its outer covering) and cerebral infarction (the death of brain tissue caused by a blocked blood vessel that cuts off blood flow, oxygen, and nutrients). Record review of Resident # 56's admission MDS assessment dated [DATE] indicated he was unable to make self-understood and understood others. Resident #56 had a BIMS score of 00 indicating severe cognitive impairment. Record review of Resident #56's Order Summary Report, dated 07/02/2026, reflected an order for lorazepam oral tablet 0.5mg, give 1 tablet every 4 hours as needed for anxiety. The start date was 07/02/2026. There was not an end date listed. During an interview on 07/29/2026 at 1:00 p.m., the DON stated Resident #56 was on hospice and he was using his Lorazepam frequently. She stated the Lorazepam order should have had a 14-day end date to be reevaluated and written for an extended period if needed. She stated she was unsure how it was overlooked. She stated it was the responsibility of the ADONs to review orders the day after they are written to ensure the validity of each order. She stated because Resident #56 used the Lorazepam there was no risk of harm to the resident. During an interview on 07/29/2026 at 1:30 p.m., the Administrator stated Resident #56's PRN lorazepam should have had an end date. He stated he did not know the risk of it not having an end date because he is not clinical. Record review of the Facility's policy, Medication and Treatment Orders, last revised July 2024, reflected: .Orders for medications and treatments should be consistent with principles of safe and effective order writing.c. PRN medications such as psychotropic medications ordered for 14 days should have a stop date and then the need to continue be evaluated by the physician to determine a continued need for scheduling the medication ongoing.		

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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** Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 12 residents (Resident #14) reviewed for respiratory care. The facility failed to change the oxygen tubing and water reservoir for Resident #14. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Findings included: Record review of Resident #14's face sheet, dated 3/16/24 revealed a [AGE] year-old female originally admitted on [DATE] and most recently re-admitted on [DATE] with diagnoses that included Chronic Obtrusive Pulmonary Disease (a long-term lung problem that makes it hard to breathe, featuring trouble catching your breath, a daily cough, and wheezing), Shortness of Breath, Nausea. Record review of Resident #14's quarterly MDS assessment, dated 06/2/26, revealed Resident #14 had a BIMS of 12, which indicated mild cognitive impairment. Revealed that Resident #14 could be understood and understood others. The MDS revealed that Resident #14 received oxygen therapy. Record review of an order for Resident #14 dated 6/19/2026 revealed that staff were to change oxygen tubing every night shift every Wednesday. Record review of Resident #14's care plan revealed a problem initiated on 6/2/2025 revealed that Resident #14 required the use of oxygen therapy. The care plan reflected that staff were to change Resident #14's oxygen tubing as per facility policy. During an observation on 7/27/26 at 10:01 a.m. it was observed that Resident #14's oxygen tubing was labeled and dated 7/20. The water reservoir was empty and dated 7/20. During an observation and interview on 7/28/26 at 10:32 a.m. it was observed that Resident #14 oxygen tubing was labeled and dated 7/20. The water reservoir was empty and dated 7/20. Resident #14 said that her nose was getting dry. She said that a nurse should come by and change it for her. She said she would push her call button and ask for a nurse as she was bothered by the dry air she was being provided. During an interview on 7/29/26 at 10:17 a.m. the Director of Nurses said that it was the responsibility of the night nurses to ensure that residents who used oxygen have their tubing replaced and the water reservoir replaced with new water. She said that residents who did not get their tubing and reservoir replaced as ordered were placed at risk of nose bleeds and respiratory infections. During an interview on 7/29/26 at 10:24 a.m. the Administrator said that he expected that nursing staff replace oxygen tubing and their water reservoirs as ordered. He said that residents could be placed at risk of respiratory infections and nose bleeds if their equipment is not properly maintained. Record review of a facility policy titled, Oxygen Administration dated October 2010 revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Periodically re-check water level in humidifying jar. The date and time that the procedure was performed.		

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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** Based on observations, interviews, and record review, the facility failed to ensure all drugs were stored in a locked compartment and only accessible by authorized personnel for 1 of 1 (Resident #71) residents reviewed for medication storage and 1 of 8 of medication carts. 1. The facility failed to ensure the medication cart on Hall C was locked while there were no staff around on 7/28/26. 2. The facility failed to keep medication being administered under the direct observation of the person administering medications. Resident #71 had in his possession a medication cup with an unknown red liquid in it. This failure could place residents at risk for health complications and not receiving the intended therapeutic benefit of their medication. Findings included: 1. During an observation on 7/28/26 at 12:30 PM of a medication cart on Hall C revealed there were no staff around the cart and the cart was unlocked. The unlocked cart was in the hallway close to the nurse's station with the drawers assessable to anyone came in contact with the cart. The drawers were opened by the surveyor; syringes, insulin and medications given by mouth were present. During an interview on 7/28/26 at 12:38 PM, LVN F stated she was responsible for the cart. She stated the cart was supposed to be locked. She stated the cart was her treatment cart. The nurse stated she let someone use her keys and they must have left the cart unlocked. During an interview on 7/29/26 at 9:22 AM, LVN F stated she let someone used her keys to use the bathroom yesterday. She stated that while the person was using the bathroom, she left her cart unlocked so she could continue working to do blood sugar and gave insulin, but she was called away from her cart and left it unlocked. She stated she had taken the bathroom key off the key ring that goes to the cart. She stated a risk was that anyone could walk up to the cart and get into the cart. During an interview on 7/29/26 at 9:30 AM, ADON K stated the nurse or medication aide utilizing the cart was responsible for ensuring the cart was locked. She stated the risk was a safety issue, and the cart was accessible to anyone that came in contact with the cart. During an interview on 7/29/26 at 1:06 PM, the Director of Nursing stated she expected all the carts to be locked when staff were not attentive to them. She stated the nurse or medication aide was responsible to ensure the carts were locked. She stated the risk was that a resident could get medication off the cart that could be harmful to them. During an interview on 7/29/26 at 1:13 PM, the Administrator stated he expected medication carts to be always locked unless staff were using them. He stated the nurse or medication was responsible for the med cart. He stated the risk was that anyone that went by could get into the cart. 2. Record review of Resident #71's face sheet, dated 10/2/13, indicated he was a [AGE] year-old male, admitted to the facility on [DATE], and readmitted most recently on 07/03/25. His diagnoses included Anemia (a common blood condition where your body lacks enough healthy red blood cells or hemoglobin to carry needed oxygen to your organs, leading to fatigue, weakness, and shortness of breath), Constipation (happens when you have fewer than three bowel movements a week, or pass hard, dry and painful stools), Dysphagia (trouble swallowing, including oropharyngeal and esophageal types, often caused by nerve damage, muscle weakness, or physical blockages). Record review of Resident #71's Annual MDS assessment, dated 06/30/26, indicated he had a BIMS score of 14, which indicated intact cognition. The MDS further indicated Resident #71 could be understood and could understand others. Record review of Resident #71's care plan indicated that a problem initiated on 03/16/2026 revealed that Resident #71 had very poor vision and eyesight and staff should provide a safe environment. During an observation on (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/27/26 at 9:28 a.m. revealed Resident #71 had a medication cup with an unknown red liquid in the cup. The cup was sitting on Resident #71's bedside dresser. Resident #71 was not in the room to be interviewed. During an interview on 7/29/26 at 10:13 a.m. the Director of Nurses said that the medication aide or nurse that administered medication was supposed to watch the resident to see if they took their medication. She said that if the resident did not want to take the medication then they could go back later and try to have the resident take the medication. She said that residents of the facility were put at risk because anyone could take the medication that was not stored. She said that whoever was passing medication was responsible to ensure it was taken before leaving the resident unsupervised. During an interview on 7/29/26 at 10:22 a.m. the Administrator said that it was the responsibility of the medication aide or nurse to ensure that residents that were given medications actually take the medication. He said that other residents could be put at risk if they took a medication that did not belong to them. Record review of a facility policy titled, Security of Medication Cart dated April 2007 revealed that the purpose of the policy was, The medication cart shall be secured during medication passes.4. Medications carts must be securely locked at all times when out of the nurse's view.5. When the medication cart is not being used, it must be locked and parked at the nurse's station or inside the medication room. Record review of a facility policy titled, Administering Medications dated December 2012 revealed that the purpose of the policy was to, Medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the medication administration record space provided for that drug and dose. The individual administering the medication must initial the resident's medication administration record on the appropriate line after giving each medication and before administering the next ones. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.		

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 25 resident personal refrigerators reviewed for food safety (Resident #71). The facility failed to ensure the refrigerator for Resident #71 did not contain [NAME] salami that was spoiled and out of date. This failure could place resident at risk for food borne illnesses. Findings include: Record review of a face sheet dated 07/29/26 indicated Resident #71 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, leading to problems with memory, planning, and judgment), diabetes, and cerebral infarction (the death of brain tissue caused by a blocked blood vessel that cuts off oxygen and blood flow). Record review of the MDS dated [DATE] indicated Resident #71 understood others and was understood. The MDS indicated Resident #71 was cognitively intact with a BIMS score of 14. The MDS indicated Resident #71 required setup or clean up assistance with eating. Record review of a care plan for Resident #71 dated 07/05/26 indicated he had impaired cognitive and impaired decision-making abilities due to history of a stroke with cognitive deficits. During an observation on 7/27/26 at 9:42 a.m. Resident #71 had a package of [NAME] Salami in his personal refrigerator. The expiration date was 05/10/26. The meat was greyish in color around the edges and had a large amount of sour smelling liquid in the container. During an observation and interview on 7/29/26 at 8:26 a.m. Resident #71 had a package of [NAME] Salami in his personal refrigerator. The expiration date was 05/10/26. The meat was greyish in color around the edges and had a large amount of sour smelling liquid in the container. Resident #71 was up in his wheelchair propelling around the room. He said he did not remember the last time staff had cleaned out his refrigerator. He said he did not know the salami was spoiled and he would have eaten it. During an interview on 07/29/26 at 10:38 a.m., CNA B said it was both housekeeping and the CNAs job to clean out residents' personal refrigerators. She said really, only the residents went in their refrigerators. She said they did not go in the residents' refrigerators unless they smelled something. During an interview on 07/29/26 at 10:51 a.m., Housekeeper C said housekeeping was responsible for cleaning out residents' personal refrigerators including expired foods. She said when the room was cleaned the refrigerators should be checked every day. She said she mainly just cleaned offices. She said whoever had been cleaning Resident #71's room should have removed the expired meat. During an interview on 07/29/26 at 11:00 a.m., RN E said housekeeping staff were responsible for removing expired food from resident's refrigerators. She said she had even removed expired food items from residents' refrigerators. She said she would have expected for the salami to have been removed from Resident #71's refrigerator when it expired. She said it was important for expired food items to be removed because they can grow mold, make people sick, and stink. During an interview on 07/29/26 at 1:01 p.m., the DON she said housekeeping was responsible for cleaning out Resident #71's refrigerator. She said he had refused before to let anyone clean his refrigerator. She said the temperatures should be checked daily and expired foods should be checked weekly. She said it was important to keep the residents' refrigerators cleaned out because residents could eat expired food and could get food poisoning. She said it was also important for hygiene. During an interview on 07/29/26 at 1:07 p.m., Resident #71 said he had never refused to have his refrigerator cleaned out. He said he did not want good food thrown out because there were too many starving children in the world, but if the food was expired and not any good, he did want staff to throw it out. During an interview on 07/29/26 at 1:25 p.m., the (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator said housekeeping had been overseeing cleaning out residents' refrigerators. He said it was the responsibility of all staff to ask the resident if they could look in their refrigerator and get out whatever was expired. He said it was important because if Resident #71 had eaten the salami, it may have made him really sick. Record review of a Food Receiving and Storage facility policy last revised on 07/2014, indicated, .Foods shall be received and stored in a manner that complies with safe food handling practices.Food Services, or other designated staff, will maintain clean food storage areas at all times.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 of 25 residents (Resident #31) reviewed for infection control practices. 1. The facility failed to ensure CNA G and CNA H donned (to put on) their gowns prior to providing catheter care for Resident #31, who was on enhanced barrier precautions, on 7/29/26. This failure could place residents at risk for cross contamination and the spread of infection. Findings include: Record review of Resident #31's face sheet dated 7/29/26 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #31 had diagnoses which included: benign prostate hyperplasia (a non-cancerous enlargement of the prostate gland that commonly affects older men) and infection following a procedure. Record review of Resident #31's MDS assessment, dated 5/6/26, reflected Resident #31 was understood and understood by others. Resident #31's BIMS score was a 13, which indicated cognition was intact. Resident #31 required moderate assistance with ADLs. Resident #31 had an indwelling catheter. Record review of Resident #31's care plan dated 4/29/26 reflected Resident #31 required the use of enhanced barrier precautions Resident #31 had an open wound which increases my risk of developing MDRO (multi drug restraint organism) infection. The interventions: EBP PPE required - Wear a gown and gloves for the following High-Contact. Resident Care Activities: dressing, bathing/showering, transferring (especially when anticipating close body contact), providing hygiene (e.g., brushing teeth, combing hair, shaving), changing linens, changing briefs or assisting with toileting. Device Care or Use (e.g., catheter, feeding tube, central line care), wound care (any skin opening requiring a dressing). Enhanced barrier precautions: Post signs outside of my room that state the required precautions and PPE that list activities that require gown and gloves. Ensure the appropriate PPE is available outside of my room. Provide an alcohol-based hand rub in my room and outside of my room when possible. Place a trash can for PPE disposal inside of my room and near the exit. Provide ongoing training for staff, residents, and visitors. Follow infection prevention practices (e.g. hand hygiene and PPE.) Record review of Resident #31's care plan dated 5/8/26 reflected Resident #31 had a Foley catheter due to obstructive uropathy. Resident #31 cannot void without the foley catheter with history of TURP (transurethral resection of the prostate) with perforated bladder. The interventions: provide foley catheter care every shift. Record review of Resident #31's care plan dated 5/8/26 reflected Resident #31 had a foley catheter due to obstructive uropathy. He cannot void without the foley catheter with a history of TURP (transurethral resection of the prostate) with perforated bladder Record review of Resident #31's order summary, dated 4/28/26 reflected Urinary Catheter- Care every shift related to benign prostatic hyperplasia with lower urinary tract symptoms. Record review of Resident #31's order summary reflected enhanced barrier precautions while providing personal care every shift for foley catheter, dated 6/18/26. During an observation on 7/13/26 at 10:07 AM, revealed CNA G and CNA H performed catheter care on Resident #31 and did not don a gown prior to performing catheter care. Resident #31 had an EBP sign on the room door and PPE in cart was outside the door. During an interview on 7/29/26 at 10:12 AM, CNA H stated they were supposed to wear the gowns during the catheter care. She stated each staff member was responsible for ensuring they wear the appropriate PPE. She stated the risk was cross contamination. During an interview on 7/29/26 at 10:14 AM, CNA G stated they should have worn a gown during the catheter care. She stated the staff were responsible for ensuring they wore the appropriate PPE. She (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the risk was cross contamination. During an interview on 7/29/26 at 10:15 AM LVN L stated the staff knew to wear the appropriate PPE with residents on EBP, because they had been educated on that. She stated they were just nervous. She stated the risks were cross contamination and the risk of spreading infections. During an interview on 7/29/2026 at 12:32 PM, ADON K stated she excepted for the staff to wear a gown during catheter care. She stated each staff member and the charge nurse were responsible for ensuring staff followed EBPs. She stated the risk was the spread of infection. During an interview on 7/29/26 at 1:06 PM, the Director of Nursing stated she excepted the staff to wear the appropriate PPE with a resident on EBP. She stated the charge nurse, The DON and herself were responsible for supervising the staff. She stated the risks were infection control and cross contamination. During an interview on 7/29/26 at 1:13 PM, the Administrator stated that he expected all staff to wear the appropriate PPE. He stated anyone responsible for going into the resident's room was responsible for what they need to wear. He stated the risk of not putting on the gown was cross contamination and infection control. Record review of the facility's policy and procedure Enhanced Barrier Precautions (EBP) undated, indicated Purpose: To reduce the transmission of multidrug-resistant organisms (MDROs) and other epidemiologically significant pathogens within the facility through the implementation of Enhanced Barrier Precautions (EBP) in accordance with current infection prevention and control practices. Policy: The facility will implement Enhanced Barrier Precautions for residents as indicated by current clinical guidance and infection prevention recommendations. Enhanced Barrier Precautions are intended to reduce the risk of pathogen transmission during resident care activities while promoting resident quality of life and participation in facility activities. The facility follows current guidance from the Centers for Disease Control and Prevention (CDC) and applicable federal and state regulations regarding infection prevention and control practices. Procedure: 1. Residents may be placed on Enhanced Barrier Precautions based on: The presence of specific multidrug-resistant organisms or other epidemiologically important pathogens, as identified by the Infection Preventionist, medical provider, or clinical team. The presence of wounds, medical devices, or other risk factors associated with increased transmission potential. Recommendations from public health authorities or current infection control guidance. 2. Staff shall: Perform hand hygiene before and after resident contact and after contact with the resident's environment. Utilize appropriate personal protective equipment (PPE) during high-contact resident care activities as indicated by facility protocols. Follow standard infection prevention practices at all times. Receive education regarding Enhanced Barrier Precautions and proper PPE use. 3. Residents on Enhanced Barrier Precautions may: Participate in communal dining, therapy, activities, and social interactions when clinically appropriate. Leave their room unless otherwise restricted for a specific infection control reason. 4. Signage and communication regarding Enhanced Barrier Precautions shall be utilized in accordance with facility procedures while maintaining resident privacy and dignity. 5. The Infection Preventionist or designee shall: Monitor implementation and compliance with Enhanced Barrier Precautions. Provide ongoing education and guidance to staff. Review infection prevention practices and update procedures as necessary based on current recommendations. Record review of the facility's policy and procedure Catheter Care, Urinary dated September 2014, indicated Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. 2. Assemble the equipment and supplies as needed. General Guidelines: 1. Following aseptic insertion of the urinary catheter, maintain a closed drainage system. 2. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered. Equipment and Supplies: The (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following equipment and supplies will be necessary when performing this procedure:6.Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents could call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 of 6 residents (Resident #42) reviewed for resident call system. The facility failed to ensure Resident #42 had a call light button functioning at bedside. This failure could place residents at risk of a delay in assistance and decreased quality of life, self-worth, and dignity. Findings include: Record review of Resident #42's face sheet, dated 7/28/26, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #42 had diagnoses which included: acute and chronic respiratory, non-pressure chronic ulcer, chronic obstructive pulmonary disease (an ongoing lung condition that limits airflow and makes it hard to breathe), pain, chest pain, repeated falls, cerebral infarction (a medical emergency that occurs when a blocked blood vessel stops blood and oxygen), shortness of breath and hemiplegia and hemiparesis following a cerebral infarction (nervous system conditions that affect one side of the body). Record review of Resident #42's comprehensive MDS assessment, dated 7/8/26, reflected Resident #42 was understood and understood by others. Resident #42's BIMS score was 12, which indicated moderate cognition impairment. Resident #42 was dependent on all ADLs. Resident #42 was occasionally incontinent to bowel and bladder. Record review of Resident #42's care plan, dated 7/20/26, reflected the potential to have falls related to my poor balance and posture. Resident #42 also receives multiple medications. The interventions included: encourage to use call light and to ask for assistance as needed. Keep call light and frequently used items in reach. During an observation and interview on 7/27/26 at 11:20 AM, revealed Resident #42 was sitting up in wheelchair watching television. Resident #42 stated he had one complaint; his call light did not work beside his bed. Resident #42's call light was the on floor. Resident #42 stated the call light had not worked since he had been in the room. He stated some of the staff knew the call light did not work. The Surveyor pushed the call light button on the resident's side of bed, and the call light did not work. Resident #42 stated he had no other concerns except for his call light did not work. Resident #42 stated the problem with the call light was when a staff member came into the room and did not know this call light did not work. During an observation and interview on 7/28/26 at 8:44 AM, revealed Resident #42 was lying in bed. Resident #42 stated the facility still had not fixed the call light, and it was not working. Resident #42 stated the staff pulled the other call light from the other side of the room to his side of the bed, so they were aware of the situation. During an observation on 7/28/26 at 10:24 AM revealed Resident #42's call light was not working at bedside. Record review of the maintenance request book on 7/29/26 at 9:15 AM at the nurses' station on Hall D revealed there was not an entry for room D2 (Resident #42) call light was not working. During an interview on 7/29/26 at 9:10 AM, CNA H stated the call light next to Resident #42's bed was not working, but the other call light worked from the other side of the room. She stated she was not sure if anyone had looked at the call light. She stated she knew the call light closest to Resident #42's bed did not work, so she attached the other call light to his bed. She stated she was not sure if the issue had been reported in the maintenance book. She stated the risk would be Resident #42 could not get help if needed it, due to his call light not working. During an interview on 7/29/26 at 9:17 AM, LVN L stated she was not aware of the Resident #42's call light not working close to his bed. She stated he had a call light, but she would put it into the maintenance logbook now. She stated she was responsible for putting in a report to maintenance about replacing a call light. She stated Resident #42 needed the call light (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accessible to have access to staff, it was necessity. During an interview on 7/29/26 at 9:30 AM, ADON K stated it seemed like there was something wrong with the call light close to Resident #42's bed, but staff used the other call light. She stated whoever discovered the call light was not working was responsible for putting the issue in the maintenance logbook. She stated the risks would be the resident falling, immobility or not having access to staff. During an interview on 7/29/26 at 9:45 AM, the Maintenance Supervisor stated he was not aware of the call light not working until staff contacted him today. He stated the issue was not in the Maintenance logbook prior to today. He stated he replaced the whole wall box for the call light. He stated the risk was if the resident needed to call for help and the light did not work. During an interview on 7/29/26 at 1:06 PM, the Director of Nursing stated she expected for all the residents to have access to their call light, and they were always functioning properly. She stated the charge nurse, and CNAs should be checking the call lights every shift. She stated the risks were a resident could have a fall, need pain medication and no access to staff. During an interview on 7/29/26 at 1:13 PM, the Administrator stated he expected all residents to have a call light accessible and functioning properly. He stated that anyone who realized the call light was not working should put it in the maintenance logbook and the Maintenance Supervisor should ensure the call light was functioning. He stated the risk was that the resident could not call for help. Record review of the facility's policy and procedure Answering the Call Light dated October 2010, indicated .The purpose of this procedure is to respond to the resident's requests and needs.6. Some residents may not be able to use their call light. Be sure you check these residents frequently.7. Report all defective call lights to the nurse supervisor promptly.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for 1 of 2 wings reviewed for the environment. The facility did not maintain an effective pest control program to ensure the B Wing was free of roaches and water bugs. This could place residents at risk for an unsanitary environment and a diminished quality of life. Findings include: During an interview and observation on 7/27/26 at 9:37 a.m. it was observed Resident #6's bathroom had a large roach approximately half an inch in size and several, approximately 5 to 8, small roaches on the floor. A large water bug approximately 2 inches long was observed entering a hole in the wall in the bathroom. Resident #6 said that it bothered him that there were bugs in his bathroom and they came into his room as well. He said he did not know if anyone did anything about it, but they had been there for a while. During an observation on 7/27/26 at 9:51 a.m. revealed Resident #29's bathroom several large cockroaches were observed going under the toilet and into loose wall trim in the bathroom. Resident #29 was not in the room to interview. During an interview on an undisclosed date and time with anonymous staff revealed that they knew there was a pest problem in B Wing. They said that they had not seen pest control in that part of the building for a while. She said that there have been a lot of roaches and other bugs in this section of the building for 6 months. During an interview on 7/29/26 at 10:17 a.m. the Director of Nurses said that their contracted pest control service needed to come more often and focus on that part of the building. She said that the risk to residents having pests in their bathroom and rooms was both resident hygiene and the potential for pests to get into their food. During an interview on 7/29/26 at 10:26 a.m. the Administrator said that it was the responsibility of maintenance to ensure that pests were not entering the building via damage to the walls and that pest control services should direct their attention to problem areas in the building. He said that pests could affect residents' health. During an interview on 7/29/26 at 12:54 p.m. the Maintenance Manager said that he saw insects occasionally in B Wing. He said that pest control came out once a month. He said he would focus on those rooms with pests and that section of the building. He said that he could caulk or fix the floor trim so the entry into the bathrooms was sealed. He said he did not put out pesticide and left it to the contracted pest control service to poison. Record review of a facility policy titled, Pest Control dated May 2008 revealed that, Our facility shall maintain an effective pest control program. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Maintenance services assist, when appropriate and necessary, in providing pest control services.		