

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2025
NAME OF PROVIDER OR SUPPLIER  Marshall Manor West		STREET ADDRESS, CITY, STATE, ZIP CODE 207 W Merritt St 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 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.  (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2025
NAME OF PROVIDER OR SUPPLIER  Marshall Manor West		STREET ADDRESS, CITY, STATE, ZIP CODE  207 W Merritt St Marshall, TX 75670	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the residents' practicable physical, mental, and psychosocial well-being for 1 (Resident #2) of 10 residents reviewed for care plans. The facility failed to implement a person-centered fall prevention care plan with interventions for Resident #2 to meet medical, nursing, mental and psychosocial needs. The facility failed to implement added interventions of providing a therapy evaluation, failed to drop the seat of his wheelchair, and failed to add non-skid material to wheelchair after fall resulting in fracture. These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Record review of an undated face sheet revealed Resident #2 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of traumatic subarachnoid hemorrhage (a type of brain injury where bleeding occurs in the space between the brain and the thin membrane covering it), hemiplegia (paralysis of one side of the body), and convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders). Record review of an admission MDS assessment dated [DATE] revealed Resident #2 had a BIMS of 12 which indicated a mild cognitive impairment. Resident #2 required partial to moderate assistance with ADLs such as toileting, transfer, and bathing. Resident #2 had 1 fall with major injury, had a seizure disorder, and had verbal and other behaviors 4 to 6 days per week. Record review of a care plan conference worksheet dated 10/02/2025 revealed a care plan conference was held with Resident #2 and his family members along with the DON, ADON, Administrator and Social Worker to discuss Resident #2's recent fall. The worksheet revealed interventions agreed upon by the family for therapy to evaluate Resident #2's wheelchair to drop the seat. Record review of a care plan dated 10/03/2025 titled History of Falls with major injury stated Resident #2 leaned forward to lock his wheelchair and fell out of his wheelchair. His interventions were listed as therapy evaluation for a restorative program, non-skid material to seat, and x ray of bilateral hips related to complaint of pain. Facility failed to follow interventions of therapy evaluation, and non-skid material to seat of wheelchair. During an interview on 10/20/2025 at 10:00 a.m., Family Member #1 of Resident #2 stated they attended a care plan meeting on 10/02/2025 after a fall that caused a fractured hip. She stated they discussed therapy evaluating Resident #2 for safety and to drop his seat. Family Member #1 stated therapy never evaluated Resident #2 even after they confirmed his hip fracture, he had surgery and returned to the facility, nor did they drop his seat to increase his safety. Family Member #1 stated that put Resident #2 at risk for a repeat fall with a surgically repaired fracture. During an interview on 10/20/2025 at 11:00 a.m., LVN C stated she was the nurse for Resident #2 when he fell. She stated Resident #2 was in his wheelchair and reached forward, locking his brakes and slid in slow motion to the floor. She stated she was surprised he had a fracture from the fall because it was a slow soft fall. LVN C stated the interventions were for Resident 2 to be evaluated by therapy, Resident #2's wheelchair seat was to be dropped to prevent him from sliding out when locking his brake. LVN C stated Resident #2 was to have nonskid material in his seat as well. LVN C stated she was told therapy could not evaluate him because of his payer source. LVN C stated she never saw Resident #2 in a wheelchair with a drop seat or nonskid material in his chair. During an interview on 10/22/2025 at 10:00 a.m., the MDS Coordinator stated it was the job of the DON and herself to update all care plans. She stated she was unsure how she missed adding the care plan interventions for a therapy evaluation and a dropped seat for safety. She stated she was also uncertain why the intervention of nonskid material to the chair was not carried out. She stated it was the job of the entire facility to read the care plans and carry out the interventions. During an interview on 10/22/2025 at 11:00 a.m., the DON stated Resident #2 was private pay and had no funding for therapy services. She stated a restorative nursing plan was written for Resident #2. She stated it was initiated 10/13/2025 when he returned from the hospital where he had surgery on his hip. She stated therapy had to evaluate him and drop his seat if it was a safe intervention and they would have provided the nonskid material to put in his chair, but because he was not evaluated before he went to the hospital on [DATE], he had not gotten the nonskid material. She stated not following interventions decided on during the care plan meeting could have resulted in further injury to the residents from another fall. During an interview on 10/22/2025 at 11:30 a.m., the Administrator stated it was important to follow interventions decided on by the IDT (interdisciplinary team)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2025
NAME OF PROVIDER OR SUPPLIER  Marshall Manor West		STREET ADDRESS, CITY, STATE, ZIP CODE 207 W Merritt St Marshall, TX 75670	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2025
NAME OF PROVIDER OR SUPPLIER  Marshall Manor West		STREET ADDRESS, CITY, STATE, ZIP CODE  207 W Merritt St Marshall, TX 75670	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 3 residents reviewed for transfers. (Residents #1)The facility failed to keep Resident #1 free from injury after he was improperly transferred by CNA A on 10/19/25 causing extensive bruising to his chest and multiple rib fractures.This failure resulted in the identification of an Immediate Jeopardy (IJ) on 10/21/25 at 11:35 a.m. While the IJ was removed on 10/22/25 at 11:30 a.m., the facility remained out of compliance at a scope of isolated and a severity level of actual harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.This failure could place residents at risk of injury from accident and hazards.Record review of the face sheet dated 10/20/25 revealed Resident #1 was a [AGE] year-old male. Resident #1 was initially admitted on [DATE] with diagnoses including dementia, abnormalities of gait and mobility, and assistance with personal care. Record review of the quarterly MDS assessment dated [DATE] revealed Resident #1 was usually understood and sometimes understood others. The MDS indicated a BIMS was not conducted due to Resident #1 being rarely to never understood. The MDS indicated Resident #1 required moderate assistance with chair/bed-to-chair transfers. Record review of the care plan last revised on 08/25/25 indicated Resident #1 had a poor transfer status related to age, diminished strength, diminished sensation, and problems with vision and/or hearing. The care plan indicated an intervention dated 06/11/25 for Resident #1 to be transferred with a mechanical lift and 2-person assistance. Record review of a Nurses Note for Resident #1 dated 10/19/25 at 11:00 p.m. by LVN B indicated, .Res (Resident #1) noted (with) large swollen and bruised are to (left upper) chest area and bruising mid chest area. (Resident #1) also has discoloration to (left upper) area. (Skin tear) to (right) arm with transparent dressing. Record review of a Nurses Note for Resident #1 dated 10/20/25 at 4:30 a.m. by LVN B indicated, Area to mid chest more darker area, larger than when first found. Record review of an Emergency Medicine Note dated 10/20/25 at 11:35 a.m. indicated, (Resident #1).presented to the Emergency Department with chest bruising.he has chest swelling and bruising, which he seems to attribute to being picked up by a 300 pound guy. The time of onset is uncertain but he states he was picked up yesterday; he experiences pain only when pressure is applied to the area. No history of falling is reported.He denies any acute fall or trauma. The author of the note was the Emergency Department Physician. Record review of an ED (emergency department) Note indicated, .Family called, to update, family stated (Resident #1) been telling her they pick him up and it hurts. The note was signed by the emergency room RN. Record review of Intake Report Child Protective Service dated 10/20/25 at 12:21 p.m. indicated, .(Resident #1) is unable to walk or transfer independently.On 10/20/25 (Resident #1) was brought to the ER (emergency department) from the nursing home for bruising to his chest wall. (Resident #1) was found to have bruising all throughout his upper chest extending across both shoulders. The bruising was black, purple, and yell in coloration and appeared to be in multiple stages of healing and associated swelling throughout. (Resident #1) denied any recent falls or trauma and was echoed by the nursing home. When (Resident #1) was alone, he stated that there is a man at the facility that is 300 pounds who regularly picks him up incorrectly. (Resident #1) stated that the man will pick him up by his body under his arms despite (Resident #1) having a hoier lift that should be used. (Resident #1) stated that he frequently tells this person being picked up that way hurts, but that his complaints are ignored. It is uncertain if there is only one person lifting (Resident #1) incorrectly as his memory is not always accurate., and information that he's shared with family in the past about the man who lift him incorrectly has not lined up with that person's schedule or presence at the facility. The reporter was the hospital emergency department Health Unit Assistant. Record review of CT Chest results dated 10/20/25 at 12:43 p.m. for Resident #1 indicated, .Left 11 and 12 posterior (back of the body) lateral (side, away from the middle of the body) rib fractures may be recent or subacute (recent onset). Right 10th and 11th lateral rib fractures appear recent/subacute. Old sternal fracture.Impression: Left 11 and 12 rib and right 10th and 11th rib fractures appear recent/subacute.Record review of hospital records dated 10/20/25 indicated, .Primary Diagnosis.Contusion (bruising) of chest wall. There was a note that indicated, . Please take caution when helping patient transfer. The note was signed by the Emergency Department Physician on 10/20/25 at 1:39 p.m. There was a photograph of Resident #1 included in the hospital records. The photograph showed extensive dark bruising to the left and right upper chest and a dark bruise to the left</p>		