

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/04/2026
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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the appropriate care and services to prevent urinary tract infections to the extent possible for 1 of 2 residents reviewed for indwelling catheters. (Resident #9) -Resident #9 had a urinalysis specimen obtained on 01/30/26 due to complaint of discomfort from lower abdomen to his penis and cloudy urine. The facility staff did not follow up on obtaining results and Resident #9 continued with signs of a possible UTI. This failure could place residents at risk of not receiving the required level of care and possible sepsis. Findings included:Record review of a face sheet dated 02/04/26 indicated Resident #9 was a [AGE] year-old male admitted on [DATE]. His diagnoses included multiple sclerosis (a chronic condition where the immune system mistakenly attacks the protective covering of nerve cells), urinary retention (when the bladder (where urine is stored) doesn't empty when a person pees), urogenital implants (a medical device that is surgically placed within the male's penis to treat various conditions), neuromuscular dysfunction of bladder (when an injury or disease interrupts the electrical signals between the nerves that control bladder function), benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland), and history of urinary tract infections (an infection in the kidneys, ureters, bladder, or urethra). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #9 had moderately impaired cognition and he had an indwelling catheter. Record review of a care plan revised on 11/13/25 indicated Resident #9 had an indwelling foley catheter and was at risk for frequent UTIs, dislodgement, or other complications. Interventions included monitor for and report foul smelling, turbid urine, low-grade temp, blood in tubing or drainage bag, urine is no longer straw colored, etc.; monitor for and report inflammation or signs of infection in the area around the catheter. Signs of infection include pus or irritated, swollen, red, or tender skin; and monitor for and report to MD pain or cramps for a prolonged period, urine stops for 2 or 3 hours, bloody urine, urine that is cloudy, irritation around the abdominal opening, signs of infection such as fever or chills, an unusual, strong smelling discharge, urinary spasms, which cause sharp pains in the lower abdomen. Record review of Nurse Notes for Resident #9 indicated the following entries:* on 01/29/26 at 04:00 p.m., he reported pain radiating from the lower abdomen/stomach down to his penis; and* on 01/30/26 at 09:20 a.m., he allowed the nurse to assess his lower abdomen which was slightly distended and he complained of pain when touched. His catheter tubing had cloudy urine sediment. Hospice was contacted and an order was received for urinalysis with culture and sensitivity for complaint of lower abdominal pain. Hospice indicated they would have their laboratory to run the urine test. Record review of a Physician's Telephone Orders form indicated Resident #9 had an order dated 01/30/26 for UA /c C&S c/o lower abdominal pain. Record review of Nurse Notes for Resident #9 indicated the following entries:* on 01/30/26 at 10:30 a.m., the urine sample was collected from Resident #9 and placed in the refrigerator for pick up; * on 01/30/26 at 02:30 p.m., his catheter had amber colored urine flowing into the drainage bag; * on 01/31/26 at 12:30 a.m., there was no documentation of laboratory results received;* on 01/31/26 at 01:00 p.m., his catheter had dark colored urine and there was no documentation of laboratory results received;* on 01/31/26 at 03:15 p.m., his catheter had cloudy (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 02/04/2026
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 0690 Level of Harm - Actual harm Residents Affected - Few	urine and there was no documentation of laboratory results received;* on 02/01/26 at 10:00 a.m., hospice nurse was contacted because Resident was complaining of abdominal pain; urine to catheter drainage bag thick, appeared mucous tinged, and copious; he complained of being cold with temperature assessed at 97.8 degrees; and there was no documentation of laboratory results received;* on 02/01/26 at 11:20 a.m., hospice nurse was at the facility, spoke with Resident family member and family member said abdominal pain from upcoming gallbladder surgery; hospice nurse notified MD about the Resident's upcoming surgery; there was no documentation of resident urine being assessed and addressed; and there was no documentation of laboratory results received;* on 02/01/26 at 06:00 p.m., his catheter had cloudy urine in the tubing and there was no documentation of laboratory results received;* on 02/02/26 at 09:00 a.m., urine to catheter tubing noted thick and yellow and there was no documentation of laboratory results received; and * on 02/02/26 at 11:00 a.m., hospice nurse at facility, no new orders, and awaiting C&S. There was no indication any initial laboratory results were received. During an observation on 02/02/26 at 11:02 a.m. Resident #9 was resting in bed. He had a catheter bag on the right side of the bed. There was thick yellow/white colored mucous appearing urine noted in catheter bag tubing. During an observation and interview on 02/03/2026 at 10:59 a.m. Resident #9 had urine in his catheter bag tubing with thick, turbulent, yellow colored sediment, with dark amber streaks. The Tx Nurse said the urine in the catheter tubing did look bad like he may have an infection. She said there was a specimen obtained for urinalysis on Friday (01/30/26) but did not know if the results were back yet. During an interview on 02/03/2026 at 11:10 a.m. LVN D said Resident #9 had an order for a UA with C&S on 01/30/26 and the specimen was obtained. She said hospice had sent the same day. She had not received anything back yet on Resident #9's urinalysis. She said she had not followed up with the hospice nurse on the results at this time. During an interview on 02/03/2026 at 02:45 p.m. the DON said they received the order for the urinalysis on Friday (01/30/26), the specimen was obtained, and hospice picked up the specimen to send to their lab. She said they had to send the specimen off to their lab who just received the specimen today (02/03/26). She said she had not followed up on the specimen report as well as the charge nurses. She said because of the delay they had received a stat (fast, quickly, immediately) order today (02/03/26) to obtain the specimen and to send to their lab so they would have a result tonight. She said a delay in getting lab results could be a delay of treatment. She said this could result in the resident's infection progressing into sepsis (a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) and could possibly cause death. Record review of a Physician's Telephone Orders form indicated Resident #9 had an order dated 02/03/26 for UA /c Reflex to PCR. During an interview on 02/03/26 at 03:22 p.m. the IP said she was not aware Resident #9 had not had the results of the urine specimen returned. She said she had not followed up with the CN, the hospice nurse, or the laboratory about the results. She said she was to follow up when residents had suspected infections or infections. She said an untreated urinary infection could lead to sepsis. During an interview and record review on 02/03/2026 at 5:15 p.m. the DON provided a lab result dated 02/03/26. The results indicated Resident #9 was positive for leukocyte esterase (an enzyme produced by white blood cells-presence usually means infection), nitrites (usually indicate a bacterial urinary tract infection), or catalase (it did not specify which one) and positive for catalase bacteria screen (an enzyme that can be detected in urinary tract infections). She said they should be getting the remaining results this evening or tomorrow and would provide to surveyor. She said the physician did not want to place the resident on any antibiotic at this time. Record review of a laboratory result dated 02/03/26 indicated Resident #9's urine was dark yellow colored (should be clear, yellowed colored), 3+ blood (normal level would be negative), 2+ protein (normal level would be negative), 3+ leukocyte esterase (normal level would be negative, and positive for catalase bacteria screen (normal level would be negative). Record review of the Antibiotic Stewardship - Staff and Clinician Training and Roles policy dated Policy Statement: The facility will educate and train staff and practitioners about the facility Antibiotic Stewardship Program, including (continued on next page)		

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 02/04/2026
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 0690 Level of Harm - Actual harm Residents Affected - Few	appropriate prescribing, monitoring, and surveillance of antibiotic use and outcomes. Policy Interpretation and Implementation:Nursing and Direct Care Licensed Staff:1. Nurses will receive initial orientation and ongoing training on: . c. How to utilize the standardized assessment and communication tool for residents suspected of having an infection;.f. Specific information that should be reported to the physician or provider upon identifying signs and symptoms of possible infection;. Record review of the facility's undated Urinary Tract Infection Protocol indicated the following: When a resident is suspected of having a urinary tract infection or Physician has requested an order for urinalysis the Charge Nurse must take the following steps.1. If resident is continent of urine request a clean catch urine specimen; if resident is continent but has some cognitive deficit the Charge Nurse must assist in obtaining urine specimen.2. If resident is incontinent request order for in and out cath.3. Store urine on ice or in specimen refrigerator until urine is collected by the lab; because most lab draws are collected in the early am, 10/6 shift is responsible for collecting urine specimens.I. Symptomatic urinary tract infection One of the following criteria must be met:.2. The resident has an indwelling catheter and has at least two of the following signs or symptoms:(a) fever (38 CJ or chills,(b) new flank or suprapubic pain or tenderness,(c) change in character of urine, (d) worsening of mental or functional status.II. When there is a patient history of urinary infection within the past three weeks and where there may be a relapse from the previous urinary infection and / or antibiotic resistance. The facility had not received the final laboratory results prior to the survey team exiting the facility.		

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 02/04/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation in that: The facility failed to ensure the fryer was clean and free of debris. The facility failed to ensure baking sheets did not have brown and black colored buildup and debris of particles on the outside. The facility did not ensure skillets did not have brown and black colored buildup on the inside and outside. The facility failed to ensure a pack of cigarettes, and a fly swatter was not stored under the cutting boards touching the oven mittens. The facility failed to maintain cleanliness of the floor in the kitchen prep area. The facility failed to ensure dietary staff had all their hair in the hair restraints. The facility failed to ensure the Maintenance Supervisor wore a beard restraint while in the kitchen. The facility failed to ensure the dishwasher had an internal temperature starting at 80 degrees Fahrenheit then ended at 110 degrees Fahrenheit after 3 attempts on 02/02/2026 at 8:45 a.m. These failures could place residents at risk of foodborne illnesses. Findings include: During an observation and initial tour of the kitchen on 02/02/2026 at 8:45 a.m. - the fryer had thick layers of brown and yellow colored crusted debris along the outside of the fryer. The fryer had black and brown debris above the frying baskets.- 13 baking sheets had brown and black colored buildup and debris particles on the outside on the outside.- 4 skillets had brown and black colored buildup and debris particles on the outside on the outside.- one pack of cigarettes and a fly swatter were stored on the kitchen prep table under 4 cutting boards touching 2 oven mittens.- there was brown colored debris on the floor throughout the kitchen prep area, under the refrigerator, freezers and pan/pot storage.- Dietary aide B, Dietary C, and [NAME] D had loose hair hanging from the front and back of the hair restraint during meal preparation. During an initial tour observation and interview on 02/02/2026 at 8:45 a.m. the dishwasher had an internal temperature started at 80 degrees Fahrenheit and ended at 110 degrees Fahrenheit after 3 attempts. During an interview on 02/02/2026 at 9:00 a.m. with the DM she said the dishwasher's temperature must be at the manufacturer's recommendation of 120 degrees for the dishes to be sanitized. She said the chemicals they use to sanitize the dishes require the water in the dishwasher to be at a minimum of 120 degrees. She said the potential risk was cross contamination. During an observation and follow-up kitchen tour on 02/02/2026 at 10:00 a.m., the Maintenance Supervisor entered the kitchen without a beard restraint while assessing kitchen equipment. During an interview with the Maintenance Supervisor on 02/02/2026 at 10:05 a.m., the Maintenance Supervisor said he should have worn a beard restraint while in the kitchen. He said he was in a rush to look the refrigerator and forgot. He said wearing an beard restraint would ensure hair did not fall into the food. During an interview with the DM on 02/02/2026 at 11:00 a.m. she said all staff were responsible for cleaning the kitchen and she expected the kitchen to be cleaned after each meal service at a minimum. She said the fryer should not have built- up food particles on it. She said all baking sheets, pots, and skillets should be free of debris, grease and buildup to avoid potential risk of cross contamination. She said she could not recall the last time it was cleaned. The DM said cigarettes should never be stored in the kitchen prep area. She said the cigarettes were from an employee. She said the fly swatter should not be stored under the cutting boards touching the oven mittens. She said she was not aware that the cigarettes nor fly swatters were under the cutting boards. The DM said all employees have been educated on wearing hair restraints and beard restraints for facial hair while in the kitchen to avoid hair potentially getting in the food. She said the new hair nets the facility order rising from their heads, making it easier for hair to escape. She said she would have to ensure staff readjust nets as needed. She said she expected staff to follow policy and procedure while in the kitchen and while handling food. During an interview with [NAME] A on 02/02/2026 at 11:35 a.m. she said the fryer should be cleaned after use and could not recall the last time it was cleaned. [NAME] A said she could not recall how long the (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/04/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	fryer had the debris on it nor how long the baking sheets/ skillets had built up on it. She said all kitchen staff were responsible for ensuring all kitchen cooking equipment was cleaned after use to prevent the potential of cross contamination. During an interview with the Administrator on 02/02/2026 at 11:45 a.m. he said he expected the kitchen to be clean and free of debris. He said the pans and skillets should be free of buildup to prevent the potential transfer to the food. He said personal items should not be stored in the kitchen prep area. He said hair should be restrained while in the kitchen, including facial hair to prevent hair from getting into the food. The Administrator said the manufacturer's instructions for the dishwasher's temperature should be followed to ensure the dishes are being sanitized correctly. The administrator said if dishes were not washed at 120 degrees, the residents can potentially be harmed by cross contamination. Record review of the manufacturer's recommendation. It says for water temperature to be at a minimum of 120 degrees for the dishes to be sanitized. Record Review of the facility policy titled: Sanitization dated: October 2008 indicated in part: Policy StatementThe food service area shall be maintained in a clean and sanitary manner.Policy Interpretation and ImplementationAll kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corruptions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. Record review of the facilitys policy titled Sanitization revision dated October 2008 indicated in part: Policy Statement: The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions.Dishwashing machines must be operated using the following specifications:High-Temperature Dishwasher (Heat Sanitization)Wash temperature (150 - 165 F) for at least forty-five (45) seconds;Rinse temperature (165 - 180 F) for at least twelve (12) seconds. Low-Temperature Dishwasher (Chemical Sanitization)Wash temperature (120 F);Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds		

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 02/04/2026
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that facility was free of pests and rodents for 1 of 1 kitchen. The facility did not maintain an effective pest control program to ensure the facility was free of roaches in the kitchen. This failure could place residents at risk for an unsanitary environment and a decreased quality of life. The findings included: During an observation of the facility's kitchen on 02/02/2026 at 11:16 a.m., During lunch meal prep there was approximately one dime size light brown roach crawling from the stove area to where pan sheets were stored in the kitchen. During an observation on 02/03/2026 at 11:00 a.m. there was approximately a half quarter inch roach crawling on the shelf above where food was being pureed. The DM grabbed the roach with a napkin and discarded it. During an interview on 02/03/2026 at 12:05 p.m. with the DM she said they had a roach issue in the past. She said the roach issue had gotten better. She said they had regular pest control that would come to the facility regularly to address general pests and insects. The DM said having roaches in the kitchen potentially could get resident's sick. She said food was covered to ensure food was safe. During an interview on 02/03/2026 at 3:00 p.m. with the Administrator he said he had pest control come out routinely, every 2 weeks and as needed. He said cross contamination would be the potential risk associated with roaches in the kitchen. He said it was all staff's responsibility to notify him if pests or insects were seen so he could call the pest control to come and spray outside the scheduled visits. Record review of the facility's pest control records for 2026 indicated the pest control company visited the facility every two weeks and had last visited the facility on 01/05/2026 to treat pests and insects. The kitchen was last treated for general pests on 01/05/2026. On the report it stated Treated and inspected A wing and kitchen for general pests. No issues at this time. Record review of the facility policy tilted: Sanitization revision date: October 2008 indicated in- part Policy StatementThe food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and ImplementationAll kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.		

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 02/04/2026
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 10 residents (Resident #42) reviewed for care plans. The facility failed to complete a comprehensive care plan for Resident #42's diet preferences on 12/19/2025 for Resident #42 when she was initially assessed by the Dietitian. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings included: Record review of Resident #42's face sheet dated 02/02/2026 indicated a [AGE] year-old female that was admitted to the facility on [DATE] with diagnosis: myocardial infarction (heart attack), generalized muscle weakness and lack of coordination, depression, heart failure. Record review of Resident #42's Quarterly MDS assessment dated reflected she had a BIMS score of 15 indicating her cognition was intact. Record review of Resident #42's care plan revised 01/15/2026 indicated there was no diet listed nor a vegetarian preference listed. Resident #42's food allergies were listed as, Chamomile, Chocolate, Eggplant, Potato, Lanolin, [NAME] oil, and lemon flavoring. Record review of Resident #42's Order summary dated 02/04/2026 indicated a regular diet with regular texture and thin consistency. The order summary listed her diet as Cardiac that was ordered since 12/08/2025. Record review of Resident #42's social service progress note dated 12/29/2025 indicated Resident #42's family member made a complaint that resident's dietary restrictions/ wishes are not being honored. Her specific diet is not complete or nutritious enough. Record review on 02/04/2026 of Resident #42's list of foods she likes, dislikes, and is allergic to.-Grilled cheese-Vanilla pudding-Butterscotch pudding-Sweet potatoes-Squash-Onions-Broccoli- Salad-Ranch dressing-Beans-Rice-Cornbread-Cheetos-Apples-Peaches-Peanut butter crackers-Eggs-Grits-Toast-Biscuits-Tuna-Salmon-Impossible burgers-Mac n cheese-Black beans- No meat-No potatoes-No chocolate-No rosemary-No tomatoesPlease pick multiple for meals- Written and signed by DM. Record review of Resident #42's dietician initial assessment progress notes dated 12/19/2025 indicated Resident #42 had a diet of vegetarian. The Dietician wrote The resident is vegetarian, and DM has a detailed list of likes/ dislikes and food intolerances and continue diet/ POC. During an interview on 02/03/2026 at 4:30 p.m. with the Administrator, he said the care plan should include Resident #42's diet preferences. He said they couldn't meet every preference but could make reasonable accommodations. He said her diet preferences were more of a presbyterian diet because she ate tuna and salmon. He said Resident #42's food preferences not care planned could lead to her being happy. During an interview on 02/03/2026 at 6:00 p.m. with the DON, she said the facility included residents' food/diets preferences on the care plan. She said Resident #42's care plan should have had her preferences listed. She said the nurses and herself were responsible for updating the care plans. She said Resident #42's food preferences were oversight. Record review of the facility's undated policy entitled Comprehensive Resident Centered Care Plans indicated in- part: Intent: The care plan will contain information about the physical, emotional/ psychological, psychosocial, spiritual, educational and environmental needs as appropriate. Updating Care Plans:1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems, and goals.3. The Care Plan will be updated and/ or revised for the following reasons: a. Significant change in the resident's condition.b. A change in planned interventions.c. Goals are obtained and new goals established to meet current resident needs and/or goals.d. New diagnosis, new medications, or abnormal labs.4. Any revisions, additions, or deletion to the plan of care will be dated and initialed. Resident/ Resident Reprehensive Involvement: Residents are involved in decisions regarding the provision of care.		

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 02/04/2026
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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 of 20 residents (Resident #42) reviewed for diet preferences. The facility failed to ensure Resident # 42's vegetarian dietary preferences were met. This failure could place residents at risk of their preferences not being considered. Findings included: Record review of Resident #42's face sheet dated 02/02/2026 indicated a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses of - myocardial infarction (heart attack), generalized muscle weakness and lack of coordination, depression, heart failure. Record review of Resident #42's Quarterly MDS dated she had a BIMS score of 15 indicating she was cognitively intact. Record review of Resident #42's care plan revision dated 01/15/2026 indicated there was no diet listed nor a vegetarian diet listed. Resident #42's food allergies was listed Chamomile, Chocolate, Eggplant, Potato, Lanolin, [NAME] oil, and lemon flavoring. Record review of Resident #42's Order summary dated 02/04/2026 indicated a regular diet with regular texture and thin consistency. The order summary listed her diet as Cardiac that was ordered since 12/08/2025. There was no vegetarian diet listed in the orders. Record review of Resident #42's social service progress note dated 12/29/2025 indicated Resident #42's family member made a complaint related to resident's dietary restrictions/ wishes are not being honored. Her specific diet is not complete or nutritious enough. Record review on 02/19/2026 of Resident #42's list of foods she likes, dislikes, and is allergic to. -Grilled cheese-Vanilla pudding-Butterscotch pudding-Sweet potatoes-Squash-Onions-Broccoli- Salad-Ranch dressing-Beans-Rice-Cornbread-Cheetos-Apples-Peaches-Peanut butter crackers-Eggs-Grits-Toast-Biscuits-Tuna-Salmon-Impossible burgers-Mac n cheese-Black beans- No meat-No potatoes-No chocolate-No rosemary-No tomatoesPlease pick multiple for meals- Written and signed by DM. Record review of Resident #42's dietician initial assessment progress notes dated 12/19/2025 indicated Resident #42 had a diet of vegetarian. The Dietician wrote The resident is vegetarian, and DM has a detailed list of likes/ dislikes and food intolerances and continue diet/ POC. Record review of Resident #42's meal tray card non-dated indicated she had a cardiac/ renal diet. During an observation and interview 02/03/2026 at 5:50 p.m. Resident #42 was served shredded lettuce (no topping), a bag of corn chips (on the plate next to the shredded lettuce), side of green beans, side of fruit and juice. Resident #42 stated would you eat this? Now you see what I've been dealing with since December. How is this supposed to be nutritious? During an interview with the DON on 02/03/2026 at 6:00 p.m. she said the plate Resident #42 received did not meet her expectations. She said Resident #42 should never have been served plain lettuce with corn chips. She said she was aware that the resident did not eat meat but would eat salmon and tuna. She said she did not know about the written complaint that was written by Resident #42's family member. She said there was no order for Resident #42's preference for a vegetarian diet. During an interview with the Administrator on 02/03/2026 at 6:10 p.m. he said the evening meal Resident #42 was served did not align with his expectations. He said no one in the facility should be served that. He said the vegetarian diet was a preference not a diet ordered by the physician. He said the DM had ordered items off the list of food Resident #42 would eat. He said he followed up more than once on the food complaint when he received it and ensured Resident #42's preferences were met. He said she liked the food's and had no complaints since. He said the associated potential risk was Resident #42's food preferences would not be met. During an observation and interview with Resident #42 (DM present) on 02/04/2026 at 9:30 a.m. Resident #42 showed the surveyor and DM a picture that was time stamped- December 12, 2025, at 5:44 p.m. depicted a bowl of raw broccoli, ice cream, and juice for her dinner tray. A picture (continued on next page)		

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 02/04/2026
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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was taken on December 28, 2025, at 12:39 p.m. depicted a main dish of brussels sprouts (no sides). Resident #42 stated I am angry and frustrated because I keep telling the staff the over -and -over what I can and cannot eat. My family had to bring food up here for me to eat so I would have something to eat. I've gone hungry before because I did not want to eat the raw broccoli they served me with a side ice cream. They can just get me a spoon and peanut butter, and I'll eat that. Resident #42 told the DM that she knows she orders foods for her but her staff does not carry out the serving part. She said she did not know why she was served brussels sprouts because it wasn't on the list that was provided to the facility. During an interview on 02/04/2026 at 1:00 p.m. with the Dietician, she said Resident #42 asked for a vegetarian diet but would eat tuna and salmon. She said she had verbally educated the DM on what a vegetarian diet was and how to accommodate residents on that diet. She said Resident #42 was the only resident that had a vegetarian diet preference. She said it was important for the facility to take residents diet preferences into consideration when meal planning because it is their right. Record review of facility policy tilted : Resident Food Preferences revision date: November 2015 indicated in-part: Policy StatementIndividual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent.Policy Interpretation and ImplementationUpon the resident's admission (or within twenty-four (24) hours after his/her admission) the Dietitian or nursing staff will identify a resident's food preferences.When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes.Nursing staff will document the resident's food and eating preferences in the care plan.The Dietitian and nursing staff, assisted by the Physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences.The Dietitian will discuss with the resident or representative the rationale of any prescribed therapeutic diet. The Physician and Dietitian will communicate the risks and benefits of specialized therapeutic vs. liberalized diets.Therapeutic diets will be ordered only after the resident/representative agrees with and consents to such a diet.The resident has the right not to comply with therapeutic diets.If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with and agrees to comply with.Documenting that a resident is refusing meals due to non-compliance with diet orders is not appropriate.The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to foods throughout the day and night.The facility's Quality Assessment and Performance Improvement (QAPI) Committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc.		

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 02/04/2026
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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview, and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for 5 of 9 dietary staff reviewed for food handler's certificates. The facility failed to have current food handler's certificates for five kitchen staff until surveyor intervention on 02/02/2026. (Cook-A, Dietary Aide B, Dietary Aide C, Dietary Aide D, Dietary Aide E.) This failure could place residents at risk for food borne illness. The findings included: Record review on 02/04/2026 of Kitchen hire dates indicated: [NAME] A was hired 11/07/2024- Did not have a food handler's certificate until 02/02/2026. Dietary Aide B was hired 11/1/2018- Did not have a food handler's certificate until 02/02/2026. Dietary Aide C 10/14/2024-Did not have a food handler's certificate until 02/02/2026. Dietary Aide D was hired 07/15/2025- Did not have a food handler's certificate until 02/02/2026. Did not have a food handler's certificate until 02/02/2026-Did not have a food handler's certificate until 02/02/2026. Dietary Aide was hired 07/19/2024-Did not have a food handler's certificate until 02/02/2026. Record review of the Dietary Staff's Food Handler Certificates indicated Cook-A, Dietary Aide B, Dietary Aide C, Dietary Aide D, Dietary Aide E had Food Handler Certificates dated 02/02/2026 as the date they had completed the training for the certificate. During an interview on 02/02/2026 at 1:10 p.m. with the DM she said she could not produce the food handlers license for Cook-A, Dietary Aide B, Dietary Aide C, Dietary Aide D, Dietary Aide E that was issued before 02/02/2026 (after surveyor's intervention). She said the employees could not remember their passwords to access their license online. She said she did not have a paper copy of their licenses because she knew they had one. She said she was responsible for ensuring the food handlers were current. Review of the Texas Food Code indicated the following in part: The Texas Department of State Health Services (TXDSHS) requires that all food employees must successfully complete an accredited food handler training course within 30 days of employment. The training courses teach employees about food safety, including good hygiene practices and how to avoid cross-contamination.		

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 02/04/2026
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 stove. The facility failed to ensure the rear 2nd, 3rd, and 5th burners ignited when the knobs were turned on. The rear 2nd, 3rd, and 5th would not ignite when the knobs were turned until the 3rd try on 02/02/2026 at 9:18 a.m. These failures could place the residents at risk of a fire and cross contamination. Findings included: During an initial tour observation and interview on 02/02/2026 at 9:18 a.m. The rear 2nd, 3rd, and 5th burners on the stove would not ignite when the knobs were turned on until the 3rd time. No smell of gas was noted by the staff when it was turned on. The pilots' light remained on, and the front burners were working. During an interview on 02/02/2026 at 9:25 a.m. the DM said she was not aware the rear 2nd, 3rd, and 5th burners were not lighting because staff had cooked on them that morning. She said they had not had any issues with the stove prior to 02/02/2026. She said she would have someone come out and check it. During an interview on 02/02/2026 at 9:45 a.m. the Administrator said he was not aware that the burners were not igniting. He said he had not had any reports that the oven was igniting. He said he would get it maintenance that day. Record Review of the facility policy titled: Sanitization dated: October 2008 indicated in part: Policy StatementThe food service area shall be maintained in a clean and sanitary manner.Policy Interpretation and Implementation2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.		

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 02/04/2026
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to formulate an advance directive was provided for 1 of 4 residents reviewed for resident rights. (Resident #51) The facility failed to ensure Resident #51, who was listed as DNR (Do Not Resuscitate), had a valid Out-of-Hospital Do Not Resuscitate (OOH-DNR) form that was not missing required information or the witness signature and date. This failure could place residents at risk of lifesaving procedures being performed against their wishes resulting in bruising, broken ribs, electrical shocking of the heart, having a tube placed in the throat and provided artificial breathing methods, and possibly being brought back to life in an unaware and unresponsive state. Findings included: Record review of Resident #51's admission record, dated [DATE], indicated a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning), dysphagia (difficulty swallowing), dysphasia (impairment in the production of speech resulting from brain disease or damage), osteoarthritis (protective cartilage that cushions the ends of the bones wears down over time), and muscle weakness. Advance directive indicated DNR (Do Not Resuscitate). Record review of Resident #51's quarterly MDS assessment dated [DATE] indicated Resident #51 had minimal difficulty hearing, she had unclear speech, she was rarely/never able to make herself understood, she sometimes understood others, and she had severely impaired cognition and was unable to be interviewed. Record review of Resident #51's care plan indicated Resident #51 and her family requested she have a DNR status and long-term goal-initiated date of [DATE] and revision date of [DATE]. Interventions included if resident was found unresponsive with no palpable pulse or no respirations, do not initiate CPR, facility RN to pronounce and advanced directives would be reviewed by care plan team quarterly and prn. Record review of Resident #51 physician orders dated [DATE] indicated Resident #51 was a DNR. Record review Resident #51's OOH-DNR form dated [DATE] indicated the the date of birth section was blank; Section C labeled, Declaration by qualified relative of the adult person adult child box was checked signed and dated [DATE]. Section labeled TWO WITNESSES indicated, Witness #2 signed, dated [DATE], two years prior to the qualified relative signed the DNR indicating the qualified relative signature was not witnessed. The bottom of the form indicated All persons who have signed above must sign below, acknowledge that this document has been properly completed. The bottom of the form was not signed by witness #1 or witness #2. During an observation on [DATE] at 9:30 a.m. Resident #51 was lying in her bed in her room. She was unable to answer the interview questions. Attempted to contact Resident #51's responsible party on [DATE] at 11:10 a.m. and 1:15 p.m. with message requesting a return call; no returned call received. During an interview on [DATE] at 1:15 p.m., SS E said that she was responsible for assisting with OOH DNR. She said that she did not know that the witnesses had to sign the bottom of the OOH DNR form under All persons who have signed above must sign below, acknowledging that this document has been properly completed until awhile back. She said when she was notified of the witness signatures required at the bottom of the OOH DNR, she reviewed the current residents with OOH DNRs and must have missed Resident #51's not being signed or completed correctly. She said if the form was not completed correctly, that made it null and void. She said she would notify the facility staff and DON immediately and contact Resident #51's responsible party to have a new OOH DNR completed. The SS E said she would check all the DNRs for proper completeness of signatures and dates. The SS E said a resident's wishes may not have been followed if their advance directive was not completed. SS E verified there were no additional advance directives for Resident #51. During an interview on [DATE] at 2:15 p.m., the DON said Advance Directives were reviewed by the social worker to ensure accuracy. The DON said Advance Directives should be completed thoroughly to include dates that the document was witnessed and signed. The (continued on next page)		

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 02/04/2026
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON said she was made aware of the incomplete OOH-DNR on Resident #51 by SS E and the current OOH DNR was incomplete which would meant Resident #51 was a full code (staff would have to initiate CPR). The DON said it was important for Advance Directives to be completed thoroughly to ensure the documents were legally binding. The DON said the negative outcome would be that the resident could have CPR performed on them against their wishes. The DON said she would ensure the advance directive for Resident #51 was updated as soon as possible. Record review of a Do Not Resuscitate Order back page instructions read, .the OOH-DNR order Must be signed and dated by two competent adult witnesses who have witnessed either the competent adult person making his or her signature in section A.The original or copy of a fully and properly completed OOH-DNR order or the presence of an out of hospital DNR device on a person is sufficient evidence of the existence of the original out of hospital DNR order and either one shall be honored by responding health care professionals. Record review of the facility policy undated Do Not Resuscitate Order policy indicated: . It is the policy of the facility to honor Do Not Resuscitate Orders in accordance to State and Federal regulations .		

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 02/04/2026
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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure development and implementation of an effective discharge planning process that focused on the resident's discharge goals for 1 (Resident #15) of 10 residents reviewed for care plans. The facility failed to develop and implement a person-centered discharge care plan with interventions for Resident #15. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings Record review of Resident #15's admission record dated 02/03/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of dementia (loss of cognitive functioning), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), memory deficit following a stroke, COPD (chronic obstructive pulmonary disease-a lung disease that blocks airflow making it difficult to breathe), malignant neoplasm (cancer) of prostate. Record review of an admission MDS assessment dated [DATE] indicated Resident #15 had a BIMS score of 07 which indicated a severe cognitive impairment. He required partial to moderate assistance with self-care ADLs such as toileting, bathing, and was independent with his mobility. He had behaviors of disorganized thinking. He had active discharge planning already occurring for the resident to return to the community with no referral made to the local contact agency due to resident declined referral. Record review of Resident #15's care plan, revised 10/22/2025, indicated he had a risk for elopement. The care plan did not indicate Resident #15 had a care plan implemented or developed for discharge plans or resident's preference and potential for future discharge. Record review of Resident #15's physicians order dated 01/30/2026 indicated ok for discharge to home/community. Record review of Resident #51's psychosocial assessment dated [DATE] indicated Resident #15 expectation for discharge was to discharge to the community at another facility or community. The comments indicated he was admitted for long term placement, but Resident #51's family does have a goal to take him home if able. Record review of Resident #51's psychosocial assessment dated [DATE] indicated Resident #15 discharge assessment included: expectation for discharge was to discharge to the community at another facility or community, active plans for resident to return to community, discharge was a feasible goal and referral was made. During an interview and observation on 02/02/2026 at 10:26 a.m., Resident #15 said he was being discharged from the facility soon. Resident #15's family member entered the room and stated that Resident #15 had a plan to discharge on [DATE], but it was delayed waiting for approval or paperwork for the home health referral and acceptance. Resident #15 and family member (facility nurse) said the discharge plan was to return home with the family member, and supervision and monitoring would be provided. Resident #15 and the family member said they had care plan meetings and discussions with the facility staff regarding discharging home and safe discharge processes and was waiting for new discharge date. During an interview on 02/02/2026 at 11:00 a.m., LVN M stated she was the nurse for Resident #15, and he had physician orders for discharge, but it was postponed due to awaiting paperwork for approval for home health and a safe discharge assessment. During an interview on 02/04/2026 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 received a psychosocial assessment from the social services department and entered the information into the EMR to create the MDS. She said from the data entered, the MDS care plans were generated. She said she was unsure how she missed developing and implementing the care plan and interventions for discharge on Resident #15. She said Resident #15's comprehensive care plan should have discharge plans. During an interview on 02/04/2026 at 10:15 a.m., SS E said she performed social services responsibilities under the corporate SW. She said she discussed discharge planning during her psychosocial assessments that she completed on (continued on next page)		

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 02/04/2026
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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission, quarterly and as the need arose. She said she completed the psychosocial assessment on paper and gave it to the MDS Coordinator for it to be entered in the EMR as part of the MDS. She said she was aware Resident #15 had planned to return home or into the community with family, and she worked with home health services that were within his insurance network to start when he was discharged . During an interview on 02/04/2026 at 11:00 a.m., the DON stated Resident #15 had planned discharge the end of January 2026, but due to him being admitted as an elopement risk, the facility wanted Resident #15 to remain at the facility for 180 days with no elopement issues to provide a safe discharge to the home/community. She said Resident #15 and the family agreed on the delayed discharge and were waiting for approval for home health services. She said she could not think of a negative outcome for discharge planning not being on the care plan, but the facility and staff should follow state regulations and policy, and it is required that discharge plans be on the care plan. During an interview on 02/04/2026 at 02:00 p.m., the Administrator said he expected staff to follow facility policies and to update and revise residents' care plans to accurately reflect the residents' needs. Record review of the facility's undated policy titled "Comprehensive Care Planning indicated Intent: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessments, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate. 2. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following a. The services that are to be furnished to attain or maintain the residence highest practical physical mental and psychosocial well-being; . d. In consultation with their resident and their resident's representative(s): i. the residence goals for admission and desired outcomes. ii. The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose. iii. Discharge plans in the comprehensive care plan as appropriate in accordance with the requirements. Updating care plans: 6. Discharge planning concerns will be identified by all disciplines through ongoing assessment. The licensed nurse will make appropriate referrals to the interdisciplinary team members as necessary.		

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 02/04/2026
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 - Few	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** Based on interviews and record reviews, the facility failed to develop and 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 #45) of 10 residents reviewed for care plans. The facility failed to develop and implement a person-centered PICC Line IV care plan with interventions for Resident #45. This failure 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 Resident #45's Face Sheet, dated 02/03/26 indicated a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with urinary tract infection and mycoplasma pneumonia (Bacteria that causes respiratory infection). Record review of Resident #45's Quarterly MDS Assessment, dated 12/09/2025, indicated the resident's cognition was intact with a BIMS score of 15. Record review of Resident #45's Care Plan, dated 11/12/25, indicated there were no care plans for PICC line dressing care, flushing, or for IV antibiotic. Review of Resident #45's Physician Order, dated 01/28/26, indicated Sodium Chloride 0.9% solution 50ml with Cefepime 2 gm, inject 2gm into the vein every 12 hours for 3 days diagnosis mycoplasma pneumonia. There were no orders for PICC line flushes. Record review of Resident #45's MAR/TAR, dated 01/26, indicated there was no documentation to indicate administering PICC line dressing, flushes, or for IV antibiotic. During an interview on 02/03/26 at 2:29 PM, the MDS nurse said Resident #45's care plan should have been revised on 01/28/26 when the order was obtained for the IV antibiotic. The MDS Nurse, when asked if Resident #45 had a care plan for the IV PICC line checked the resident's medical record and said there were no care plans related to the IV or Flushing. She stated either the ADON or DON was responsible for updating care plans. The MDS Nurse said all information about a resident was to be care planned. She stated the interdisciplinary team, and all staff was to follow what was documented on the plan of care for each resident, and if IV flushes were not on the care plan, there was a possibility if a nurse reviewed the care plan, the nurse may not know how to use the IV line. In an interview on 02/03/26 at 2:00 p.m., the DON stated there should be a care plan on Resident #45's chart about the PICC line with interventions to flush before connecting the IV bag with antibiotics and after. She said there should also be interventions on when to change the dressing and what to assess, like check for signs and symptoms of infections. She said everything done for the resident should have care plan. She said the nurses might know what to do, but there should be a care plan so the staff would be insync with the resident's care. The DON said the MDS nurse was responsible for care plans, and she (DON) reviewed the care plans for completeness. In an interview on 02/04/2026 at 3:00 p.m., the Administrator stated the expectation was care plans to be in place to make sure the staff were doing the care correctly. Record review of the facility's undated policy entitled Comprehensive Resident Centered Care Plans indicated in- part: Intent: The care plan will contain information about the physical, emotional/ psychological, psychosocial, spiritual, educational and environmental needs as appropriate. Updating Care Plans: 1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems, and goals. 3. The Care Plan will be updated and/ or revised for the following reasons: a. Significant change in the resident's condition. b. A change in planned interventions. c. Goals are obtained and new goals established to meet current resident needs and/or goals. d. New diagnosis, new medications, or abnormal labs. 4. Any revisions, additions, or deletion to the plan of care will be dated and initialed.		

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 02/04/2026
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 administer parenteral fluids consistent with professional standards of practice and in accordance to physician orders for 1 of 1 (Resident #45) residents reviewed for parenteral (delivery of medications through injection)/IV (intravenous: administering fluids or medications directly into a vein) fluids. The facility failed to ensure Resident #45 had orders to flush the IV before and after medication administration. This failure could place residents receiving IV medications at risk for injury, infections, IV infiltration, clogging, and pain,. Findings included: Record review of Resident #45's Face Sheet dated 02/03/26 indicated a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with urinary tract infection and mycoplasma pneumonia (bacteria that causes respiratory infections). Record review of Resident #45's Quarterly MDS Assessment, dated 12/09/2025, indicated the resident was cognitively intact with a BIMS score of 15. Record review of Resident #45's Care Plan, dated 11/12/25, indicated there were no care plans for PICC line dressing care, flushing or for IV antibiotic. Review of Resident #45's Physician Order, dated 01/28/26, indicated Sodium Chloride 0.9% solution 50ml with Cefepime 2 gm, inject 2gm into the vein every 12 hours for 3 days diagnosis mycoplasma pneumonia., there were no orders for PICC line flushes. Record review of Resident #45's MAR/TAR, dated 01/26, indicated there were no documentation to indicate for administering PICC line dressing flushes or for IV antibiotic. During an interview on 02/03/26 at 2:29 PM, LVN N said before connecting the IV, the PICC line should be flushed to ensure the line was patent and would not get clogged. When asked if Resident #45 had orders for flushing and dressing changes, LVN N checked the resident's medical record and said there were no orders for flushing and dressing changes and there should be an order. In an interview on 02/03/26 at 2:00 p.m., the DON stated there should be an order on the Resident #45's chart about flushing the PICC line before connecting the IV bag with antibiotics and after. She said there should also be orders on when to change the dressing and what to assess and check for signs and symptoms of infections. She said everything done for the resident should have orders. She said the nurses might know what to do, but there should be orders so the staff would be insync with the residents' care. The DON said, for example, if there was no order when to flush the IV line, the staff would not be able to flush the IV because it would not be on the resident's eTAR/MAR. She said she already started an in-service. In an interview on 02/04/2026 at 3:00 p.m., the Administrator stated the expectation was that orders would be in place to make sure the staff were doing the care correctly. He said the DON already started an in-service. Record review of the facility's policy Central Venous and Midline Catheter Flushing 2001 MED-PASS, Inc., revised April 2016 indicated Purpose: The purposes of this procedure are to maintain patency of midline and central venous catheters. Flushing Protocol 1. Flush catheters at regular intervals to maintain patency AND before and after the following.administering of medication.		

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 02/04/2026
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 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, only accessible by authorized personnel for 1 of 22 resident (Resident #37) reviewed for storage and labeling of medications. -Resident #37 had medications Nyquil cold & flu 12 oz bottle and Cloraseptic spray (Red) 6 oz bottle opened and used at the bedside. This failure could place residents at risk for misuse of medication, overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications. The findings include: Record review of Resident #37's face-sheet dated 02/04/26 indicated he was a [AGE] year-old male, admitted to facility on 10/03/25. His diagnosis included: Allergic rhinitis(seasonal allergies). Record review of Resident #37's admission MDS dated [DATE] indicated in part- understood or understands others and had clear speech-BIMS score= 9 of 15, indicating moderately impaired cognitively for decision making Record review of Resident #37's electronic record indicated there was no Care Plan addressing may keep medications at bedside and no care plan to self-administer medications. Further review of the electronic record revealed Resident #37 did not have a Self-Administration Medication Assessment initiated or completed. Record review of Resident #37's consolidated report of current Physician orders dated 1/2026 and 2/2026 indicated no scheduled or PRN order for Nyquil cold & flu, Cloraseptic spray, self-administer medications or to leave at bedside. Observation during initial tour, on 02/02/26 at 9:30 a.m. indicated Resident #37 was not in the room and the door was open. On his bedside nightstand was an opened and used 9 ml bottle of Nyquil liquid, with no pharmacy label. On the bedside table was an opened and used bottle of chloroseptic with no pharmacy label. Observations on 02/02/26 at 2:45p.m. revealed Resident #37 was not in the room. The door was open and on bedside nightstand was the same bottle of Nyquil liquid, and on the bedside table was the same used bottle of chloroseptic red. During an interview on 02/03/2026 at 9:10 a.m. with LVN-N she said no resident should have medications at their bedside. She said she did not know of any residents having medications in their rooms. She said a physician's order must be on file for the resident to receive the medication as well as to self-administer medications. She said a resident could take inappropriate amounts of the medication or another resident could wonder in the room and get the medication and take it. She said residents could have an allergic reaction or become ill from taking unprescribed medication. During an interview on 02/03/26 at 9:18 a.m. MA-L said she's not aware of any resident having medications in their room. She said a resident can make themselves sick by taking unprescribed medications. She said all medications must have a physician's order and be given by a nurse or medication aide. Interview on 02/03/26 at 9:30 a.m. with the DON while at the Nurses station revealed she was aware of the medications Nyquil & chloroseptic at Resident #37's bedside but could not remember who told her. The DON said her expectation was for nursing staff to follow facility policy and procedure and not leave medications at the bedside. The DON said Resident #37 would need a doctor's order and medication self-administration assessment completed before he would be able to keep meds at the bed side and administer them himself. The DON revealed she would have to look in the computer to see if Resident #37 had an order or med assessment, after looking in the computer the DON told surveyor that Resident #37 did not have an order for medications or to leave medications at bedside and no self-administer medication assessment had been done for Resident #37. The DON said leaving medications at the bedside puts residents at risk of not taking properly or giving it to someone else to take, but that she (DON) felt Resident #37 was cognitively intact enough to take the medication correctly and would need to have a MD order or Self-Med Assessment first. The DON agreed that Residents in the facility must have a doctor's order to receive medications and that no resident can keep medication in their rooms and were not allowed to self-medicate. She (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/04/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated there must be a physician's order to leave the medication at the bedside and an order for the resident to self-medicate. During and observation and interview on 02/03/26 at 10:00 a.m. indicated Resident #37 was in his room sitting on the side of his bed. When asked what does he use the Nyquil and chloroseptic for and how often does he use it, Resident #37 said that he uses the Nyquil at night for a cough and the chloroseptic for numbing a sore tooth in that back of his mouth and that his family member brought it for him approximately 3 weeks ago. Resident #37 said he did not report it to the nurses because the medication can be bought from the drug store without a Doctor's prescription and didn't see any point in it. When asked if he stored the medications in a different area Resident #37 said I keep it out like that very much like you see it there is not much room here to put things. Interview on 02/03/26 at 12:00pm with RP for Resident #37 indicated she had no concerns with the Medications Resident #37 was taking and was to meet with the facility for a quarterly meeting. The RP said she was the person responsible for bringing in the medications Nyquil and chloroseptic and she had done so approximately 3-4 weeks ago. The RP revealed she had not notified the nurses about the medications because she was not aware that she had to tell them since the medications were over-the-counter medications. The RP also said no one from the facility had contacted her about the medications, or that they could not be left out unattended at the bedside. During an interview on 02/04/26 beginning at 3:02 p.m., the Administrator stated his expectations were that all medications were left with the nurse unless the resident was assessed to self-administer. The Administrator stated the nursing department head was responsible for monitoring and overseeing. The Administrator stated it was important to ensure medications were not left at bedside for resident safety. Record review of the facility's policy titled, Medication Access and Storage, revised 05/2007 reflected . It is the policy of this facility to store all drugs and biological in locked compartments . Record Review of Pharmacy Policy & Procedure Manual 2003 titled Bedside storage of medications indicated, 10. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not unauthorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy when necessary.		