STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F497	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hansford Manor	707 S Roland St Spearman, TX 79081

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure food items were properly stored, labeled, and dated.2. The facility failed to the kitchen was free of expired foods.These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings included: Findings included: In an observation and interview of the kitchen with the DM and the RD on 9/8/25 at 10:10 AM the following was observed in the freezer:1. large plastic bag of French fries, open to air, not in original box2. 3 brown bags of a food item, no label, not in original boxIn an interview during the observation of the freezer on 9/8/25 at 10:12 am the DM stated of the large bag of French fries Oh yes, it should be fastened. I will throw it out now. The DM stated the brown bags of food were French fries. She stated the facility only received brown bags with French fries in it. She stated the staff did not mark the brown bags because everyone knew the brown bags were French fries. The RD stated all frozen items should be labeled and dated when they are taken out of the box. She stated the French fries should have been marked when they were taken out of the box. She stated she trained the kitchen staff in the kitchen rules and regulations. She stated food borne illness were consequences of not labeling and storing foods properly.In an observation of the kitchen on 9/8/25 at 10:20 AM revealed a large container of Parsley spice with an expiration date of July 2025 on the spice shelf.In an observation and interview on 9/9/25 at 9:00 am, a plastic bag of cheese was observed in the cooler, open to air. The RD stated the package should have been closed to air.In an observation and interview on 9/10/25 at 9:05 am the RD was shown the expired Parsley spice container on the spice shelf. She stated the spice was expired and should have been thrown out. Record Review of the facility policy titled Food Safety Requirements (Use and Storage of Food and Beverage Items), dated 1/1/2023, revealed: Proper sanitation and food handling practices to prevent the outbreak of foodborne illnesses will be followed. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include storage of foods in a manner that helps prevent deterioration or contamination of the food including from growth of microorganisms. Practices to maintain safe storage include labeling, dating, and monitoring refrigerated foods including use by its use by date, discarded when expired and keeping foods covered in airtight containers

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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 all residents had the right to formulate an advanced directive for 1 (Resident #25) of 24 residents reviewed for advanced directives. Resident #25 had a DNR in her record that was missing the date of when Resident #25 signed the DNR. This failure could place residents a risk for not receiving healthcare as per their or their legal representatives wishes.Findings included: Record review of Resident #25's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include (idiopathic) normal pressure hydrocephalus (a neurological condition primarily affecting older adults characterized by enlarged ventricles in the brain and a specific triad of symptoms: difficulty walking, gait disturbances, cognitive decline, and urinary incontinence), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs). Resident 25 was listed in Advance Directives as being a DNR. Record review of Resident #25's last MDS was a quarterly assessment completed [DATE] listing her with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of being independent with most of her ADL's. Record review of Resident #25's care plan with admission date of [DATE] revealed the following: Focus:In fulfilment of my rights and my desire to retain control and autonomy over my health care decisions, I have an OOH-DNR. Record review of the clinical record for Resident #25 revealed an Order Summary with Active Orders as of [DATE] with the following order: -DNR/DNI - Active [DATE] Record review of the clinical record for Resident #25 revealed a DNR dated [DATE] (signed by the physician) with the following:Section - A. Declaration of the Adult Person: -Resident #25 signed the form and printed her name. There was no date of when Resident #25 signed the form. During an interview on [DATE] at 1:39 PM LVN A (the nurse responsible for Resident #25 this shift) reported if a staff member reported to her Resident #25 did not have a pulse or was not breathing, she would check Resident #25's chart for her code status then she would get an RN if an RN was available and verify Resident #25's condition. If Resident #25 was a full code she would start CPR. LVN A reported that if Resident #25 was a DNR then she wound not start CPR and contact the primary physician. LVN A then checked Resident #25's chart and noted on the front of the chart a sticker that read DNR. LVN A reported that Resident #25 was a DNR and therefore she would not start CPR. LVN A reviewed Resident #25's DNR form in Resident #25's chart. LVN A reported that Resident #25 did not date when she signed the DNR. LVN A reported that she did not think the DNR was valid because it was an incomplete form. When asked again LVN A reported that she would treat Resident #25 as a full code at this time and start CPR. During an interview on [DATE] at 09:48 AM the DON with the ADON present reported the social worker was responsible for verifying the accuracy of the DNRs for each resident. The DON reported that if the person who implements the DNR such as with Resident #25 did not date when they sign the DNR then the DNR was not valid and if the DNR was not implemented validly then the DNR would not be carried out correctly. During an interview on [DATE] at 10:05 AM the SW reported that she did not verify the actual DNR for Resident #25. The SW reported that MR C was responsible for checking the DNRs and that MR C probably just missed that this one was not dated. The SW reported that she felt the DNR was still valid since the doctor and the two witnesses signed the DNR. During an interview on [DATE] at 10:09 AM MR C reported that Resident #25 was admitted with her DNR already completed and that was before she was in this position and the DNR was the responsibility of a prior employee no longer employed at the facility. MR C reviewed Resident #25 DNR, reported that Resident #25 did not date her signature, and that she did not feel it was an issue because the witnesses and the doctor signed the DNR. Record review of the facility provided policy titled Out-of-Hospital Do-Not Resuscitate Order date issued [DATE], revealed the following: Purpose: The purposed of this policy (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is to establish a process for informing, recording, educating, and implementing Out-of-Hospital Do-Not Resuscitate order (OOH-DNR) in compliance with state law. Procedure: C. Medical Records personnel will place a copy of the completed OOH-DNR form . Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following:- Section A - If an adult person is competent and at least [AGE] years of age, he/she will sign and date the Order in Section A. - The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional

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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 observation, interview and record review, the facility failed to implement a comprehensive care plan for each resident 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 and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 15 Residents reviewed for comprehensive care plans. -The facility failed to include a care plan for Resident #1's wounds. This failure could result in resident not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Record review of Resident #1's face sheet dated 9/08/2025 revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and pressure ulcer of right ankle (damage to an area of the skin caused by constant pressure on the area for a long time). Record review of Resident #1's annual MDS completed 8/01/25 listed him with a BIMS of 15 indicating he was cognitively intact, and he had a functionality of being independent with most of his ADL's. Resident #1 was listed with one unhealed stage 3 pressure ulcer, one unstageable pressure ulcer, and diabetic foot ulcers. Record review of Resident #1's order summary reports revealed the following:- Active orders as of 9/10/25:Rt anterior ankle: .change daily in the morning related to PRESSURE ULCER OF RIGHTANKLE (L89.51) Phone Active 08/06/2025 Rt medial Ankle: .change daily in the morning related to PRESSURE ULCER OF RIGHT ANKLE (L89.51) Phone Active 08/28/2025 - Active orders as of 8/01/25:Rt anterior ankle: .change daily in the morning related to PRESSURE ULCER OF RIGHT ANKLE (L89.51) Phone Active 07/28/2025 Rt medial Ankle: .change daily in the morning related to PRESSURE ULCER OF RIGHT ANKLE (L89.51) Phone Active 07/28/2025 - Active orders as of 7/01/25:Right medial ankle: .Change daily. in the morning for Pressure ulcer Phone Active 06/23/2025 Record review of Resident #1's care plan with admission date 11/18/21 and last revision 8/13/25 revealed no care plan for pressure ulcers, diabetic foot ulcers, or wound care. During an observation on 09/08/2025 at 10:34 AM Resident #1 was observed in his room in his wheelchair with his head placed on the edge of his bed sleeping. He did not wake to knocking or introduction. During an interview on 09/08/2025 at 4:00 PM the DON reported Resident #1 refused to allow this surveyor to observe his wounds and his wound care. The DON reported Resident #1 would often refuse care for example he would leave the dining room if a certain person was serving meals, and he only allows one staff member to purchase his cigarettes. During an interview on 09/10/2025 at 9:58 AM the DON with the ADON present reported that Resident #1 has had a wound to his ankles/feet for approximately a year that have healed, worsened, and healed. Resident #1 recently had MRSA in one of his wounds. The DON reported Resident #1 was a diabetic, smoked, was not compliant, and refuses to stay of his wounds to prevent the pressure. The ADON reported Resident #1 has had a small wound on his foot that has always been there. The ADON reported that any wound to include Resident #1 should always be care planned and that she did not know if Resident #1 wounds were care planned. The ADON reported she would have to contact the wound nurse to find out if they were in his care plans. During an interview on 09/10/2025 at 11:12 AM the DON reported that she talked with the MDS Coordinator (who was responsible for completed the care plans) and the MDS Coordinator reported Resident #1 had frequent changes in the condition his wounds and that his care plan for his wounds had been resolved out which meant they had removed it from his care plan. The DON reported Resident #1's wound care had not been added back to his care plan and that the current care plan should address his wound care needs. The DON reported if a care plan was not updated with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident care and condition then orders will not be followed, care will not be done, the resident could be at risk for infection, and they could have a worsening of the wound. During an interview on 09/10/2025 at 11:19 AM the MDS RN reported Resident #1's wound care should be in his current care plans and his wound care plans were resolved/cancelled on 4/23/25 and never reentered. The MDS RN reported Resident #1's wound care should have been reentered into Resident #1's care plans a couple of months ago. The MDS RN reported that if the care plans do not reflect the resident condition, then the resident would not receive the appropriate care. Record review of the facility provided policy titled Care Plans date issued 1/09/19, revealed the following: Procedure:-The Interdisciplinary Team (IDT), .develops and implements a comprehensive, person, centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.-The comprehensive, person-centered care plan will:b. describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #12) of 15 residents reviewed for respiratory care. -Resident #12 was not receiving oxygen at the correct dose. This failure could place residents at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings include: Record review of Resident #12's admission record dated 09/08/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), chronic respiratory failure (a long-term condition that occurs when the body's respiratory system can't exchange oxygen and carbon dioxide properly), dementia (a group of thinking and social symptoms that interferes with daily functioning), and dependence on supplemental oxygen. Record review of Resident #12's clinical record revealed her last MDS was a quarterly completed 6/13/25 listing her with a BIMS score of 03 indicating she was severely cognitively impaired, and she had a functionality of being independent with most of her ADL's. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #12 was marked as having oxygen While a Resident. Record review of Resident #12's Order Summary Report with Active Orders as of 9/09/25 revealed the following order:- Oxygen administered @ 2L/NC Continuous every morning and at bedtime related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED (J44.9) Prescriber Written Active 04/12/2025. Record review of Resident #12's care plan with admission date of 2/20/23 revealed the following: Focus:- I have COPD. Revised on 6/24/25. Intervention:- Give oxygen therapy as ordered by the physician. Revised on 6/24/25. During an observation on 09/08/2025 at 10:56 AM Resident #12 was in her room sleeping in her recliner wearing her O2 via NC. Noted her oxygen was at 4.5L/min. Resident #12 did not wake to knocking or introduction. During an observation and interview on 09/09/2025 at 1:18 PM Resident #12 was sitting in the main lobby with her oxygen on via a portable pump. This surveyor attempted to interview Resident #12, but she became uncomfortable and did not want to answer questions. Resident #12 stated, everything was fine and mumbled an incoherent response to any further questions. During an observation on 09/10/2025 at 8:18 AM Resident #12 was not in her room. This surveyor observed Resident #12's oxygen concentrator set at 3.5L/min. During an interview on 09/10/2025 at 8:21 AM LVN B (the nurse providing medications for Resident #12 this shift) reviewed Resident #12 orders and reported Resident #12 was ordered to be on 2l/min of oxygen. LVN B entered Resident #12's room, checked her concentrator, and reported the resident was on approximately 3L/min of oxygen. When asked if this was the correct dose of oxygen medication, LVN B reported it was not but the resident often would adjust the medication to what she felt would address her difficulty breathing. LVN B set the concentrator to the ordered dose of 2L/min. LVN B was asked three times if the oxygen medication was given correctly or if the medicator not being given at the correct dose would affect the resident and each time LVN B repeated the resident would change the dose herself. During an interview on 09/10/2025 at 09:52 AM the DON with ADON present reported Resident #12 had dementia and was supposed to have her oxygen set at 2L/min but Resident #12 will often change it. The DON reported a resident not receiving a medication at the ordered dose was an issue and she did not know what to do about this situation with Resident #12. The DON reported Resident #12 did have COPD and if a resident had compromised lungs and they get to much oxygen then it can compromise their condition. The ADON reported the nurses on the floor were responsible for taking care of the residents oxygen. Record review of the facility provided policy's titled, Physician Services and Charting Errors and/or Omissions revealed no information related to ensuring resident medication orders are implemented accurately.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review; the facility failed to ensure a medication was labeled and stored in accordance with currently accepted professional principles for 1 of 2 medication carts reviewed for medication storage. The Hall 2 medication cart had a inulin pen that had been used that was not marked with the date of when it was opened/accessed or when it should expire. This failure could result in ineffective treatment resulting in exacerbation of resident's disease processes.Findings include: During an observation on [DATE] at 8:48 AM of the Hall 2 medication cart with LVN A present, an Insulin Glargine Pen was not marked with the date of when it was opened or when it would expire. During an interview on [DATE] at 8:50 AM LVN A (the nurse administering medication from the Hall 2 medication cart that shift) reported the Insulin Glargine Pen was not marked with a date of when it was opened/accessed and when it would expire. LVN A reported that the insulin appeared to have been used and reported she had not used the insulin this shift, it was a pm administration. LVN A reported if an insulin was not marked when it is opened/accessed or when it would expire then the insulin could be expired and can potentially affect the residents blood sugars. LVN A reported she had been trained on insulin storage by the DON, and she marks all insulins when she open/access's them and this insulin was not opened/accessed by her. During an interview on [DATE] at 09:42 AM the DON with ADON present reported per investigation they determined an agency nurse had accessed the Insulin Glargine Pen the previous evening and was responsible for not marking the insulin pen found in the medication cart. The DON reported per the facility policy all insulins are to be marked when they are opened/accessed and when they are to be expired/discarded. The DON reported using an insulin that has not been labeled correctly could result in the medication not being effective and the ADON reported the medication could loose its efficacy. The ADON reported that it was the floor staff nurses responsibility to check their carts and make sure all medications were marked correctly. The ADON reported LVN A probably had not had time to check her cart the morning of this surveyor's review. Record review of the facility provided policy titled Usage, Storage, and Re-entry of Multi dose Vials date issued [DATE], revealed the following: Procedure:b. The product is to be disposed of within 28 days after initially opening.c. The product is to be clearly labeled with the date opened and initials of the nurse who opened the product.