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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675008	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Rose Nursing and Rehabilitation	203 Gibbs Blvd Glen Rose, TX 76043

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interviews and record review, the facility failed to provide a private meeting space to conduct group meetings without continued interruptions by facility staff for 13 of 48 confidential residents who were reviewed for resident council. The facility failed to provide a private area for confidential resident group meetings.This failure placed all residents who participated in a resident council of not having the right to voice their concerns without staff being present or overhearing their concerns. Findings included: During an observation and interview of a confidential group meeting on 03/25/2026 between 1:30 p.m. and 1:50 p.m., one facility staff member was observed to open the door to the dining room and walk through the dining room to get to the kitchen with a cup in her hand. The staff member then walked back through the dining room with the cup and exited through the dining room door. The resident council members stated the facility staff came in and out of the dining room with no privacy during resident council meetings. The resident council members stated the AD placed a sign at both entrances to the dining room asking staff not to enter the dining room due to resident council being held and would shut the doors. The resident council members stated the facility staff did not respect the signs and they felt their concerns may be overheard by the staff members when they cut through the dining room during the confidential group meetings.During an interview on 03/25/2026 at 2:31 p.m., the AD stated she would close the doors to the dining room and put up signs during resident council meetings to try and keep people from coming into the dining room during those meetings. She stated she does go to the resident council meetings and was invited to do so by the council members. She stated sometimes staff would walk through the dining room door to get to the kitchen for items during resident council meetings. She stated the residents have not ever made a grievance about staff walking through the meetings, but she felt that the residents needed privacy during the meetings. She stated she had gone to the ADMN herself to report staff walking through the meetings. She stated she had announced the meetings over the intercom in the past so that staff would know not to walk into the dining room during the meeting. She stated she had asked staff to leave before because they were sitting at one of the tables during the resident council meeting. She stated she did not feel that the meetings were private. During an interview on 03/25/2026 at 2:38 p.m., the ADMN stated he expected for staff not to walk through the dining room during resident council meetings. He stated the door to the dining room should remain shut and that there were signs the AD posted on the doors during the meetings to help to notify staff to not walk through. He stated he had an in-service with the staff about giving the resident council privacy and it had gotten better. He stated staff had to walk through the dining room to get to the kitchen to get drinks for the residents who did not attend the meetings if residents wanted something other than water that was stored on the halls. He stated other residents did not want to wheel through the meetings so staff would go through to get drinks. He stated if staff walked through the dining room during resident council it could cause the residents to not have privacy to voice their concerns. Record review of the facility's policy titled Resident Council, dated 12/13/2016, reflected The facility will provide the resident council with private space.Staff, visitors, or other guests may attend resident council meetings only at the respective group's invitation.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #13) of 12 residents reviewed for medications.The facility failed to hold Lisinopril (medication to lower blood pressure) per parameters stated in physicians' orders for a total of 6 doses in March 2026 for Resident #13.The facility failed to hold Diltiazem (medication to lower blood pressure) per parameters stated in physicians' orders for a total of 22 doses in March 2026 for Resident #13.The failures placed the residents at risk of harm or not receiving desired outcomes from medications not administered according to physician's orders and manufacturer's specifications.Resident #13Record review of Resident #13's electronic Face Sheet, accessed 03/24/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory disease that causes obstructed airflow from the lungs) and high blood pressure. Record review of Resident #13's Quarterly MDS Assessment, dated 03/03/2026, reflected that the resident had no impairment in cognition with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident had high blood pressure. Record review of Resident #13's Comprehensive Care Plan, last review completed on 03/09/2026, reflected the resident had high blood pressure with medication regimen in place and the interventions were to give anti-hypertensive (medications used to lower blood pressure) medications as ordered.Review of Resident #13's electronic physicians' orders reflected: Lisinopril Oral Tablet 40 MG Give 1 tablet by mouth in one time a day for hypertension Hold if blood pressure less than 140 systolic (top number of blood pressure) 90 diastolic (bottom number of blood pressure), order date 12/01/2025.Review of Resident #13's electronic MAR for March 2026 reflected lisinopril was given on: 3/6/26 AM for BP of 133/73 by MA-D, 3/8/26 AM for BP of 131/63 by MA-D, 3/10/26 AM for BP of 114/78 by MA-E, 3/14/26 AM for BP of 136/79 by MA-E, 3/20/26 AM for BP of 132/87 by MA-D, and 3/36/36 AM for BP of 128/75 by MA-D.Review of Resident #13's electronic physicians' orders reflected: diltiazem HCl Oral Tablet 60 MG Give 1 tablet by mouth three times a day for HTN Hold if systolic less than 140, diastolic less than 90, order date 12/01/2025.Review of Resident #13's electronic MAR for March 2026 reflected diltiazem was given on: 3/6/26 AM for BP of 133/73 by MA-D, 3/8/26 AM for BP of 131/63 by MA-D, 3/10/26 AM for BP of 114/78 by MA-E, 3/14/26 AM for BP of 136/79 by MA-E, 3/20/26 AM for BP of 132/87 by MA-D, 3/36/36 AM for BP of 128/75 by MA-D, 3/1/26 1:00 pm for BP 136/75 by MA-E, 3/2/26 1:00 pm for BP 114/83 by MA-E, 3/4/26 1:00 pm for BP 137/72 by MA-E, 3/8/26 1:00 pm for BP 122/92 by MA-D, 3/9/26 1:00 pm for BP 138/90 by MA-F, 3/10/26 1:00 pm for BP 130/70 by MA-E, 3/18/26 1:00 pm for BP 134/74 by MA-E, 3/21/26 1:00 pm for BP 115/77 by MA-D, 3/22/26 1:00 pm for BP 130/72 by MA-D, 3/23/26 1:00 pm for BP 137/85 by MA-E, 3/24/26 1:00 pm for BP 132/58 by MA-E, 3/2/26 PM for BP 121/64 by MA-F, 3/3/26 PM for BP 115/74 by MA-F, 3/18/26 PM for BP 135/80 by MA-F, 3/20/26 PM for BP 118/88 by MA-F, and 3/21/26 PM for BP by MA-F.During an interview on 03/26/2026 at 1:00 PM, MA-D stated that she did not realize that Resident #13 had those specific parameters. She stated that she would have noticed blood pressures with a systolic below 110 because that was the standard parameter.During an interview on 03/26/2026 at 1:30 PM, the DON stated she expected her staff to follow physicians' orders. She stated she expected her staff to read the MAR and follow parameters. She stated any component nurse or medication aide should have identified a low or high blood pressure and then looked at the orders to see the parameters. She stated the failure was probably caused by the parameters being higher than the standard parameters. She stated not following the parameters could lead to residents not receiving the proper treatment for their blood pressures which could lead to pressures not being controlled. The DON stated the facility (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not have a policy related to holding medications and following parameters.During an interview on 03/26/2026 at 3:40 PM, the NP stated she was unsure why Resident #13 had higher parameters than the standing ordered parameters. She stated that it was her expectation for nurses to follow the parameters set in the physician's orders. She stated he did not feel that this would have too negative of an outcome and that she would address the order and lower the parameters. She stated not holding the BP medications could cause the residents' blood pressure to get too low, but Resident #13 had not had any issues as of now. She stated this could lead to residents' blood pressure not being controlled adequately. He stated he did not expect to be notified every time a medication is held.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to properly prepare and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure foods were heated to a temperature of 165 degrees F after mechanically altering the pureed food and held at least 15 seconds when food temperature was below 140 degrees F during the lunch meal observed on 03/24/2026. The facility failed to ensure foods were heated to a temperature of 165 degrees F after mechanically altering the mechanical soft BBQ chicken during the lunch meal observed on 03/24/2026.These failures could place residents that eat out of the kitchen at risk for food borne illnesses.Findings included:During an observation on 03/24/2026 at 11:48 a.m., [NAME] B pureed BBQ chicken that she removed from steam table pan with some warm liquid. After she got the food to pureed texture, [NAME] B placed the pureed BBQ chicken in a divided plate. The plate remained by the blender. No temperature of the pureed BBQ chicken was taken.During an observation on 03/24/2026 at 11:50 a.m., [NAME] B pureed Baked Macaroni & Cheese that she removed from steam table pan with some warm liquid. After she got the food to pureed texture, [NAME] B placed the pureed Baked Macaroni & Cheese in the divided plate next to the BBQ chicken. The plate remained by the blender. No temperature of the pureed Baked Macaroni & Cheese was taken.During an observation on 03/24/2026 at 11:52 a.m., [NAME] B pureed the Homestyle [NAME] Beans that she removed from steam table pan with some warm liquid. After she got the food to pureed texture, [NAME] B placed the pureed Homestyle [NAME] Beans in the divided plate and moved the divided plate onto the top of a aluminum pan lid on the steam table and covered the plate. No temperature of the pureed Homestyle [NAME] Beans was taken.During an observation on 03/24/2026 at 12:04 p.m., [NAME] B took temperature of the pureed food items. The pureed BBQ chicken's temperature was 107 degrees F. The pureed Baked Macaroni & Cheese was 106 degrees F. The pureed Homestyle [NAME] Beans was 119 degrees F. [NAME] B did not reheat any of the pureed food items.During an observation on 03/24/2026 at 12:17 p.m., [NAME] B handed DA C the pureed food items for Resident #19 and he gave to LVN A for dining room delivery. The food items were never reheated prior to being served.During an observation on 03/24/2026 at 12:20 p.m., the DM showed a bin in the kitchen where food recipes were stored including pureed menu items for that lunch service. During an observation on 03/24/2026 at 12:23 p.m., the DM took BBQ chicken from the steam table and mechanically altered it to mechanically soft texture. She added the mechanically soft BBQ chicken into a pan on the steam table without taking the temperature of the food. Food was served later during food service to residents with mechanical soft diet. During an observation on 03/24/2026 at 12:25 p.m., Resident #19's dessert had been consumed and about 10% of the other items offered (pureed BBQ Chicken, pureed Baked Macaroni & Cheese, and pureed Homestyle [NAME] Beans) were consumed. During an interview on 03/24/2026 at 12:40 p.m., the DM stated her expectation would be for pureed food to be prepared and held at a safe temperature. She stated [NAME] B should have reheated the pureed food if the temperature on the steam table was 106 degrees F, 107 degrees F, and 119 degrees F. She stated she did not know why [NAME] B did not reheat the food and she felt it could be reheated by adding hot liquid so that the texture would not change. She stated the effect of food not being above 140 degrees F could cause the resident to not eat due to the food would not be palatable. She denied that not heating the food to 165 degrees F could cause the spread of illness. She stated she should have taken the temperature of the mechanically altered BBQ chicken after she altered the texture, but she stated she forgot to take the temperature since she was in a hurry to get [NAME] B the food. She stated [NAME] B and herself were responsible for making sure food was to the appropriate temperature when being prepared or the texture altered. She stated the dietitian monitored that the kitchen staff prepared food correctly and that the dietitian was not present at the facility today.During an interview on 03/24/2026 at 12:51 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., [NAME] B stated she should have heated the pureed food up to 145 degrees F when she noticed that it was not at appropriate holding temperature. She stated she did not know to reheat to 165 degrees F after altering the food texture. She stated not heating up the food could cause bacterial illness to residents. She stated she had been trained on food temperatures and preparing food. During an attempted telephone interview on 03/26/2026 at 9:28 a.m., the dietician did not answer telephone. A voice message was left and no return call was received.During an interview on 03/26/2026 at 11:56 a.m., the ADMN stated his expectation would be for the kitchen staff to follow policy related to food temperatures. He stated not following the policy could cause sickness but that would depend on several different things such as how long the food sat at the undesirable temperature and if the food was ever at the appropriate temperature. He stated the cook was responsible for taking food temperatures and reheating the food if needed. He stated the DM monitored that the cook was reheating the food as appropriate. He stated the facility had a dietitian that was present in the building at least monthly who also monitored the food was prepared appropriately.Record review of policy titled, Daily Food Temperature Control, dated 4/9/2025, reflected: We will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the Temperature Log. This is done to help ensure that food is safe and is served within acceptable ranges .Prior to meal service, the cook shall take the temperature of all hot and cold foods .All hot foods shall be cooked and held for service at temperatures of 140 degrees F or above. Any hot or cold food which does not meet the minimum acceptable temperature shall be heated to a temperature of 165 degrees F and held at least 15 seconds.Record review of mechanical soft BBQ Chicken Quarter recipe, dated 03/24/2026-Lunch, reflected: Remove cooked chicken from bones, Grind prepared recipe portions to an appropriate consistency.Reheat to an internal temperature of >165F held for 15 seconds .Maintain at an internal temperature of >140F for only 4 hours.Record review of pureed BBQ Chicken Quarter recipe, dated 03/24/2026, reflected: Measure number of servings using the regular prepared recipe portion. Drain well to minimize the use of thickener to obtain appropriate consistency. Place in a blender or food processor. Add liquid, if needed (ex: reserved liquid, broth, milk, gravy, or sauce), to assist with pureeing. Pureed with a blender or a food processor until smooth.Reheat to an internal temperature of > 165F held for 15 seconds .Maintain at an internal temperature of 140F for only 4 hours.Record review of pureed Baked Macaroni & Cheese recipe, dated 03/24/2026, reflected: Measure number of servings using the regular prepared recipe portion. Drain well to minimize the use of thickener to obtain appropriate consistency. Place in a blender or food processor. Add liquid, if needed (ex: reserved liquid, broth, milk, gravy, or sauce), to assist with pureeing. Pureed with a blender or a food processor until smooth.Reheat to an internal temperature of > 165F held for 15 seconds .Maintain at an internal temperature of 140F for only 4 hours.Record review of pureed Homestyle [NAME] Beans recipe, dated 03/24/2026, reflected: Measure number of servings using the regular prepared recipe portion. Drain well to minimize the use of thickener to obtain appropriate consistency. Place in a blender or food processor. Add liquid, if needed (ex: reserved liquid, broth, milk, gravy, or sauce), to assist with pureeing. Pureed with a blender or a food processor until smooth.Reheat to an internal temperature of > 165F held for 15 seconds .Maintain at an internal temperature of 140F for only 4 hours.According to the FDA (Food and Drug Administration) Food Code (https://www.fda.gov/food/retail-food-protection/fda-food-code), accessed on 03/26/2026, reflected: 3-403.11 Reheating for Hot Holding.(A) Except as specified under (B) and (C) and in (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C (165 F) for 15 seconds. (B) Except as specified under (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD reheated in a microwave oven for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C (165 F) and the FOOD is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. (C) READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that has been commercially (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	processed and PACKAGED in a FOOD PROCESSING PLANT that is inspected by the REGULATORY AUTHORITY that has jurisdiction over the plant, shall be heated to a temperature of at least 57 C (135 F) when being reheated for hot holding. (D) Reheating for hot holding as specified under (A) - (C) of this section shall be done rapidly and the time the food is between 5 C (41 F) and the temperatures specified under (A) - (C) of this section may not exceed 2 hours. (E) Remaining unsliced portions of MEAT roasts that are cooked as specified under 3-401.11(B) may be reheated for hot holding using the oven parameters and minimum time and temperature conditions specified under 3-401.11(B).

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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 observations, interviews, and record reviews, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for on 2 (Resident #13 and Resident #20) of 12 residents reviewed for respiratory care. The facility failed to ensure Resident #13's nebulizer (used to receive medications by breathing in mist through the mouth) for breathing treatment was properly stored when not in use on 03/24/2026. The facility failed to ensure Resident #20's nebulizer for breathing treatment was properly stored when not in use on 03/24/2026. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: Resident #13 Record review of Resident #13's electronic Face Sheet, accessed 03/24/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory disease that causes obstructed airflow from the lungs). Record review of Resident #13's Quarterly MDS Assessment, dated 03/03/2026, reflected that the resident had no impairment in cognition with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had chronic obstructive pulmonary disease and was on oxygen therapy. Record review of Resident #13's Comprehensive Care Plan, completed 03/09/2026, reflected the resident had chronic obstructive pulmonary disease and the interventions were to give aerosol or bronchodilators (medication used for breathing treatment) as ordered. Record review of Resident #13's Physician's Order, dated 12/03/2025, reflected albuterol sulfate inhalation nebulization solution 0.083% 1 vial inhale orally every 4 hours as needed for cough/congestion or shortness of breath. Record review of Resident #13's Physician's Order, dated 12/01/2025, reflected budesonide inhalation suspension 0.5MG/2ML 1 dose inhale orally two times a day for chronic obstructive pulmonary disease. Observation and interview on 03/24/2026 at 12:24 PM, revealed Resident #13's nebulizer laying on the bedside table and not bagged with no date. Resident stated she had laid it there when her treatment was finished. Resident #20 Record review of Resident #20's electronic Face Sheet, accessed 03/26/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with acute respiratory failure (a disease where the lungs cannot adequality supply oxygen to the blood.) Record review of Resident #20's Quarterly MDS Assessment, dated 03/20/2026, reflected that the resident had no impairment in cognition with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had respiratory failure and was on oxygen therapy. Record review of Resident #20's Comprehensive Care Plan, completed 03/18/2026, reflected the resident had altered respiratory status and the interventions were to give medications as ordered. Record review of Resident #20's Physician's Order, dated 12/13/2025, reflected Ipratropium-Albuterol inhalation solution 0.5-2.5MG/3ML- 3ml inhale orally every 4 hours as needed for shortness of breath. Observation and interview on 03/24/2026 at 4:18 PM, revealed Resident #20 was up in her chair with sling underneath her. Resident's nebulizer was lying in a drawer not bagged and was not dated. She stated that the nurse had placed it there when her treatment was done. During an interview on 03/26/2026 at 1:30 PM, the DON stated that all nebulizers and oxygen tubing not in use should have been placed in a plastic bag. She stated that when the nebulizer was removed from the resident after receiving treatment the nurse should have placed the nebulizer in the bag. She stated this failure could have led to an infection. Record review of the facility's policy titled, Aerosolized Hand-Held Nebulizer, not dated, revealed POLICY: A compressed-driven nebulizer will be used to administer aerosolized medication as ordered by the physician. Procedure. #13 rinse the nebulizer and store in a plastic bag that is labeled.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure the menu was followed for 1 of 1 (Resident #19) resident who received a pureed meal reviewed. The facility failed to ensure residents receiving a pureed texture diet were provided with Honey Kissed Roll according to the menu, including a roll during the lunch meal observed on 03/24/2026. This failure could place residents that eat food from the kitchen at risk of poor intake, chemical imbalance and/or weight loss. Findings included: Record review of Resident #19's electronic face sheet, dated 03/26/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and cognitive communication deficit (communication impaired by brain function). Record review of Resident #19's quarterly MDS, dated [DATE], reflected a BIMS score of 01 indicating severe cognitive impairment. Further review of the MDS reflected Resident #19 had been on a mechanically altered diet while a resident, had lost weight and was not on a physician-prescribed weight-loss regimen.Record review of Resident #19's care plan, dated 02/24/2026, reflected she had a significant unplanned weight loss with intervention to monitor and record food intake at each meal and offer substitutes as requested or indicated.Record review of Resident #19's dietitian progress note, dated 02/22/2026, reflected Resident #19's weight was down eleven pounds in the last ninety days. Further review reflected she received hospice services and was on a pureed diet consuming 0-50% of meals. Resident #19 was given health shakes three times a day. There was no evidence Resident #19 should not have pureed bread.Record review of Resident #19's nurses progress note, dated 03/24/2026 at 1:26 p.m., written by LVN A reflected: Resident only drank health shake for breakfast and lunch. Informed [hospice company].Record review of Resident #19's dietitian progress note, dated 03/26/2026, reflected Resident #19's weight was down fourteen pounds in the last ninety days. Further review reflected she received hospice services and was on a pureed diet consuming 0-25% of meals. Resident #19 was given health shakes three times a day. There was no evidence Resident #19 should not have pureed bread.During an observation on 03/24/2026 at 11:40 a.m., a weekly posted menu was observed in the dining room on the wall that reflected week 1 lunch menu for Tuesday was BBQ Chicken Quarter, Baked Macaroni & Cheese, Homestyle [NAME] Beans, Honey Kissed Roll and Apple Cobbler.During an observation and interview on 03/24/2026 between 11:48 a.m. and 11:52 a.m., [NAME] B stated there was only one resident (Resident #19) who received a pureed diet. [NAME] B prepared pureed food for Resident #19 and no roll was pureed.During an observation and interview at 03/24/2026 at 12:25 p.m., Resident #19 was being fed by the SW. The SW stated the resident cannot have a roll and had not previously received one due to being on a puree diet. She stated Resident #19 would choke if she was given a roll. The SW stated she did not consider the roll could be pureed. The SW stated she would ask the resident if she wanted a roll if it were pureed. Resident #19 did not answer the SW to if she wanted a roll. The SW stated the small bowl was cobbler. There was no evidence a pureed roll was present on Resident #19's lunch tray. The ticket next to Resident #19's tray had Resident #19's name on it and a pureed honey kissed roll was among the items to be offered to the resident. All of Resident #19's dessert had been consumed and about 10% of the other items offered (pureed BBQ Chicken, pureed Baked Macaroni & Cheese, and pureed Homestyle [NAME] Beans) were consumed. During an interview on 03/24/2026 at 12:40 p.m., the DM stated her expectation would be for residents on a pureed diet to be offered all of the menu items. She stated she thought the cook had pureed the roll for Resident #19. She stated Resident #19 did not like to eat the food that was not sweet and she did not feel that Resident #19 would consume the roll if she had been offered it. She stated not offering all menu items could cause calory deficit to the resident who did not receive all items. She stated the cook was responsible for making sure all residents were served the appropriate items. She stated a dietician (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Cherokee Rose Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 203 Gibbs Blvd Glen Rose, TX 76043	

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitored the residents were served food appropriately when she was in the building and the DM was responsible as well. During an interview on 03/24/2026 at 12:46 p.m., DA C stated he was responsible for making sure the food order was called out to the cook. He stated he saw one bowl and the divided plate on Resident #19's tray. He stated he did not know why a pureed roll was not provided to Resident #19. During an interview on 03/24/2026 at 12:51 p.m., [NAME] B stated she did not puree a roll. She stated she had family issues going on and forgot to puree the roll. She stated not serving the roll could cause a resident to have calorie deficit. She stated she had been trained on preparing food and stated the DM monitored the kitchen staff.During an interview on 03/24/2026 at 2:27 p.m., LVN A stated Resident #19 should have been given a roll with her lunch tray. She stated Resident #19 did have poor intake due to her terminal diagnosis and mostly drank the health shakes at her meals. She stated she had checked the trays in the dining room during lunch service. She stated she checked to make sure the trays were the correct diet order and all items were present when the trays for the dining room left the kitchen and did not notice Resident #19 did not have a pureed roll. She stated she had kept Resident #19's hospice service updated on her intake and stated that even was she was offered a roll, Resident #19 probably would have not eaten it because she only likes to drink the health shakes. During an attempted telephone interview on 03/26/2026 at 9:28 a.m., the dietician did not answer telephone. A voice message was left and no return call was received. During an interview on 03/26/2026 at 11:56 a.m., the ADMN stated his expectation would be for the kitchen staff to follow policy related to following the menu. He stated Resident #19 should have received all of the menu items unless there was a contradiction for Resident #19 not have bread due to choking hazards. He stated the dietician would make a decision if bread would be a contradiction. He stated the dietician was in the building at least monthly and would make notes in the resident's medical record when she was in the building. He stated the DM monitored that the residents were served all food items on the menuRecord review of recipe titled P Honey Kissed Roll, dated March 24, 2026, reflected: Ingredients (Prep Method) .Honey Kissed Roll .Reconstituted Chicken BrothRecord review of facility polity titled, Resident Menus, no date, reflected: The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and standardize food production.The menus will be prepared as written using standardized recipes. The Dietary Service Manager and cooks are trained and responsible for the preparation and service of therapeutic diets as prescribed.