

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER Munday Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 421 West F St Munday, TX 76371	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to provide information to residents and their representatives on their rights related to filing grievances or concerns for 7 of 15 confidential residents. The facility failed to ensure 7 of 15 confidential residents were provided, through postings in prominent locations; the Grievance Procedure, access to the Grievance form, information regarding who the facility grievance officer was, their contact information, and how to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews during the Resident Council on 08/12/2026 at 11:00am, 7 confidential residents stated they did not know they could file a Grievance anonymously and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council stated there was no system for submitting a Grievance anonymously. The 7 residents in attendance had all been Residents of the facility for 6 plus months. Observed prominent postings on 8/12/2026 at 1:45pm, in the lobby area. There was no Grievance policy in the prominent postings, instructions for filing a Grievance, or directions for where a form was available. In an interview with the ADM on 8/13/2026 at 11:30am, the ADM stated she was the Grievance Officer for the facility. The ADM stated she was responsible for the review of Grievances and assigning them to department heads. The ADM stated there were forms available down one of the hallways by the staff break room. She stated there was no lock box, however, the residents could anonymously leave their completed Grievance form in the same box as the empty forms. The ADM stated she was not aware residents did not know where to acquire a Grievance form or where to submit the form. The ADM stated her protocol was to resolve grievances within 5 days once they were submitted. The ADM stated the procedure for submission of a Grievance was she assigned the grievance to the appropriate department, that department addressed the grievance, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the original Grievance form. The ADM stated completed Grievances were kept in a notebook for 3 years. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated she would also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. The ADM stated the potential negative outcome for residents not having a system to file Grievances anonymously was the Resident may not file a Grievance and the issue will not be resolved. Record Review of the facility's Grievance Policy revised January 2017 Reflected: Policy Statement Residents and their representatives have the file grievances, either orally or in writing, and anonymously to the grievance box, facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the residents and/or: 4. Upon admission, residents are provided with written (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	information on how to file a grievance or complaint. A copy of our grievance/complaint procedure is posted on the resident bulletin board. 8. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administer within 5 working days of receiving the grievance and/or complaint.9. Complaints of abuse, harassment, or mistreatment will be immediately investigated, and you may request a report of the findings, recommendations, and/or corrective action taken within five (5) working days of the filing of the report.		

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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, interview, and record review, the facility failed to provide a private meeting space for residents' monthly council meetings for 7 of 15 confidential residents who were reviewed for resident rights. The facility failed to provide a private space for resident council meetings. This failure could place residents at risk of not being able to voice concerns due to a lack of privacy. Findings include: Record review of Resident Council Minutes dated February 2026 revealed Resident Council was held in the dining room with 5 residents present. Record review of Resident Council Minutes dated March 2026 revealed Resident Council was held in the dining room with 4 residents present. Record review of Resident Council Minutes dated April 2026 revealed Resident Council was held in the dining room with 5 residents present. Record review of Resident Council Minutes dated May 2026 revealed Resident Council was held in the dining room with 4 residents present. Record review of Resident Council Minutes dated June 2026 revealed Resident Council was held in the dining room with 6 residents present. Record review of Resident Council Minutes dated July 2026 revealed Resident Council was held in the dining room with 6 residents present. Observation of dining room on 8/12/26 at 11:00AM revealed staff and residents in and out of the dining room during the Resident Council meeting. The staff and residents coming in and out of the dining room were not attending Resident Council. An interview on 8/12/26 at 11:00 AM with 7 alert and orientated residents who attended resident council stated resident council was always held in the dining room. They stated staff came in and out with no privacy, and the Residents stated they filtered what they said in Resident Council due to staff presence. Residents stated there was no sign posted for when Resident Council was in session. In an interview on 8/13/26 at 10:30AM, the Activities Director (AD) stated Resident Council meetings were held in the dining room for the entirety of her employment with the facility; 12 years. The AD stated she knew Resident Council was supposed to be held in a private meeting space. The AD stated the dining room was not a private space. She stated she did not post a sign for Resident Council meeting. She stated the Resident Council meetings were on her Activity Schedule. The AD stated there were no doors to close for the dining room. She stated there were no barriers to close off the entrance/exit to the dining room. The AD stated there were other possible private meeting spaces for Resident Council, however, she had not moved the Resident Council meeting place. The AD stated the potential negative outcome for no privacy for Resident Council was residents may not speak freely in the meetings due to staff overhearing their conversations. In an interview on 8/13/26 at 11:15AM the Administrator stated that she was aware Resident Council meeting was to be held in a private setting. The ADM stated Resident Council had always been held in the dining room throughout her 10 years of employment with the facility. The ADM stated the dining room was not a private setting. She stated she was aware there was no sign posted when Resident Council was in session. She stated she had not thought of using privacy screens for the dining room during Resident Council. She stated moving Resident Council to a private setting was not a hard fix. She stated the potential negative outcome of not having a private setting for Resident Council was the Residents may not feel comfortable sharing their needs, thoughts, feelings, and complaints. Record Review of the facility's Resident Council Policy Revised April 2017, revealed it did not include relevant references to the failure.		

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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 observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: Observed 08/11/2026, the facility failed to properly label food stored in the refrigerator. This failure could place residents at risk for foodborne illness. The following observations were made on 08/11/2026 at 09:35 A.m. during the initial tour of the kitchen:-Bowl of red gelatin with no label.-Bag of sausage patties with no label.-Two pitchers of tea with no label. During an interview on 08/13/2026 at 10:15am, the DS confirmed the gelatin, and the sausage patties were not labeled. The DS stated she did not know the tea needed to be labeled before being served at lunch in an hour and a half. She stated the gelatin, sausage patties, and the tea were not labelled when placed in the refrigerator. She stated all items should be labeled when placed in the refrigerator. She stated all staff had been trained in proper food storage. She stated she was not aware the gelatin, the sausage patties, and the tea pitchers were not labeled. She stated she checked the refrigerators every Tuesday as that is the day she places her weekly food orders. She stated the purpose for labelling and dating food was food safety. She stated the potential negative outcome could be food borne illness. During an interview on 08/13/2026 at 11:35am, the ADM stated all food in the refrigerator should be labelled and dated. She stated the purpose of labeling the food was to know when it was opened and when it would expire. She stated all staff had been trained in proper food storage. She stated she was not aware food was being stored without a label. She stated the DS was responsible for making sure food was properly stored. She stated the DS checked the refrigerators weekly and the dietitian checked them monthly. She stated the potential negative outcome could be food borne illness. Record review of the facility's policy titled Storage of Frozen and Refrigerated Foods, revised 4/2006 reflected: Potentially hazardous foods will be refrigerated or frozen using proper procedures.9. Refrigerate foods in shallow containers. Label cold/frozen foods in the refrigerator with the date open or prepared, time, expiration or use by date. Once a product has been opened the dated opened shall be written on the product and use by date is 7 days from date opened. Food prepared in the building and properly cooled will be dated as to the date prepared and used by date which will be 7 days from the date prepared.		

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F 0690 Level of Harm - Minimal harm or potential for 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 ensure residents who were incontinent of bladder or had a urinary catheter received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 Residents (Resident #18) reviewed for quality of care. CNA A failed to properly secure the foley catheter tubing (indwelling tube to empty the bladder) while providing incontinent care to Resident #18. This failure placed the residents at risk of their Foley catheters getting dislodged, unwanted pain, trauma, infections, and decreasing their quality of life. Findings include: Record review of the admission record for Resident #18, dated 08/13/26, revealed an [AGE] year-old male who was admitted on [DATE] with the following diagnoses: dementia (cognitive loss), neuromuscular dysfunction of bladder (impaired bladder control), heart failure, hypertension (high blood pressure) and difficulty in walking. Record review of the quarterly MDS assessment for Resident #18, dated 05/18/26, revealed Resident #18 had an indwelling catheter and diagnosis of neurogenic bladder (impaired bladder control). Record review of the current care plan for Resident #18, dated 12/18/25, revealed there was a focus area: Resident has indwelling catheter: neurogenic bladder. During an observation on 08/12/26 at 09:10 a.m., CNA A provided catheter care for Resident #18. CNA A held tip of penis with left hand while cleaning catheter tubing with right hand. CNA A failed to secure tubing while cleaning. During an interview on 08/12/26 at 09:40 a.m., the DON stated the proper way to clean tubing was to secure tubing at the tip of penis and wipe away from the penis. She stated she was not aware CNA A was not securing tubing. She stated all CNA staff had been trained in proper incontinent care. She stated the DON and CN were responsible for monitoring the CNAS for proper care. She stated the potential negative outcomes could be pulling the catheter out with bulb inflated and pain to the resident. During an interview on 08/12/26 at 10:15 a.m., the ADM stated the catheter tubing should be secured during incontinent care. She stated all staff have had proper catheter care training. She stated she was not aware staff were not securing the tubing during catheter care. She stated the DON and the ADON were responsible for monitoring staff. She stated the potential negative outcome could be pulling out the catheter and unnecessary pain to the resident. During an interview on 08/12/26 at 10:54 a.m., CNA A stated she was not aware she did not secure the catheter tube. She stated the process was to secure the tubing at the tip of penis and wiping the tubing downward. She stated had been trained in proper catheter care. She stated the potential negative outcome could be pain or damage to the resident. Record review CNA Skill: Foley Catheter Care dated 04/13/26 for CNA A revealed satisfactory skills for foley catheter care. Record review of the facility policy titled, Catheter Care, Urinary, with revised dated 09/2014 reflected the following: Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections.Steps in the Procedure.13. With nondominant hand separate the labia of the female resident or retract the foreskin of the uncircumcised male resident. Maintain the position of the is hand throughout the procedure.17. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.		

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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. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 1 of 1 medication carts reviewed for medication storage. The facility failed to properly store medication in the medication cart. The medication cart contained four loose pills. This failure could place residents at risk of not receiving prescribed medications as ordered and place the facility at risk of drug diversions. The findings included: On 08/12/26 at 11:15 a.m., an observation of the medication cart was conducted with LVN B. Four loose pills were found in drawer of the medication cart. LVN B placed the pills in a dispensing cup and took them to the DON for identification. During an interview on 08/12/26 at 11:15 a.m., LVN B stated the medication cart should not have loose pills. She stated the nursing staff was responsible for keeping the medication cart clean. She stated they cleaned the cart daily. LVN B stated she had been trained through in-services on proper medication storage. She stated a potential negative outcome for loose pills on the cart was residents not getting medications. During an interview on 08/12/26 at 11:32 a.m., LVN B stated the loose pills in the medication were identified by DON and ADON. She stated the pills were identified as Lisinopril/HCTZ (hydrochlorothiazide) 100/12.5 mg (1 Tablet), Oxybutynin 15mg (1 tablet), Eliquis 2.5mg (1tablet), and Carvedilol 12.5mg (1 tablet). During an interview on 08/12/26 at 09:40 a.m., the DON stated medications should be stored in blister packs or original medication bottles. She stated she was not aware there were loose medications on the carts. She stated medication cart was to be cleaned weekly. She stated all nurses had been trained on proper medication storage. She stated the nurses were responsible for checking the medication cart. She stated the potential negative outcome for loose pills on the cart was wrong pills given, dropped pills on floor, and residents not getting the medication. During an interview on 08/12/26 at 10:16 a.m., the ADM stated medications should be stored in a blister pack or manufacture bottles. She stated she was not aware medications were loose in the drawer of the medication cart. She stated the nurses have been trained, and they have a small vacuum to clean the drawers. She stated the medication cart should be cleaned every shift. She stated the DON was responsible for monitoring the medication cart for loose pills. She stated the potential negative outcome for loose pills on the cart was residents not getting medications appropriately as prescribed. Record review of the facility-provided policy titled, Storage of Medications; revised April 2007 revealed:Policy Statement: The facility shall store all drugs and biologicals in a safe, secure and orderly manner.Policy Interpretation and Implementation1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received.2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 1 of 1 resident (Residents #6) reviewed for infection control. On 08/12/26 the facility failed to implement and maintain contact precautions and ensure staff utilized Personal Protective Equipment (PPE) appropriately to prevent cross contamination for Resident #6 with a wound. This failure could place residents at risk for the spread of infection and cross contamination. Findings include:Record review of Resident #6's clinical record revealed a face sheet, dated 08/13/26, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #6's diagnoses included Parkinsonism (brain disorder that slowly affects movement and coordination), muscle weakness, dementia (cognitive loss), and hypertension (high blood pressure).Review of Resident #6's comprehensive MDS assessment, dated 06/26/26, revealed his BIMS score of 06 which indicated her cognition was severely impaired. MDS section M - Skin Condition revealed resident #6 had a risk of developing pressure ulcers.Record review of Resident #6's care plan dated 07/03/26, revealed a focus area for stage 2 pressure ulcer to right lower calf with interventions to administer treatments as ordered. Record review of Resident #6's physician orders dated 08/13/26 revealed an order Clean pressure area to right lower calf with wound cleaner, pat dry, apply Medihoney, cover with foam and wrap with Curlix daily and prn until healed one time a day for wound care, dated 07/01/26.During an observation on 08/12/26 at 09:10 a.m., the DON provided wound care for Resident #6 with the ADON assisting. The DON and ADON entered Resident #6's room to perform wound care. DON and ADON washed hands and donned gloves. Approached Resident #6 bed and performed wound care. The DON and ADON did not put on a gown before starting the wound care. Observed EBP signage and PPE hanging in a bag at the head of bed at the top of privacy curtain.During an interview on 08/13/26 at 09:40 a.m., the DON stated, I did not wear a gown during wound care. She stated she did not realize she did not put on a gown until she went to wash her hands after wound care. She stated Resident #6 was on EBP for an open wound. She stated EBP was for any resident that has an open wound and indwelling catheter. She stated she had been trained in EBP. She stated she and the ADM were responsible for monitoring staff for infection control compliance. She stated the potential negative outcome could be the spread of infection.During an interview on 08/13/26 at 10:01 a.m., the ADON stated she forgot to put a gown on when entering Resident #6's room for wound care. She stated the purpose of EBP was to prevent infection and cross contamination of residents with wounds and indwelling tubes. She stated she had been trained in EBP and should have worn a gown. She stated the CN, ADON, DON and ADM were responsible for monitoring compliance with EBP. She stated the potential negative outcome could be infection control issues.During an interview on 08/13/26 at 10:16 a.m., the ADM stated the purpose of EBP was to prevent infection and cross contamination. She stated she was not aware the DON and ADON did not wear proper PPE. She stated Resident #6 had a wound, and the DON and ADON should have worn a gown during wound care. She stated all staff were trained on EBP. She stated EBP was for residents with wound care, catheter care and wound vacs. She stated the potential negative outcome could be infection control.Record review the facility policy titled Enhanced Barrier Precautions revised dated December 2024, revealed the following:Policy Statement - Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.Policy Interpretation and Implementation .1. Enhanced barrier precautions (EBPs) refer to infection (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities.2b. A resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained, .7. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply.a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) .8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: .j. wound care (any skin opening requiring a dressing) .		