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: 675418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER The Manor at Seagoville		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 Elizabeth LN Seagoville, TX 75159	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 2 (200 Hall and 300 hall) out of 3 hallways reviewed for accidents and hazards. 1.The facility failed to ensure that the mechanical lift on 200 hall and 300 halls were locked and secured when not in use.This failure could place residents at risk of falls and/or injuries. Observation on 04/01/26 at 11:17 AM of 300 hall revealed an unlocked and unsecured mechanical lift parked on the doorway of room [ROOM NUMBER] residents were observed maneuvering their wheelchairs around the Hoyer lift. Observation on 04/01/26 at 10:24 AM of 200 hall revealed an unlocked and unsecured mechanical lift parked on the doorway of room [ROOM NUMBER] residents were observed maneuvering their wheelchairs around the Hoyer lift. During an interview on 4/1/26 at 10:35 AM with RN A revealed that Hoyer /mechanical lifts should be stored away from high traffic areas where residents could access them and get hurt. He stated he had been in serviced on mechanical lifts to include storage. During an interview on 4/1/26 at 10:38 am LVN C stated that mechanical lifts should always be locked in the common areas, such as the hallways when they are not being used. LVN C stated that Hoyer's are stored at the end of the hall away from residents. She stated failure to lock Hoyer lifts could cause accidents to include that someone could break a body part, such as an arm or leg when a mechanical lift is unlocked During an interview on 04/01/26 at 11:05 am with CNA D, she stated mechanical lifts must aways be locked and the red button activated to make sure there are no moving parts. She stated the risk was that a resident might attempt to support themselves and get injures that could be serious to include hospitalization she stated she had been in serviced on Hoyer lifts to include securing and storing. During an interview on 04/01/26 at 4:15pm with the DON, she stated that her expectation was that all mechanical lifts were to be locked when they are not being used. The DON stated that all staff have been educated and trained in the proper usage and safety of mechanical lifts. She stated that she will re-educate staff with In-Service training on Mechanical Lifts and Mechanical Lift Storage and Safety. She stated that there was a risk to residents if attempted to pull themselves up using an unlocked and unsecured mechanical lift, which could cause injuries. Record Review of facility's policies titled Mechanical Lift Protocol undated reflected 5.All lifts will be returned to their assigned lift station to charge when not in use.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that enteral feeding and administration sets were properly labeled consistent with professional standards of practice for 1 (Residents #1) of 3 residents reviewed for enteral feeding. The facility failed to ensure the G tube (a method of delivering liquid nutrition directly into the stomach or small intestine when a person cannot eat enough by mouth) feeding was properly labeled and dated before administering the feeding to Resident#1. This failure could put the residents at risk of inaccurate delivery of prescribed nutrition.Record review of Resident #1's MDS assessment, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 12 indicating moderate cognitive impairment. Her diagnoses included hypertension (is a chronic condition where the force of blood against artery walls is consistently too high), aphasia (a neurological disorder caused by brain damage that impairs a person's ability to communicate), and respiratory care. Section K0310 was coded for feeding tubes. Record review of Resident #1's care plan initiated [DATE] reflected The resident requires tube feeding. Interventions included: The resident needs the HOB elevated to 45 degrees during and thirty minutes after tube feeding. every shift for FEEDING 2 CAL HN (is calorie and protein dense nutrition) at __40__ml/hour via feeding tube. Up at_9:00am__, to run continuously until total volume of __880_ml administered. May remove for care and services. Up at 9am down at 7am x 22 hours Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 60 cc aspirate (withdrawing fluid from the body using suction) Record review of Resident #1's active physician's orders dated [DATE] revealed Enteral Feed Order every shift for FEEDING 2 CAL HN at__40__ml/hour via feeding tube. Up at_0900___, to run continuously until total volume of__880_ml administered. May remove for care and services. Up at 9am down at 7am x 22 hours. During an observation on [DATE] at 10:22am, revealed Resident#1 was observed to have enteral feeding administered via a gastronomy. The feeding set up included the feeding bag and tubing connected to the G-tube, was observed to be unlabeled, with no indication of date time of initiation or resident information. During an interview on [DATE] at 10:24am LVN C confirmed she was the nurse for Resident #1. She stated the facility policy required labeling of enteral feedings to ensure timely replacement and prevent contamination. LVN C acknowledge that the feeding set up should have been labeled and stated that it was the night shift that initiated the feeding. During an interview [DATE] at 10:24am with RN A revealed that enteral feeding should be labeled before administration. He stated the risk of not properly labeling the feeding was administration of expired feeding because all feedings should be discarded after 24 hours. He stated he had been in-serviced on g-tube feeding administration. During an interview [DATE] at 10:24am with the DON revealed that her expectation was the nurse that administered the feeding should label, date the feeding before administration. She stated that every nurse assigned to the resident should check as part of their assessment to make sure the feeding was properly labeled. She stated the risk was administering the wrong feeding and staff would not know how long the feeding had been infused. She stated the nurses had been in-serviced on G-tube feeding administration. Record review of facility policy titled Administration of Formula via feeding tube Gravity, Bolus, Pump dated 06/2026 reflected the following: DocumentationDate and time of feeding. Amount of feeding method of deliveryRoutes of delivery Patient reactions to feeding tolerance or feeding include diarrhea, vomiting they got abdominal distension include condition G-tube. Record formulas and water amounts and medication administration medication administration record be sure to include water used for flushing and water used for meditation.

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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 observations, interviews, and record reviews, the facility failed to ensure parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Residents #1) of 2 residents reviewed for parenteral and intravenous care.The facility failed to ensure Resident #1's IV antibiotic was initialed and labeled with the date/time of administration.The facility failed to ensure Resident #1's IV tubing was dated, per the facility policy, when the IV antibiotic was administered.This failure could put the residents at risk of medication error and infectionRecord review of Resident #1's MDS assessment, dated 03/17/2026, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 12 indicating moderate cognitive impairment. Her diagnoses included hypertension (is a chronic condition where the force of blood against artery walls is consistently too high) and respiratory care. Section O - Special treatments, procedures, and programs was coded for IV medications and IV access. Record review on 04/01/2026 at 10:10am of Resident #1's active care plan did not indicate any focus areas or interventions related to this failure. Record review of Resident #1's active physician's orders dated 04/01/2026 revealed Cefepime HCl Solution (an antibiotic used intravenously or intramuscularly to treat severe bacterial infections) 2 GM/100ML Use 2 gram intravenously every 8 hours for infection for 14 Days Phone Active 03/20/2026. An observation on 04/01/26 at 10:20am revealed Resident # 1 was receiving Cefepime HCl Solution 2 GM/100ML intravenously via midline (flexible tube inserted into a peripheral vein in the upper arm, with the tip resting just below the armpit). The IV antibiotic did not have the date/time it was initiated and initials of the nurse who administered the medication Observation also revealed the IV tubing was not dated. During an interview on 04/01/26 at 10:24am LVN C confirmed she was Resident #1's nurse, and she administered the IV antibiotic. She stated that she forgot to date and initial the medication and dated the IV tubing. She stated the risk to the resident was potential for medication error because it would not be possible to know what time the medication was started and when the IV tubing was last changed. She stated she had been in-serviced on administration of IV medication to including dating and initialing at the time of administration. In an interview on 04/01/26 at 4:26 pm, the DON stated nurses were expected to initial and date IV medication and IV tubing during every antibiotic administration. The DON stated the risk was infection and not knowing when the medication was started which could lead to a medication error. Record review of the facility's Intravenous Therapy implemented 12/1/2025 revealed:1. IV tubing is changed every (96) hours or sooner if contamination is suspected or integrity of system is compromised.5. All IV tubing is to be labeled with date, time and initials.

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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 review, the facility failed to ensure respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, for 1 of 4 residents (Resident#2) reviewed for respiratory care. The facility failed to ensure that Resident#2's oxygen tubing, and humidifier were changed per physician's orders. This failure had the potential to affect residents receiving oxygen therapy by increasing their risk of health -associated infections. Record review of Resident #2's MDS Quarterly Assessment, dated 2/04/2026 reflected the resident was an [AGE] year-old female. Initially admitted [DATE] and had a BIMs score of 12 indicating moderate cognitive impaired. The resident had diagnoses which included Heart Failure (a chronic, progressive condition where the heart cannot pump enough blood to meet the body's needs). Record review of Resident #2's Comprehensive Care Plan active 4/1/2026 revealed the resident has oxygen therapy Date Initiated: 08/08/2025 Facility intervention includes: Monitor for s/sx of respiratory distress and report to MD. Record review of Resident #2's Active order 4/1/2026 reflected: Oxygen: Obtain SPO2 as needed for SOB Phone Active 07/13/2025. Record review of Resident #2's Active order 4/1/2026 reflected Oxygen: Oxygen at 2L as needed for SOB Phone Active 07/13/2025 . Record review of Resident #2's Active order 4/1/2026 reflected Oxygen: Tubing and Humidifier Change every night shift every Wed for EQUIPMENT Verbal Active 01/10/2026. In an observation on 4/1/2026 at 11:05 AM Resident # 2 was observed to be using oxygen 2l/min via nasal cannula. The oxygen tubing was dated 3/12/2026 and the humidifier was empty. During an interview on 4/1/2026 at 1:02 PM with RN A revealed that he was Resident #2 on continuous oxygen. He stated it was the responsibility of the nurses to check and change oxygen tubing when ordered. He stated oxygen tubing and humidifiers were changed every Wednesday night. He stated the risk to the residents was respiratory infection from prolonged use of the tubing and nose bleeds. He stated that he had been in-serviced on infection control and oxygen tubing care. During an interview on 4/1/2026 at 1:34PM with LVN B revealed that oxygen tubing and the humidifier were supposed to be changed on the Saturday night shift. She stated she usually checked the oxygen tubing to make sure they were dated. She stated the importance of changing oxygen tubing, and the humidifier was to track its age so it could be replaced according to the recommended schedule. She stated that she had been in-serviced on infection control and oxygen tubing care. During an interview on 4/1/2026 at 4:30 PM with the DON revealed her expectation was the nurse assigned should check the oxygen tubing and nebulizer masks as part of overall assessment to make sure they were functioning properly. She stated the facility policy was to change oxygen tubing and the humidifier weekly and when they became dirty or contaminated. She stated the risk to the resident if tubing was not stored in sanitary ways, was infection. She stated that the nurses had been in-serviced on oxygen tubing care. Record review of the facility Policy titled Oxygen Administration not dated revealed: The purpose of this procedure is to provide guidelines for safe oxygen administration.DocumentationAfter completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record:1. The date and time that the procedure was performed.2. The name and title of the individual who performed the procedure.3. The rate of oxygen flow, route, and rationale.4. The frequency and duration of the treatment.5. The reason for p.r.n. administration.6. All assessment data obtained before, during, and after the procedure.7. How the resident tolerated the procedure.