

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Mansfield Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 E Broad St Mansfield, TX 76063	

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)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489</p> <p>Based on interviews and record review, the facility failed to ensure care plans were developed in consultation with the resident and</p> <p>the resident's representative for 4 of 4 residents (Resident #20, Resident #24, Resident #42, Resident #167) reviewed for Comprehensive Care Plan.</p> <p>The facility failed to ensure Resident #20, Resident#24, Resident #42, and Resident 167, and/or the resident's representative were invited to participate in the comprehensive care plan meeting per resident rights guidelines that residents have the right to participate in their planning of care.</p> <p>This failure affected 4 residents and placed 62 residents at risk for a loss of independence, psychosocial well-being, and the opportunity for them to participate in their planning of care.</p> <p>Findings included:</p> <p>Record review of Resident #20's face sheet dated 04/25/2024, revealed a [AGE] year-old female readmitted to the facility on [DATE] with an initial admission to facility on 02/01/2013. Her diagnoses included Aphasia following unspecified cerebrovascular disease (impairment of language caused by stroke), cerebral palsy, unspecified (a congenital disorder of movement, muscle tone, or posture), and other intellectual disabilities (mental retardation).</p> <p>Record review of Resident #20's file revealed documentation that care plan conferences were held with resident's sister the responsible party on the following dates, 04/28/2021, 05/26/2021, 07/21/2021, 10/15/2021, 01/18/2022, 09/21/2022, 09/21/2022, 05/10/2023, 07/19/2023, and the last meeting held on 09/18/2023. There were no further documented care plan conferences held with resident's sister after 09/18/2023.</p> <p>Record review of Resident #24's face sheet dated 04/25/2024, revealed a [AGE] year-old male readmitted to facility on 02/06/2022 with an initial admission to facility on 03/04/2021. His diagnoses included major depressive disorder, recurrent, moderate (feelings of worthlessness, appetite, other disturbances), carcinoma inside of the esophagus (Cancer of the throat)., and other dysphagia (most common symptom of esophageal cancer that prevents food from passing normally through esophagus).</p> <p>(continued on next page)</p>

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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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #24's file revealed that care plan conferences were held with the resident and daughter on 09/03/2021, 06/23/2022, 04/19/2023, 07/20/23, and the last meeting held on 09/13/2023. There were no further documented care plan conferences held with the resident and daughter after 09/13/2023.</p> <p>Record review of Resident #42's face sheet dated 04/25/2024, revealed a [AGE] year-old female readmitted to facility on 04/07/2024 with an initial admission to facility on 08/24/2023. Her diagnoses included chronic obstructive pulmonary disease, unspecified (lung disease), essential (primary) hypertension (force of the blood against the artery walls is too high), and generalized anxiety disorder (Mental disorder).</p> <p>Record review of Resident #42's file revealed the initial admission care plan meeting held with the resident and spouse on 08/24/2023. There were no further documented care plan conferences held with the resident and spouse after 08/24/2023.</p> <p>Record review of Resident #167's face sheet dated 04/25/2024, revealed a [AGE] year-old male readmitted to facility on 04/19/2024 with an initial admission to facility on 09/28/2022. His diagnoses included metabolic encephalopathy (chemical imbalance in the blood), neuromuscular dysfunction of bladder, unspecified (bladder that does not fill or empty correctly), and essential (primary) hypertension (force of the blood against the artery walls is too high).</p> <p>Record review of Resident #167's file revealed quarterly care plan meetings with the resident on 04/19/2023, 06/22/2023, and the last held on 08/23/2023. There were no further documented care plan conferences held with the resident after 08/23/2023.</p> <p>Interview on 03/24/2024 at 3:40 PM with the Social Worker stated that the facility has been without a consistent Social Worker on staff. The new Social Worker started in December 2023. The SW was working on setting up the care plan meetings to coincide with the MDS (Minimum Data Set) schedules. The SW invited residents and family members and/or representatives to the care plan meetings that are scheduled quarterly. The care plan meeting provides information related to the daily care of the resident in the facility and focuses on the problems, goals, and interventions to assist the resident in meeting their needs. The care plan summarizes a person's health conditions, specific care needs, and current treatments. Expectations are to invite residents and their family members and/or responsible parties quarterly to the meetings and have them be a part of goals set for the resident. The SW is setting up the calendar to invite the residents and family and/or responsible party to coincide with the quarterly MDS (Minimum Data Set) schedule.</p> <p>On 04/25/2024 at 4:00 PM, requested a policy related to Care Plans. Administrator provided policy.</p> <p>Facility's policy for Resident Participation - Assessment/Care Plans revealed: The resident and his or her representative were encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan.</p> <p>1. The resident and his or her legal representative are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan.</p> <p>44894</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489</p> <p>Based on observations, interviews, and record review, the facility failed to provide residents with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one (Resident #44) of 24 residents reviewed for call lights.</p> <p>The facility failed to ensure Resident #44's call light was within reach of the resident.</p> <p>This failure could place the residents at risk of falling, injury, and feelings of low self-worth due to not being able to call for help.</p> <p>Findings included:</p> <p>Review of Resident #44's face sheet, dated 04/25/24, reflected the resident was a [AGE] year-old male, admitted on [DATE]. His diagnoses included cerebral palsy (a condition affecting motor control), other lack of coordination, and severe intellectual disabilities.</p> <p>Review of Resident #44's quarterly MDS assessment, dated 01/27/24, revealed he had unclear speech, was sometimes understood by others, and sometimes understood others. He had a BIMS score of seven, indicating severe cognitive impairment. Resident #44 was dependent on staff for most ADLs but was able to feed himself with supervision/ touching assistance. He was noted to use a wheelchair and have no impairment to his range of motion on either side, upper or lower body.</p> <p>Review of Resident #44's care plans dated 09/16/21 reflected a behavioral problem of rolling off his bed onto the floor and rolling on the floor. The care plans also reflected the resident had impaired visual function, was incontinent of bowel and bladder, had risk for skin breakdown, and falls.</p> <p>An interview and observation on 04/23/25 at 9:35 AM revealed Resident #44 in his wheelchair, sitting next to his bed. The call button was on his bed, to his left, and just behind the back of his wheelchair. When asked if he could reach his call light, he attempted to reach out with his left hand, and was not able to reach far. He said he could not reach it.</p> <p>An interview and observation on 04/25/25 at 9:38 AM revealed CNA E went into Resident #44's room and when the state surveyor said he could not reach his call light she moved it to clip it to his blanket at his right hand. She said most of the time the resident was in his bed, and they put it closer to him. As soon as the CNA and the state surveyor left the room, he put his call light on.</p> <p>An interview and observation on 04/25/25 at 3:23 PM revealed Resident #44 was in his bed, and his call button was not visible on his bed. When the state surveyor asked him where it was, he pointed and said, over there and it was clipped to the privacy curtain in the middle of the room.</p> <p>An interview and observation on 04/25/24 at 3:26 PM revealed CNA F and another staff member were transporting a resident to the shower room on the shower bed, but she paused to tell the state surveyor that she and CNA G had transferred Resident #44 to his bed earlier. She did not have time to be interviewed at that time.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 04/25/24 at 2:28 PM with CNA G revealed she and CNA F had transferred Resident #44 to his bed earlier, after she weighed him, but she left CNA F at that point, so she could change him by herself. She said the call button was normally clipped to the resident or his bed, and she did not know why it was not. She said that it was important to keep the call buttons within reach so the resident could call for help if they needed anything. She said the call lights were everyone's job, even if she was not that resident's CNA and was just assisting his CNA. She said she felt responsible for the residents and normally when she was done changing someone, she would put the call light where they could reach it.</p> <p>An interview and observation on 04/25/23 at 3:33 PM revealed LVN H said the call lights were for the residents to draw attention to themselves if they needed anything. He said it was everyone's responsibility to make sure they were in place where the resident could reach them, but especially the nurses and CNAs. He said the CNAs must have transferred the resident and forgotten to put it back when they were done. He then went to Resident #44 and placed his call light where he could reach it and apologized to the resident. CNA G also entered the room to check on the resident.</p> <p>An interview on 04/25/24 at 6:13 PM with the Administrator revealed the call lights were always supposed to be within reach of the residents, so they could call for assistance if needed. He stated not having them in place could contribute to residents not getting care when they needed it.</p> <p>Review of the facility policy for answering call lights, revised March 2021, reflected: Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: (.) 4. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489</p> <p>48520</p> <p>Based on observations and interviews the facility failed to provide a clean and functional environment for six (Residents #34, #54, #16, #59, #36, and #7) out of 24 residents reviewed for a sanitary, functional, and homelike environment, as evidenced by:</p> <ol style="list-style-type: none"> 1. Resident #34's room had grimy, stained, dusty floors, a badly scraped chest with missing wood veneer and handle, and grimy, stained floor, and a bent privacy curtain runner. The bathroom, which was shared with Resident #54 in the room next-door had a non-working sink and toilet, and a damaged and badly repaired wall in the bathroom. The bathroom floor was also grimy, stained, and was repaired with noticeably mismatched tiles. Resident #34's door would not close completely, due to the placement of a bed next to the door. 2. Resident #16's room had gnats, and the unmade bed was saturated with urine. 3. Resident #59's room had a cracked, flaking, translucent film over part of the window, and damaged windowsill and wall below the window. 4. Resident #36's room was only partially painted, having walls with different colors of paint. In addition, the room had damage to the baseboard and walls, and the bathroom was grimy, stained, and had unrepaired damage to the wall under the sink, cracked and peeling caulking, and missing tiles. 5. Resident #7's room had a dusty, grimy, stained floor with cracked tiles, and damaged walls (including damaged and stained areas around her window), areas of different colored paint, and a damaged dresser with a hinged padlock which was unscrewed from one side. <p>These failures could place residents at risk for infection, for feelings of low self-worth due to living in an unclean, visually unappealing, and non-functional environment.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Residents #34 and #54: <p>Review of Resident #34's face sheet, dated 04/25/25, reflected she was a [AGE] year-old female, admitted on [DATE], with diagnoses of paraplegia (lower body paralysis), colostomy, pressure ulcers, mood disorder, bi-polar disorder, post-traumatic stress disorder, anti-social personality disorder, and seizures.</p> <p>Review of Resident #34's Quarterly MDS, dated [DATE], revealed she could understand others, and be understood by others. She had a BIMS score of 14, indicating intact cognition. Resident #34 had impaired range of motion of her lower body, on both sides, and used a wheelchair to move around in the facility. She was dependent on staff for some ADLs but was able to feed herself and do her own oral hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview and observation on 04/23/24 at 10:53 AM with Resident #34 revealed her to be fully alert and oriented, and lying in her bed. The floor appeared stained and grimy around the edges, especially near the doorways. She said she was not happy at the facility, and while going over her concerns with the state surveyor, directed the state surveyor to the bathroom. She said that when it rained a lot, the bathroom floor flooded, water came in, and it was disgusting. The state surveyor went in the bathroom and observed that the floor was dark and grimy, with stained tiles overall, but build-up of grime around the edges. The floor had been repaired around the toilet, and the newer tiles highlighted how dirty and stained the older, unmatching tiles were. The door and doorway had staining, and paint chipped off. The walls near the sink were dirty and stained, and had been repaired poorly in the past, leaving the surface uneven, with cracks discoloration, and peeling around the lumpy repaired area. The wall appeared chipped around the edges of the mounted sink. The state surveyor asked the resident about the water in the sink, and the resident said it never drained properly. The state surveyor waited four minutes to see if the sink drained, and no change was visible in the level of the water. The toilet had urine and toilet paper in it, and the resident said it did not flush properly, and sometimes overflowed. She told the state surveyor you have to hold the handle down the whole time, so the state surveyor flushed the toilet, holding the handle down the entire time. The contents swirled, and only about half of the contents flushed, very slowly. The resident said that she was not able to use the bathroom, but her mother visited often, and was disgusted by the bathroom. She said she and her mother had complained numerous times. She said the toilet had overflowed sometimes when her mother used it, and it has poop and stuff in it and was gross. Resident #34 said pointed out that she had no privacy curtain, and said she had not had one since she moved in. The railing for the privacy curtain was bent downward about 1/3 of the length from the end, which she said prevented them from being able to replace it. She said they were supposed to fix it, and she had asked about it before, but it was still broken. The door would not close all the way (opening was approximately 12 as measured by the floor tiles). Resident #34 said when her roommate moved out, they moved the longer bed into the room, and it got in the way of the door closing.</p> <p>An interview and observation on 04/24/24 at 4:33 PM with Resident #34 revealed the bed that had been keeping the door from closing had been moved out. The bedside dresser table had been moved to the corner, and the state surveyor could see it was badly scraped, and had areas of veneer missing, and was missing the handle on the top drawer. The floor where the bed was removed was stained with brown-ish orange areas, and purple stains, as well as a significant amount of dust and debris, which was heavier around and under the bedside dresser table. Resident #34 said the housekeeping typically came into the room and swept or mopped a little, but did not bother to sweep very well. She said, they just pushed the dresser into the dirt.</p> <p>Review of a grievance form, dated 03/21/24, filed by Resident #34's family member, reflected the sink and toilet in Resident #34's (and 54's) room was clogged, and Maintenance unclogged it the same date.</p> <p>Review of Resident #54's Face sheet, dated 04/25/24, reflected she was a [AGE] year-old female, admitted on [DATE], with diagnoses of congestive heart failure, breast cancer, rheumatoid arthritis, depression, chronic pain, and colitis (chronic inflammation of the inner lining of the colon.) Resident #34 was a hospice patient.</p> <p>Review of Resident #54's quarterly MDS, dated [DATE], reflected she could understand others, and be understood by others. She had a BIMS score of 13, indicating she was cognitively intact. She was able to walk independently and required little to no assistance from staff with ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview and observation on 04/23/24 at 11:42 AM with Resident #54 revealed the jack-and-[NAME] bathroom she shared with Resident #34 did not work, and the toilet overflowed, which made her afraid to flush it. She said sometimes she could not wash her hands because the sink did not drain , and she did not like it. She wanted them to fix it.</p> <p>2. Resident #16</p> <p>Review of Resident #16's face sheet, dated 04/25/24, reflected he was an [AGE] year-old male, admitted on [DATE], with diagnoses of one-sided weakness following stroke, major depressive disorder, kidney failure, and Parkinson's disease (a nervous system disorder).</p> <p>Review of Resident #16's quarterly MDS assessment, dated 02/07/24, reflected he could be understood by others, and was able to understand others. He had a BIMS score of 11, indicating moderate cognitive impairment. He had impaired mobility on both sides of his lower body and used a wheelchair.</p> <p>Review on 04/24/24 at 1:18 PM revealed the windowsill by his bed was broken, with bare, splintered wood exposed for the length of the windowsill. The wall under the windowsill was damaged, with the drywall peeling off between the window and the baseboard for approximately one-third of the length of the window. His window was partially covered with a cracked, peeling, and cloudy film.</p> <p>Interview and Observation on 04/24/24 at 1:30 PM of Resident #16 revealed he was in the dining area in his wheelchair, watching TV. The state surveyor was unable to understand the resident's speech clearly, but he nodded that he was fine, and did not have problems with his room.</p> <p>3. Resident #59</p> <p>Review of Resident #59's face sheet, dated 04/25/24 revealed he was a [AGE] year-old man, admitted on [DATE], with diagnoses of stroke and residual effects of stroke, major depressive disorder, and encephalopathy (a condition causing brain dysfunction).</p> <p>Review of Resident #59's quarterly MDS, dated [DATE], reflected he was able to understand others, and be understood by others. He had a BIMS score of nine, indicating moderate cognitive impairment.</p> <p>Observation on 04/24/24 at 1:16 PM of Resident #16's room revealed his bed was unmade and saturated with urine. There were several gnats resting on his bed, which started flying and landing on the bed and other furniture when the state surveyors got near the bed.</p> <p>An observation and interview on 04/24/25 at 2:00 PM with Resident #59 revealed him to be seated in his wheelchair in the dining area, wearing stained, but dry clothing. He said he was fine, and he was dry, and he did not have any problems. He had not noticed any gnats.</p> <p>3. Resident #36</p> <p>Review of Resident #36's face sheet dated 02/25/24, revealed a [AGE] year-old female admitted to facility on 12/20/23. Her diagnoses included end stage kidney disease on dialysis Monday, Wednesday, Friday, nasal congestion, seasonal allergies, heart diseases, and unspecific lump in the left breast.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #36's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Resident #36 could be understood by others, and she could understand others. Activities of daily living revealed resident required supervision or touching assistance from the facility staff for toileting. Resident #36 was always continent and on dialysis.</p> <p>Observation and interview with Resident #36 in her room on 04/25/24 at 09:00 AM, revealed grimy greyish and black floors in the room, floor tiles were broken along the edge of the room. Black colored baseboards were loose and gapping from the wall exposing holes in the drywall. The bathroom mirror was not broken but had a missing tile on the right side of the mirror. The sink had a brown/orange stain inside it. The bathroom tiles above the sink and below the sink were missing. A white floor fan was observed connected and on an electric socket that was broken by B bed. The walls in the room were partially painted and unfinished in a grey color on two walls and a tan/gold color by the window wall and an eggshell/cream color by on the fourth wall by A bed. Cracks were observed around the left side of the window seal. Resident said she had been reporting and had filed grievances on her room's state. She said she had been complaining since being admitted to the facility in December 2023. She showed the state surveyor the copies of filed grievances and she said the facility had not resolved her grievance. She said the previous maintenance man started to work on her bathroom and replaced the broken mirror at the time, but he never replaced the tiles around the mirror. She said that she was frustrated by the state of her room and had put it on herself to place some boxes with her personal belongings to block the view of the holes in the walls. She said that she was also frustrated because she has been asking someone to help her put her dresser together for about a month. She said the maintenance persons don't really follow through and will tell her they will come back and fix something, but they never do.</p> <p>Review of grievances reflected a grievance filed on 04/04/24 by Resident #36, regarding a sewage smell coming from the bathroom, bathroom tiles and the mirror coming off the wall, the commode loose and rocking, and the room only half painted. The date the grievance occurred reflected on-going since January (2024). The Grievance Official Follow-Up reflected Over the next two weeks I will get all things fixed. [sic]</p> <p>4. Resident #7</p> <p>Record review of resident #7 face-sheet reviewed on 4/23/2024 revealed admission to the facility on [DATE] she was an [AGE] year-old female who admitted with diagnoses of chronic kidney disease, dementia, type 1 diabetes, and end stage renal failure.</p> <p>Record review of Resident #7's MDS reviewed on 4/24/2024 revealed that resident diagnoses included major depressive disorders and cognitive communication deficit. BIMS (Brief interview for Mental Status) score of a 9 indicating that the resident had severe cognitive impairment. Review of functional abilities and goals indicate that the resident requires assistance with day-to-day function ability.</p> <p>Record review of Resident #7 Care Plan dated 2/21/2024 revealed Resident #7 required dialysis r/t Renal failure.</p> <p>Resident received Dialysis three times a week and was at risk for increased SOB , chest pains, blood pressure, itchy skin, nausea/vomiting, and infected access site</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident #7's room on 4/23/2024 revealed the room had a dusty, grimy, stained floor with cracked tiles, and small bits of black debris near the corners. The wall beneath the window was damaged, with brownish-yellow staining, concentrated near the baseboard. The room was painted incompletely and with different colored paint on the walls. The edges and other parts of walls had not been painted, and in some areas the a paint roller or brush were used visible, as though the paint had been started, and left undone. The wall behind and beside the bed was damaged with badly scraped and stained drywall. The built-in wardrobe was badly scraped, and doors were uneven. The bedside dresser table was badly scraped, with missing veneer, and a hinged padlock which was unscrewed from one side, but still had a lock. The room had a strong urine smell. There were visible holes in the baseboard near the door.</p> <p>Observation of Resident #7 on 04/23/2024 at 2:23 PM revealed she was too tired to be interviewed and said she just wanted to sleep.</p> <p>Observation of Resident #7 on 04/25/24 at 2:23 PM revealed she was sleeping .</p> <p>An interview on 04/25/24 at 3:42 PM with the Environmental Service Director revealed he helped to patchwork when the problems happened. He said he was aware the floors were bad but there was only so much he could do with cleaning them. He said his housekeeping staff and himself deep clean, mop, and dust the residents' rooms .</p> <p>An interview with the maintenance director could not be completed because he left the building without notice on 04/24/24.</p> <p>An interview on 04/25/24 at 6:13 PM with the Administrator revealed the Administrator thought the maintenance man (prior to the one who just left) had not worked in long term care before and did not realize how much upkeep there was. She said she felt that he was more focused on the regulatory aspects than getting things done. She said she started in February of 2024, and some staff blamed her for him leaving because she was asking him to fix things. She said the building was very old, and some of the problems, like the call light system, was due to age. She said the corporation was supportive about making improvements and they had talked about new flooring, but she did not know when that was planned. She said the condition and cleanliness of the building was an infection control and quality of life issue. She said the environment should be homelike and it could affect people clinically. She said that on the first day of the survey (04/23/24) she smelled urine when she walked in the door, but it was not normally that bad, and they had addressed it. She said there were certain rooms where the housekeepers would be sent to clean when she smelled urine, but the building as a whole was not bad. She was not aware of issues with gnats until the surveyors brought it to her attention, but they did have regular pest control, and they normally stopped to check in with her to see if there were issues. She also was not aware of the problem with the privacy curtain in Resident #34's room, and that would have been something maintenance should have addressed.</p> <p>Review of the facility policy Homelike Environment, revised February 2021, reflected: Homelike Environment</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Mansfield Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 E Broad St Mansfield, TX 76063	
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Policy Statement: Residents are provided with a safe, clean, comfortable, and homelike environment (.)</p> <p>Policy Interpretation and Implementation: 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:</p> <p>a. clean, sanitary and orderly environment; (.) c. inviting colors and decor; d. personalized furniture and room arrangements; e. clean bed and bath linens that are in good condition; f. pleasant, neutral scents; (.)</p> <p>Review of the facility policy Maintenance Service, revised November 2021, reflected: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. (.) c. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. (.) f. Establishing priorities in providing repair service. g. Maintaining the paging system in good working order. (.) 3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489</p> <p>Based on interviews and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one resident (Resident #34) of 24 residents reviewed for care plans.</p> <p>The facility failed to create a care plan addressing Resident #34's PTSD and colostomy.</p> <p>This failure could affect residents by placing them at risk for not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Review of Resident #34's face sheet, dated 04/25/25, reflected she was a [AGE] year-old female, admitted on [DATE], with diagnoses of paraplegia (lower body paralysis), colostomy, pressure ulcers, mood disorder, bi-polar disorder, post-traumatic stress disorder, anti-social personality disorder, and seizures.</p> <p>Review of Resident #34's Quarterly MDS, dated [DATE], revealed she could understand others, and be understood by others. She had a BIMS score of 14, indicating intact cognition. Resident #34 had impaired range of motion of her lower body, on both sides, and used a wheelchair to move around in the facility. She was dependent on staff for some ADLS but was able to feed herself and do her own oral hygiene.</p> <p>An interview and observation on 04/23/24 at 10:53 AM with Resident #34 revealed her to be fully alert and oriented, and lying in her bed. She said she was trying to get the approval to get a surgery to fix a large hernia, which was making her very uncomfortable. She stated the surgery would be more involved because they would have to move her colostomy to the other side in order to perform it.</p> <p>An interview on 04/25/24 at 6:02 PM with CCM revealed she shared the responsibility for the care plans with the DON and the SW. She said they would normally tag the colostomy in the baseline care plan, and it would carry over to the comprehensive care plan, and the (former) DON would have been the one to do that. She did not remember when the DON left, and she did not know why the care plans did not get done. She said the care plans were to track progress, were based on the individual resident, and should have been done. She said they were reviewed when it was time for the MDS .</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 04/25/24 at 6:13 PM with the Administrator and the DON revealed the DON had only been at the facility for a very short time and was trying to assess and address a lot of issues. The Administrator said the care plans were typically done by the IDT . She said nursing put in the acute care plans, and the MDS was responsible for quarterly, comprehensive, and significant change updates to the care plans. She said the admitting RN would put the baseline care plan in, and when things got added would depend on when the diagnosis that was made. She stated it would normally be put in by the Administrator, or the ADON. When Resident #34 was admitted , there was a different DON, and she should have done her initial care plan. The MDS would have identified the diagnosis from there, and updated the comprehensive care plan .</p> <p>Review of Resident #34's admission progress note, dated 01/10/24, indicated she was admitted from another facility, and ostomy care was done.</p> <p>Review of Resident #34's care plans reflected no care plans for her colostomy or her diagnosis of PTSD.</p> <p>Review of the facility policy Comprehensive Care Plans, revised 01/26/24, reflected: Policy:</p> <p>It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment and by Day 21 of the patient's stay. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the care plan. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the care plan. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. (.) f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. (.) g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>35489</p> <p>44894</p> <p>Based on observations, interviews, and record review, the facility failed to ensure each resident received and the facility provided food that was palatable and attractive for two of two meals (lunch meals on 04/23/24 and 04/25/24) reviewed for food and nutrition services.</p> <p>The facility failed to deliver food with an appetizing taste for the lunch meals on 04/23/24 and 04/25/24.</p> <p>The deficient practice could place residents at risk of poor intake of nutrition, weight loss, and a decreased quality of life.</p> <p>Findings included:</p> <p>An interview on 04/23/24 at 10:53 AM with Resident #34 revealed she thought the food had gone downhill in quality since the new DM started, about a month and a half ago, and it was terrible. She also felt the current dietary manager was not very nice and was not accommodating. She told the state surveyor if there was any doubt about the food, to ask the other residents, because everyone hates it. She said they talked about food at every resident council meeting, and everyone she knew was unhappy with it.</p> <p>In an anonymous group interview on 04/24/24 at 1:00 PM six of six residents agreed the food in the facility was of poor quality and flavor, and they did not like it.</p> <p>Observation on 04/23/24 at 12:59 PM revealed the lunch test tray of regular and pureed diets were tasted by four state surveyors. The regular chicken enchiladas, which came with one packet of sour cream, did not have any sauce on them, and the corn tortillas were dry, and leathery, especially on the edges. They were also cracked and broken and unappealing in appearance. They contained diced chicken in a cheese sauce and had very little flavor. The rice had very little flavor. The beans tasted saltier than the other dishes but had very little other discernable flavor. The pureed diet tasted the same as the regular diet.</p> <p>Observation on 04/25/24 at 1:00 PM revealed the lunch test tray for a regular diet was tasted by four state surveyors. The barbequed chicken thigh was acceptable, and the state surveyors felt the potato salad was good. The green beans were overcooked and mushy, had little flavor, were noticeably oily, and had a slimy mouthfeel when chewed. The cake was dry and had a stale flavor.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 04/25/24 at 10:31 AM with the Dietician revealed she had only been contracted with the facility since February 2024. She said she did meet with new residents to check with them about dietary preferences and needs, and residents who triggered for weight loss. She stated she had not spoken with all of the residents yet and had not been made aware of food complaints. She said she had heard the residents were saying the food had improved, but it depended on who she talked to. She said the menu was pre-programmed, and they used standardized recipes which were low in sodium, but they still should have some kind of flavor. She said the Dietary Manager was brand new at the facility and walked into a lot of disorganization and was having a hard time getting acclimated. She said if someone did not like the food, and there were no alternates they liked, there could be a risk of weight loss.</p> <p>An interview on 04/25/24 at 5:02 PM with the Administrator revealed they did not have a policy regarding food palatability.</p> <p>An interview on 04/25/24 at 5:33 PM with the Dietary Manager revealed she had been working at the facility for about two months. She said when she started, she talked to the residents, and they did not like the food. She said the previous cooks were not using recipes. She said it had been hard to get them to try the food since she started, because they did not like it before. She stated she was getting more of them to try it, and they were liking it. She said the enchiladas served on 04/23/24 were premade, from the company they ordered their food from. The box did not come with sauce, and they gave everyone sour cream. She said when they cooked them, they broke up. She said she was not very happy with the way they looked either, and thought it would probably be better to just make them from scratch. She did not know how the cake could taste stale, because they made it in the kitchen, from a mix from the same company the rest of the food came from. She said she was working with a lot of new dietary staff, training them, and some of them did not know how to follow recipes. She was working on teaching them how to follow recipes, and that they could not just substitute things all the time, that they had to do their jobs even when she was not there. She said she was also telling them to taste the food they cooked, and when she cooked, she tasted it. She said the meals were the only thing some people looked forward to in a nursing home, so they should get some things they liked. She said that some of the things the residents complained about, she could not change, because they had to order from the same company. She said some of the items were not even available for her to order, because of the food plan the facility was on with the food supplier. She said she had asked and was told they had to order what was open for her to order, because they had to get what was in their budget. She said there were also problems with the food order not all coming in, and the guy who supplied the food had come in twice. She said when she placed the order, things were getting kicked out of her list and not coming in. She said they need the items, so she had to go back every time and check to make sure everything on her order went through. She wanted to get food the residents liked, so she said that she asked him what they could get that was better eating, because the residents would not eat some of it. He told her they could only get what showed up for when she placed her orders. She said the last place she worked prepared the food from scratch, and she would like to do that, but they did not have enough staff to do that. She said they did have cases of running out of some alternates, because the residents order them so much. She said the only time they were allowed to change the menu cycle was if they were out of something and had to serve a substitute, so she was not able to make any big changes. She said one problem was that she was not able to get residents to try some of the foods. She said they would argue with her and cuss her out. She had talked with the Administrator about raising the budget, but because the census was low, they could not do that .</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 04/25/24 at 6:13 PM with the Administrator revealed the new Dietary Manager had put in her notice. When informed of the state surveyors' impression of the meals, she said she was not aware that the food served during the survey was not good, and that they were always trying to work with the residents on meals and dietary preferences .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44894</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in their only 1 of 1 kitchen.</p> <p>The grease in the deep fryer was dirty with blackened grease and food particles around edges.</p> <p>The stove surface under the metal grates had a build-up of blackened food debris.</p> <p>This failure could place 62 residents who consumed food prepared in the kitchen at risk of food-borne illness.</p> <p>Findings included:</p> <p>During an observation on 04/24/2024 at 9:10 am, the edge of the deep fryer had a thick build-up of brown and black grease with food particles around the inside edges. There was grease that had run off the edges and down the sides of the deep fryer. Deep fryer was stationed beside the stove in the kitchen. Stove had been used to cook breakfast and the staff were in the process of cleaning the stove.</p> <p>During an interview on 04/24/2024 at 9:10 am, the dietary manager acknowledged the deep fryer had old grease in it. The DM revealed the deep fryer was cleaned one time a month. The used grease was used to fry foods throughout the month. The dietary staff is responsible for cleaning the deep fryer.</p> <p>On 04/24/2024 at 11:00 am the policy was requested a for cleaning dietary equipment related to the deep fryer from the Administrator. The Administrator did not have a specific policy r/t cleaning the deep fryer.</p> <p>An interview on 04/25/24 at 10:31 AM with the Dietitian concerning the grease left in the deep fryer for a month. The Dietitian revealed she had only been contracted by the facility since February of 2024, so she had limited knowledge of them, but that a month was too long to use the same fryer grease. She said she looked at overall cleanliness when she came to the facility, two to three times a month, and had mentioned at some point that they needed to clean the fryer. She said they had not scored low enough to require a performance improvement plan for anything on the checklist she used when doing the monthly quality monitoring.</p> <p>The policy titled Nutrition Services dated 10/2017 indicated All kitchen equipment will be cleaned on a regular scheduled basis.</p> <p>The Food and Drug Administration Codes October 2022, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, cleanable, properly designed, constructed, and used:</p> <p>47. Proper installation and location of equipment in the food establishment are important factors to consider for ease of cleaning in preventing accumulating of debris and attractants for insects and rodents.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 laundry room and 1 of 6 residents (Resident # 13) reviewed for infection control.</p> <p>The facility failed to handle, store, and process linens and residents clothing to prevent the spread of infection by not preventing cross contamination of staff belongings and resident personal clothing when staff placed their purses, in the same laundry cart with residents personal clothing.</p> <p>The facility failed to have in place a barrier between the clean and dirty areas of the laundry room to prevent the spread of infection.</p> <p>The facility failed to implement appropriate measures for sorting and folding resident laundry on a table that was free of staff personal keys and water cups to prevent cross contamination.</p> <p>The facility failed to ensure MA J wore gloves and performed hand hygiene when opening Resident #13's capsule medication and mixing it into apple sauce.</p> <p>These failures could place residents at risk for infections and cross contamination.</p> <p>The findings included:</p> <p>Record review of Resident #13's face sheet on 04/23/24 reflected a [AGE] year-old man that was admitted to the facility on [DATE]. His diagnoses included disorder of circulation, hip fracture, urinary tract infection, restless, agitation, disorientation, local infection of the skin, heart failure, and dementia (this is a memory problem in making decisions, reasoning, judgment and thought process.</p> <p>Review of Resident #13's orders on 04/23/24 revealed medication; Depakote Sprinkles (divalproex) capsule, delayed release sprinkle; 125 milligrams; amount: 1 capsule; by mouth for [DX: Restlessness and agitation] Three Times A Day; 08:00 AM, 02:00 PM, 08:00 PM. Start date 04/12/24- open ended date. Order description reflected may crush crushable medication, open capsules, and mix with food or jelly.</p> <p>Observation and interview on 04/23/24 at 10:30 AM, revealed MA J took a medication from the medication cart, she took 1 capsule out of the medication bubble card from a medication card, opened it with her bare fingers, and sprinkled the medication in apple sauce. MA J was asked by the state surveyor to look at the medication card which reflected Divalproex Sodium 125 MG Capsule Delayed Release Sprinkle. Pharmacy Directions: Give 1 capsule by mouth three times daily. MA J said that Resident #13 could not take pills whole. She said that she was supposed to wear gloves when opening medications to prevent cross contamination. MA J said she was employed at the facility for 1 month. She stated she forgot to wear gloves, which was a risk of infection to the resident. She said that hand hygiene was important and should be done before and after medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with the DON on 04/25/24 at 6:13 pm, revealed that she expected all staff to perform hand hygiene during the medication pass. She said she expected staff to use hand sanitizer prior to providing medications and in between, before popping the pill, before giving it, and after giving it. She said the facility performs weekly training for QIPP . They do PPE and hand hygiene, and competency checks every week. She said the QIPP program was associated with the hospital. She said they get extra funding for certain areas like infection control for doing a good job, they have monthly meetings, and they go over everything to show improvement. They have been involved in it since maybe 2020. She said the risk of poor hand hygiene was spread of infection . She said gloves should be worn when touching medication to prevent contamination and she expected staff to perform hand hygiene before medication administration and after medication administration.</p> <p>Observation and interview with Laundry Aide A and Laundry Aide B on 04/24/24 at 2:03 PM in the laundry room revealed there were two doors to the area. One door was an exterior door on the left where the dirty laundry was brought into the laundry room for processing. The clean, dry laundry exited the laundry room through a right-side exterior door in clear plastic bags in the large laundry cart with a cover to return to the main facility building. Further observation revealed there was no barrier separating the clean and dirty areas of the laundry room, and the areas were instead defined by a partial wall extending in from the exterior wall and ceiling with pass-through area that was approximately 6 feet wide. A white floor fan was placed near the dryers and chemicals for the washing machines. Observation of laundry room revealed staff members cellphones, personal car keys, water bottles, a red handbag, and a black handbag on a black table that was approximately 20 x 60 inches. Laundry Aide A stated the table was used as a folding table for linens and residents' personal items. One large laundry cart with a blue cover partially opened was observed with clothing on hangers and some in plastic bags. A smaller cart without a cover on it was close to the door near the exit door of the clean area with clothing hanging on hangers and some folded inside the basket of the cart. Laundry Aide B then took the red handbag from the sorting/folding table and placed it inside the laundry cart basket on top of the folded clean resident's items. Laundry Aide A said Laundry Aide B could not understand English therefore she could not answer the questions. Laundry Aide A said that they were expected to put their personal belongings on the floor under the folding table or in the break room. They said they enter with the dirty items on the left and exit with clean items on the right of the laundry room. Laundry Aide A and Laundry Aide B did not state the risk to the residents.</p> <p>During an interview with Laundry Aide C on 04/25/24 at 09:26 AM, it was revealed that Laundry Aide C has been employed at the facility for 1 year. She said she had never seen in place a barrier between the clean and dirty areas of the laundry room. She said the laundry room got hot due to the small space and they used the floor fan to blow cool air into the room. She said she understood after the in-service, that morning, that they were spreading germs between the clean and dirty by using the fan. She stated she had been in-serviced this morning about employees' personal belongings not being in the work areas or placed in the laundry carts to prevent the spread of germs to the residents. She said separating the clean and dirty was important for infection control.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mansfield Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 E Broad St Mansfield, TX 76063	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview and observation with the Housekeeping Supervisor on 04/24 at 02:06 PM and 04/25/24 at 09:04 AM, revealed he was employed at the facility since 2022 but in his current role as Environmental manager for 1 year. He was observed removing the red handbag from a small laundry cart and placing it under the black folding table. He stated that he had told his staff not to put their personal belongings with residents' items because that was a risk for cross contamination. He said that no one had ever informed him about having a barrier between the clean and dirty areas of the laundry room. He said he just followed what the previous laundry manager did. He said he had never looked at the laundry policy. He said all staff should prevent the spread of infection and should follow policy for infection control. He said he expected staff to enter to the left with dirty items and exit to the right with clean items. He said he expected his staff to place their personal belongings in the breakroom or on the floor under the folding table.</p> <p>Interview with the administrator on 04/25/24 at 6:13 PM, revealed she was not aware of the laundry room situation.</p> <p>A policy for laundry rooms and the separation of the clean and dirty areas was requested, but the facility did not provide it before exit 04/25/24.</p> <p>Review of facility policy titled Medication Administration-General Guidelines revision date December 2019 reflected . If breaking tablets is ultimately necessary to administer the proper dose, hands are washed with soap and water or alcohol gel [and examination gloves worn] prior to handling tablets, and examination gloves must be worn to prevent touching of tablets during the process .</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489</p> <p>Based on observations, interviews, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a centralized staff work area, for two of two nursing stations reviewed for call lights.</p> <p>The facility failed to ensure the call system was working properly for the nursing stations in zone 1 and zone 2. On two hallways, causing the call system to sound when no call light was on, and no light for call buttons appearing on the panel. In addition, the call light of one resident (Resident #34, near station #2) would not turn off properly when used.</p> <p>This failure could cause residents who relied on the call light system to have a delayed response or no way to contact staff to meet their needs.</p> <p>Findings included:</p> <p>An observation on 04/23/24 at 11:08 AM revealed Resident #34's call light would shut off. Multiple staff were observed to go in and out of the room, heard to be trying to figure out how to turn off the call light, and the call light stayed on. At 11:28 AM DOR entered the room, exited the room, entered the room, exited the room, and again entered the room in a fairly quick succession, and the call light went off.</p> <p>An observation on 4/23/2024 at 11:15 AM revealed a loud siren sound coming from nurse's station #1.</p> <p>An observation on 4/23/2024 at 11:17 AM revealed the call light system at nurse's station #1 was not lighting up (this would indicate to employees which room was calling for assistance). The call light panel showed no signs of an alarm going off and staff were attempting to figure out where the noise was coming from.</p> <p>An interview with the DON on 4/23/2024 at 11:30 AM revealed she had never heard the alarm sound that way. She stated that she knew it could not be a fire alarm or a door alarm and that none of the residents had bed alarms. She said the sound was weird when asked if it was a call light. She stated it wasn't a residents call light, because it would have lit up at the nursing station.</p> <p>An interview on 04/23/24 at 11:35 AM revealed Maintenance attempting to figure out what the alarm sound was by opening the alarmed exit door near station #1. Staff were attempting to tell him it was the call system, but he continued to focus on the exit door.</p> <p>An interview with CNA S, on 4/23/2024 at 12:15 PM revealed the call light system at Station #1 had a problem. He did not provide any information about how long the problem had been going on, but explained that it was an old building, and the system was outdated. He said he had been in other facilities, and it was easy to see this system was different. He said sometimes nobody would put on their light, but the siren would go off for hours. He stated he went from room to room to see if anyone needed something, they would all deny pushing their button, and everyone would be confused about why it was going off.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 4/23/2024 at 12:30 PM revealed a staff member calling for maintenance to come repair the call system. CNA S and the DON were observed going from rooms 40-58, pulling each call light out of the wall to see where the system was being triggered from.</p> <p>An interview with LVN G on 4/23/2024 at 12:35 PM revealed she did not recognize the sound of the alarm and could not find a reason for the alarm. She said if it was a call light, it would have been showing at the nurse's station.</p> <p>An observation on 4/23/24 at 12:40 PM revealed the DON, Maintenance, and CNA S going into room [ROOM NUMBER], and when they checked the call light on the unoccupied side of the room the alarm sound stopped. Maintenance promptly replaced the call light at that bed .</p> <p>An interview on 04/23/2024 at 2:33 PM with CNA D revealed she always answered call lights. She said she had heard the call light alarm before, but it was due to the button on a resident call light being stuck. She stated sometimes they had to pull the button out, or it would still be showing like someone was calling, even after you helped the resident. She had never seen it not light up at the station and alarm like it was that day.</p> <p>An observation on 4/25/24 at 4:50 PM revealed the same alarm sounding on zone 1 as on 04/23/24. The admin, and LVN G walked from room to room to figure out which call light was causing the siren to sound. They were seen pulling the call lights out of the walls in rooms 40-58. The call light system at the nurse's station did not indicate which room had the call light malfunction. When LVN G pulled the call light out of the wall in room [ROOM NUMBER] the siren stopped.</p> <p>An interview with the DON on 4/25/2024 at 5:15 PM revealed she had called the corporate office due to the maintenance person at the facility leaving without warning, to see if an electrician could come out to check the call light system. She said she had never heard that sound before and that due to this being an old building it could be an electrical issue. She said the corporate office scheduled to send someone out that night to look at the system on all the halls to ensure this didn't happen again.</p> <p>Review of the facility policy for answering call lights, revised March 2021, reflected: Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: (.) 4. Be sure that the call light is plugged in and functioning at all times. The policy did not address the maintenance of the call system.</p> <p>Review of the facility policy Maintenance Service, revised November 2021, reflected: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. (.) c. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. (.) f. Establishing priorities in providing repair service. g. Maintaining the paging system in good working order. (.) 3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>35489</p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for three hallways (front hall (Administrative offices and kitchen hallway), hall 16-39, and hall 40-54) of four halls reviewed for physical environment.</p> <p>1. The facility failed to ensure the facility was free from pervasive urine odors and dirt and grime (most notably around doorways) on hallway floors.</p> <p>These failures could affect all residents, resulting infections, and low feelings of self-worth.</p> <p>Findings included:</p> <p>Observation on 04/23/24 at 8:35 AM revealed when the state surveyors initially entered the building, the smell of urine was very strong upon entering the facility through the front door.</p> <p>Observation beginning on 04/23/24 at 9:20 AM, at the start of the initial tour of the facility, and throughout the survey period (through 04/25/24 at approximately 4:30 PM), observations were made by all state surveyors noting urine odors in the halls, with the odor being strongest in the halls near rooms 40-58 and 12-24 but could be smelled throughout the building. Floors throughout the front hall (where administrative offices were located), the hall where resident rooms 40-54 were located, and the hall where resident rooms 16-39 were located had a buildup of staining and grime along the edges of the halls. It was concentrated around doorways, along with doorways having the appearance of dusty accumulation at the bottoms of many doorframes. The doorway and the hallway leading to the kitchen was grimy and stained. Urine odors were noted to decrease in intensity in the facility throughout, but remained during the entire survey period, and continued to be more concentrated near rooms 40-58 and 12-24.</p> <p>Observation on 4/23/24 at 11:00am on zone 1 hallway (rooms 40- 58) revealed a strong smell of urine observed throughout the hallway. Observation revealed no housekeeping staff on the hall at this time.</p> <p>Observation on 04/23/24 at 12:14 PM revealed a strong smell of urine in the area near rooms 40-58.</p> <p>Observations at the following times near rooms 12-24 revealed a stronger intensity of pervasive urine odor than other areas of the hall, though the entire hall did have a urine odor:</p> <ul style="list-style-type: none"> - 04/23/24 at 9:44 AM -04/23/24 at 11:08 AM -04/23/24 at 3:23 PM -04/24/24 at 1:16 PM <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-04/24/24 at 4:30 PM</p> <p>An interview on 04/24/24 at 12:07 PM with the Administrator revealed the Maintenance Director, who had left the building with no communication shortly after the Life Safety Code state surveyor had arrived, had not worked in the facility very long, and had been terminated .</p> <p>An interview on 4/24/2024 at 12:14 PM with resident #45's family member revealed one of her biggest concerns about her loved one being at this facility was that the environment the residents were forced to live in. She stated that there was always such a strong odor of urine and feces, and the facility was filthy, including Resident #45's room. She asked the state surveyor if the surveyor would want to live there, and wanted to know if the state surveyor would expect their loved one to get better in that kind of environment. She said she did not bring Resident #45's children to see him, because she was afraid, they might catch something. She said she kept her mask on during her visits, because she had the same fear for herself. She said she had noticed the other side of the building seemed to be cleaner and brighter than the side Resident #45 was on, and wondered if it was because the residents on that side talked less , and wouldn't complain as much.</p> <p>An observation on 04/25/2024 at 1:22pm the hallway near Station #1 revealed a pervasive urine odor while walking the hall, which was consistent through the hallway. The floors were noted at this time to still have a buildup of grime around the edges and doorways .</p> <p>An interview on 04/25/24 at 3:42 PM with the Environmental Service Director revealed he started at the facility as the floor tech in 2022, and he thought they were without a floor tech for two years before he started. He said the floors were very old, and had a buildup of negligence, which prevented them from ever really getting them clean. He said, when you walk in the building, you notice the floors, and the smell and that if they would fix the floors, it would give the facility a different attitude. He said the corporation had talked about replacing the floors, and they had in some of the rooms, and at a sister facility, but not in this whole facility yet .</p> <p>An interview on 04/25/24 at 6:13 PM with the Administrator revealed the building was very old, and some of the problems were due to age. She said the corporation was supportive about making improvements and they had talked about new flooring, but she did not know when that was planned. She said the condition and cleanliness of the building was an infection control and quality of life issue. She said the environment should be homelike and it could affect people clinically. She said that on the first day of the survey (04/23/24) she smelled urine when she walked in the door, but it was not normally that bad, and they had addressed it, and she felt it improved after that. She said there were certain rooms where the housekeepers would be sent to clean when she smelled urine, but the building as a whole was usually not bad .</p> <p>Review of the facility policy Homelike Environment, revised February 2021, reflected: Homelike Environment Policy Statement: Residents are provided with a safe, clean, comfortable, and homelike environment (.) Policy Interpretation and Implementation: 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. clean, sanitary and orderly environment; (.)</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy Maintenance Service, revised November 2021, reflected: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p> <p>2. Functions of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. (.) c. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. (.) f. Establishing priorities in providing repair service. g. Maintaining the paging system in good working order. (.) 3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p>