STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675835	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Trails Nursing Home	330 E Bagley Rd Rusk, TX 75785

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 - Some	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 residents' environment remains as free of accident hazards as possible for 1 of 1 facility (2 of 7 mechanical lift slings) and 1 of 4 residents (Resident #55) reviewed for hazards:1. The facility failed to ensure items labeled keep out of reach of children and a razor were not kept in a basin in Resident #55's room on the secured unit.2. The facility failed to remove faded, worn and damaged mechanical lift slings from service. This failure could result in a loss of quality of life due to injuries.Findings included:1. Record review of a facility face sheet dated 5/19/26 for Resident #55 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: myocardial infarction (heart attack) and dementia.Record review of a Quarterly MDS assessment dated [DATE] for Resident #55 indicated she had severe cognitive impairment by Staff Assessment for Mental Status. She was dependent or required maximum assistance with most ADLs. Record review of a comprehensive care plan dated 9/2/25 for Resident #55 indicated she had cognitive impairment. During an observation on 5/18/26 at 10:17 am a bath basin was observed in Resident #55's room on the secured unit, and the following items were observed in the basin: A safety razor vitamin A & D ointment (labeled keep out of reach of children) an aerosol can of dry shampoo (labeled keep out of reach of children) a bottle of mouth rinse (labeled keep out of reach of children)During an interview on 5/18/26 at 2:30 pm, LVN B said the hospice aide must have left them in the resident's room. She said the items could be dangerous for cognitively impaired residents that wandered.During an interview on 5/19/26 at 9:50 am, the Administrator said the facility did not have a policy for safe environment.During an interview on 05/20/2026 11:09 am, the Administrator said if razors and items labeled keep out of reach of children were left in resident rooms in the secured unit, it could be a potential safety concern for residents. She said the facility had begun in-servicing staff and hospice staff. She also said going forward she would ensure Department Managers would look for safety concerns during their rounds. 2. During an interview and observation of the facility's laundry room on 05/19/2026 10:30 am, the Laundry Technician said she had worked at the facility for 12 years. The Laundry Supervisor said she washed the lift slings and hung them up to air dry. She said that she used bleach in the wash cycle if slings are soiled with bowel movement. Two of the seven mechanical lift slings hanging on the wall racks drying in the clean linen area had faded straps, light in color (light gray, light teal and light purple) not bright and vivid colors as the other mechanical lift slings hanging on the rack. One of the mechanical lift slings care labels was faded, illegible and attached by a few threads of stitching. The Laundry Supervisor said she had received in-servicing on mechanical lift sling care in the past, but it had been a long time. She said she considered the two lift slings still useable. She said that if a lift sling broke it could cause a fall with injury. During an observation and interview on 05/19/26 at 11:00 am, the Administrator observed the 2 mechanical lift slings. She said the risk to the resident was injury if the lift sling broke during transfer and caused a fall. The Administrator said she would remove the damaged slings from service. She said that if the lift sling broke it could cause a fall with injury. During an interview on 05/19/26 at 2:15 pm, the ADON said she was responsible for removing (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	damaged slings from service. She said the straps on the mechanical lift slings were faded and care tags were illegible. She said she would in serviced nursing staff when to remove lift slings from service. The ADON said the straps could break on damaged lift slings and cause a fall with resulting injuries. During an interview on 05/19/26 at 3:15 pm, the Housekeeping-Laundry Supervisor said he had completed an in-service with laundry staff on sling care that included not bleaching and hanging them to dry. He said that if a sling broke it could cause injury to a resident due to a fall.Record review of the facility's policy titled admission Criteria for Secured Continuous Care Unit dated 5/16/2024 read: .The secure unit provides a safe living environment for residents with dementia who wander without regard for their own safety . Record review of the facility's policy titled Quality of Life-Homelike Environment revised May 2017 reflected, .Residents are provided with a safe, clean, comfortable and homelike environment .Record review of the facility's policy titled Hydraulic Lift (Hoyer Lift) revised September 2024 reflected, .Note: Follow Manufacturer recommendations.Record review of the manufacturer's guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 05/19/26 read .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Missing or illegible care labels. Any slings with signs of wear or improper laundering should be immediately removed from use .Record review of the manufacturer's instructions for Proactive full body slings accessed https://proactivemedical.com/products/lifts-slings/patient-slings/full-body-sling/ accessed 05/19/2026 indicated, .Proactive medical products . Guideline for Identifying Deteriorated Slings Accelerated Deterioration from Bleach, High Temperature Wash or Drying Slings, especially loop straps that have been damaged from being laundered in unsuitable conditions (bleach, high heat wash or dry) may appear to be in good condition but the actual tensile strength of the material may be compromised and pose a safety risk and should not be used for lifting a patient or resident. This Guide is intended to help staff and caregivers better identify slings that have been exposed to above laundry conditions and subsequent loss of tensile strength. We encourage any sling identified with the following characteristics to be removed from service immediately as a preventive measure. Proactive Medical slings have been designed and tested for laundry wash conditions of 170 degrees and air dry or dry at low temperature. The slings should never be bleached. Commercial washer and dryers are not recommended. Care instructions on the sling label should always be followed. Laundry equipment should be properly maintained and repaired when necessary. Completely Faded / Missing / Illegible Tag while the main body of the sling fabric is still intact and in relatively good condition. Colors are not faded or show very little fading .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions for 2 of 2 medication storage refrigerators reviewed for labeling and storage (medication storage refrigerator in the medication room on mid- hallway 100 and medication refrigerator for the front hallway 100). The facility failed to monitor and record temperatures of the refrigerator used for medication storage daily as required per facility policy for medication storage. This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications.Findings included: During an observation and interview on 05/20/2026 9:00 AM of the medication storage refrigerator in the medication room on front hallway 100, revealed 3 Insulin pens and three insulin vials requiring 36 to 46 degrees refrigeration. There was no temperature log for the refrigerator in the medication room. MA D said there should be a log, and the staff should check and adjust the temperature every day. During an observation and interview on 05/20/2026 9:15 AM of the medication storage refrigerator in the medication room on mid- hallway 100 revealed 3 Insulin pens requiring 36 to 46 degrees in the refrigeration, and there was no temperature log in the medication room. MA D said there should be a log, and the staff should check and adjust the temperature every day. She said the temperature could be too cold or too hot and effect the medications effectiveness. Record review of the May 2026 refrigerator log for the medication refrigerator for the front hallway 100 refrigerator, revealed the following days had no temperature logged: 5/18/26 and 5/19/2026. Record review of the April 2026 refrigerator log for the medication refrigerator for the front hallway 100 refrigerator, revealed the following days had no temperature logged:04/04/2026, 04/05/2026, 04/06/2026, 04/20/2026, 04/22/2026, and 04/23/2026. During a record review of the May 2026 refrigerator log for the mid hallway 100 medication refrigerator, the following days had no temperature logged:05/04/2026, 05/07/2026, 05/08/2026, 05/16/2026, 05/17/2026 and 05/18/2026 During a record review of the April 2026 refrigerator log for the mid hallway 100 medication refrigerator the following days had no temperature logged: 04/10/2026, 04/14/2026, 04/15/2026, 04/16/2026, 04/17/2026, 04/18/2026, 04/19/2026 and 04/20/2026. During an interview 05/20/2026 11:00 AM with the DON she said she had just started at the facility this week and had already started in-services with staff on obtaining and logging temperatures for the medication refrigerators. She said not following the facility's policy and manufacturers medication recommendations could result in loss of medication effectiveness of medications stored too cold or too hot. During an interview 05/20/2026 11:02 AM with the Administrator, she said the ADON and the DON were responsible for training the nursing staff on medication storage and logging storage temperatures. She said not storing medications as required could result in loss of medication effectiveness of stored too cold or too hot. Record review of the facility's Medication Storage Policy dated 1/20/2021 Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturers recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security .6b. Temperatures are maintained at 36-46 degrees. Charts are kept on each refrigerator levels are recorded daily by the Charge nurse or designee.

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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 food in accordance with professional standards for food service safety for facility's only kitchen reviewed for food storage. 1. The facility did not ensure foods in the refrigerator, freezer and dry storage area were appropriately stored, labeled and dated when opened or removed from their original packaging or opened on 5/18/26. 2. The facility did not ensure food in the freezer was appropriately labeled and dated when removed from original packaging on 5/18/26. 3. The facility did not ensure food was not kept on the floor in kitchen and dry storage area on 5/18/26 and 5/19/26. 4. The facility did not ensure [NAME] C appropriately performed hand hygiene while preparing food for meal service on 5/19/26. This failure could place residents who received their meals from the kitchen at risk of food-borne illness.Findings include:During an observation on 5/18/26 at 9:45 am the following observations were made: In dry storage a zip top plastic bag was observed on shelving with what appeared to be vanilla wafer cookies inside. There was no label indicating contents, no open date, and no use by date. In dry storage there was a large, opened bag of flour sitting on the floor. In freezer there was a bag of what appeared to be thick slices of ham opened, bag was tied in a knot. There was no label of contents, no opened date, and no use by date. In freezer there was a bag of what appeared to be raisin bread, and the bag was tied in a knot. There was no label with contents, and there was no open date or use by date. In refrigerator there was a carton of thickened sweet tea with no opened date, no use by date, and the carton was not closed with the lid, lid was missing and carton was open to air. In kitchen against back wall, there was a box of sweet potatoes sitting on the floor with a large, unopened bag of sugar sitting on top of it. During an observation on 5/19/26 at 8:30 am, the box of sweet potatoes was still observed on the floor in the kitchen against the back wall with a large, unopened bag of sugar sitting on top of it.During an observation on 05/19/2026 between 11:00 am and 11:45 am [NAME] C was observed pureeing foods and checking food temperatures. [NAME] C was observed removing gloves after temping food, she then was observed to rinse her hands at the dishwashing sink, but she did not use soap. She then put on clean gloves and began placing food on steam table. She was again observed removing gloves and putting on clean gloves without washing hands and continue setting up food for meal service. After removing gloves again, she was observed to go to handwashing sink and rinse hands off, again, using no soap and then proceeded to wipe hands on her pants to dry them and put on clean gloves. Paper towels and soap were observed next to the handwashing sink. During an interview on 5/18/26 at 9:55 am, [NAME] A said the meat in the freezer was pork chops, and she had just put in there this morning, and the bread was also left over from breakfast this morning and she just forgot to date and label them when she put them in the freezer. During an interview on 05/19/2026 at 1:34 pm, [NAME] C said she was changing gloves so often because she was unsure when she touched the trash can if her hands were dirty. She said she had never been observed by state before and was nervous. She said she did not use soap at the sink because there was no soap. She said wiping her hands on her pants to dry them was not good because there could be germs on her pants. She said washing hands was important in the kitchen to prevent cross-contamination. She said she was not aware of a set schedule to clean the oven, but they would clean it when the dietary manager told them to. During an interview on 5/20/2026 at 9:58 am, the Dietary Manager said that if foods were not properly stored, dated and labeled; food preparation areas were not properly cleaned; and staff did not properly wash their hands, residents could be at risk of illness due to food contamination. She said going forward, she would be providing more education and in-services. She said they have a weekly cleaning schedule posted, and she would be responsible to monitor cleaning going forward to ensure everything was clean. During an interview on 05/20/2026 11:12 am, the Administrator said if proper procedures related to hand hygiene, food storage and labeling, and sanitation were not followed, there was a risk for infection (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	control concerns and food safety concerns for residents that consumed food out of the kitchen. She said going forward, she would be providing more education and in-services for kitchen staff, and she would personally perform spot checks in the kitchen to make unannounced observations. Record review of the facility's policy titled Hand Hygiene revised 2/11/22 read: .Hand hygiene technique when using soap and water: a. Wet hands with water. Avoid using hot water to prevent drying of skin. b. Apply to hands the amount of soap recommended by the manufacturer. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f. Use clean towel to turn off the faucet . and .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . Record review of the facility's policy titled Equipment Cleaning Procedures revised in 1/2013 read: .Routine cleaning will be practiced on a regular basis in order to keep all dietary equipment and the environment safe, sanitary, and in compliance with state and federal regulations . and .Clean ovens and ranges weekly . and .All equipment should be cleaned as needed. Equipment that becomes soiled between scheduled cleanings must be properly cleaned and sanitized . Record review of the facility's policy titled Storage of Frozen and Refrigerated Foods revised on 10/2017 read: .Refrigerated products that are opened must be labeled with an opened on date. The use by date is 7 days from when the product was opened, unless there is a manufacturer's use by, expiration or sell by date . and .Foods prepared in the building and properly cooled will be dated as to the date prepared and use by date which will by 7 days from the date prepared . and .Packaged frozen items that are opened and not used in their entirety must be properly sealed, labeled and dated for continued storage . and .All refrigerated and frozen items in storage will contain a minimum label of common name of product and dated as noted above . Record review of the facility's policy titled Dry Food and Supplies Storage revised on 11/15/2017 read .The focus of protection for dry storage is to keep non-refrigerated foods, disposable dishware, and napkins in a clean, dry area, which is free from contaminants . and .Food and food products should always be kept off the floor and clear of ceiling sprinklers, sewer/waste, disposal pipes, and vents to maintain food quality and prevent contamination . and .Items must be stored at least 6 off the floor. Foods should be off the floor and clear of ceiling sprinklers, sewer pipes and vents. This allows for easy cleaning and discourages pest harborage . and .All opened products must be resealed effectively and properly labeled, dated and rotated for use . and .Use by, Best by and Sell by dates should routinely be checked to ensure that items which have expired are discarded appropriately .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff, in 1 of two medications rooms (the front one hundred hallway medication room) reviewed for environmental concerns.The facility failed to ensure the medication room floor and under sink area, were free of roach droppings, and there was no open hole underneath the sink.These failures could place residents, staff and visitors at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, unsafe and creating a contamination risk (Additionally, cockroach droppings and skin proteins (tropomyosin) can trigger allergic reactions and worsen asthma or other respiratory conditions). Findings included:During an observation and interview on 05/20/2026 9:00 AM, roach droppings were scattered on the floor from entrance into the room for about three feet next to the sink in the medication room. An open hole 24 inches across and 12 inches long was observed with pipes exposed to the wall in the back portion of the cabinet that houses the sink . Roach droppings cover the bottom of the cabinet, up the sides of the cabinet and spill out of the cabinet into the floor. There were no active roaches seen. MA D stated, that is the worst thing I have ever seen. MA D said there were roach droppings and they were disgusting. MA D said she was aware that the medication room was dirty, but she had not looked underneath the sink and had not noticed the roach droppings on the floor. MA D said she was aware that droppings could cause allergies and spread infections. During an observation and interview on 05/20/2026 at 9:10 AM, the Housekeeping/Laundry Supervisor said he had his staff clean the medication room, when requested by nursing, but not routinely. He said he would clean the area right away. He said that the roach droppings were unsanitary. The Housekeeping/Laundry Supervisor said the condition of the medication room was unacceptable.During an observation of the medication room and interview on 05/20/2026 at 10:00 AM, the DON said she had just started working at the facility on Monday 05/18/2026. She said she had not been inside the medication room or was made aware of the unsanitary condition of the floor and underneath the sink. She said she would be providing an in-service to nursing staff to report needed cleaning and repairs needed to administration. She said the droppings were unsanitary and could spread infection.During an observation and interview on 05/20/2026 at 10:30 AM, the Administrator looked at pictures taken by this surveyor of the medication room and roach droppings. She said she was not aware of the hole underneath the sink roach droppings. The Administrator said or the droppings were unsanitary, could spread infection and cause allergic reactions. She said the DON and the ADON were responsible for oversight of the medication room and they should be setting up a time with housekeeping for routine cleanings.During an observation on 05/202/2026 at 1:45 PM, the hole underneath the medication room sink had been repaired and patched. The roach droppings had been cleaned from the floor and underneath the sink. Record review of the facility's policy titled Quality of Life-Homelike Environment revised May 2017 reflected, .Residents are provided with a safe, clean, comfortable and homelike environment . Record Review of Pest control requirements in Long Term Care, accessed 5/20/2026 at www. Orkin.com Roaches carry germs that can cause pneumonia, diarrhea and food poisoning. Cockroach droppings can also inflame allergies or asthmatic conditions.Risks of Cockroach Droppings in a Long-Term Care Facility Storage AreaCockroach droppings (cast skins) in a long-term care facility's storage area can pose serious health, safety, and compliance risks.1. Pathogen and Allergen ExposureCockroaches can carry and spread over 30 types of harmful bacteria, including E. coli, Salmonella, and Staphylococcus, which can contaminate surfaces, stored food, or medical supplies Assured Environments+1. In a storage area, droppings can settle on shelves, packaging, or equipment, creating a contamination risk for residents, staff, and visitors. Additionally, cockroach droppings and skin proteins (tropomyosin) can trigger allergic reactions and worsen asthma or other respiratory conditions Assured Environments+1.2. Impact on Vulnerable ResidentsLong-term care residents often have weakened (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	immune systems or chronic health conditions. Exposure to cockroach allergens or pathogens can lead to infections, respiratory distress, or other complications Orkin+1. Even indirect contact with contaminated storage items can be harmful.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS admission assessment was transmitted to the CMS System within 14 days after completion for 1 of 6 residents (Resident #27) reviewed for admission MDS assessments.The facility failed to ensure Resident #27's Quarterly MDS assessments dated 1/5/2026 were transmitted within 14 days of completion.This failure could place residents at risk of not having records completed and submitted in a timely manner as required.Findings included:Record review of an admission Record for Resident #27 dated 5/19/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of type 2 diabetes, dementia (decline in memory, thinking, reasoning and problem solving), bipolar (extreme mood swings) and anemia (decreased production of red blood cells in the body).Record review of a Quarterly MDS Assessment for Resident #27 dated 1/5/2026 was completed on 1/19/2026 indicated she had a BIMS score of 99 due to not being able to complete the interview. She was dependent on staff for ADLs.Record review of a Quarterly MDS Assessment for Resident #27 dated 1/5/2026 that was completed on 1/19/2026 was inactivated. Record review of a Quarterly MDS Assessment for Resident #27 dated 1/5/2026 was completed on 2/20/2026 and accepted on 2/20/2026.Record review of a Quarterly MDS Assessment for Resident #27 dated 1/5/2026 was completed on 2/20/2026 was inactivated.Record review of a CMS MDS Submission Report Final Validation dated 2/20/2026 for the facility indicated an assessment for Resident #27 dated 1/5/2026 had a warning that indicated: Resident information mismatch: submitted valued for the items listed do not match the values in the iQIES database. If the record was accepted, the resident information in the database updated. Verify that the new database was updated. Verify that the new information is correct. Assessment completed late: (assessment completion date) is more than 14 days after A2300 (assessment reference date). Record review of a CMS MDS Submission Report Final Validation dated 2/19/2026 for the facility indicated an assessment for Resident #27 dated 1/5/2026 had a warning that indicated it was rejected: This modification/inactivation record does not match a previously accepted record in the iQIES system. One or more of the items submitted in Section X of this record did not match the corresponding items of an existing record in the database.Record review of a care plan for Resident #27 dated 7/14/2025 indicated she had ADL self-care performance deficit and was at risk of not having their needs met in a timely manner. Interventions included ADL assistance required she was dependent on staff x1 except for transfers and she needed two staff. During an interview on 5/19/2026 at 2:51 pm, the MDS Coordinator said she had been employed at the facility for 2 years. She said the Regional Reimbursement Coordinator conducted an audit but was unsure of how often she did it. She said the Regional Reimbursement Coordinator would look to see if something did not go through on the batch report and would audit that assessment. She said in February 2026, the Regional Reimbursement Coordinator notified her that the assessment for Resident #27 was not completed for the assessment on 1/5/2026 until a month later because the problem was not identified until then in February 2026. She said a modification was done because that assessment was rejected and then the previous assessment was inactivated when the system would not accept the modification, so they copied the information from the original assessment, and it was accepted February 2026. She said they had 14 days until RN signature and then the assessment was submitted. She said each time she ran a batch the validation report was ran as well. She said she did not look at the validation report at that time. She said the validation report was to make sure the assessment was submitted correctly and it would let them know what was missing or needed. She said she believed she did not have a good contract number for hospice and that was why it was rejected. She said there could be a risk of the IDT team members not being aware of what was going on with the residents in the facility if they were not completed timely, they would not be aware. During a phone (continued on next page)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 5/19/2026 at 3:30 pm, the Regional Reimbursement Coordinator said a batch was created with the assessment for Resident #27 from 1/5/2026 on 1/20/2026, the MDS Coordinator for the facility submitted the batch, and there was some glitch with the system. She said she had a validation ID for the batch and when she looked in SIMPLE, it was not there. She said the MDS Coordinator for the facility did a correction to resubmit the assessment and did not understand that she could not do a correction because it was never submitted. She said the MDS Coordinator for the facility copied and created a new assessment from the original assessment dated [DATE], and submitted that one which was accepted. She said she found Resident #27's name on a missing assessment report in SIMPLE back in February 2026, and then contacted the MDS Coordinator at the facility and told her she was missing an assessment for Resident #27. She said she tried to correct it to resubmit it, but it would not allow her to submit it, because it had to be inactivated. She said they had 14 days to complete and sign the assessment, and fourteen additional days after signatures to submit. She said she conducted monthly audits and did a percentage on the facilities. She said if a problem were identified then she would instruct the facility to develop a plan to prevent recurring in the future. She said if the assessments were not completed in a timely manner, they would not show up on the quality measure reports, matrix, or care plan completions, and care could be delayed. During an interview on 5/20/2026 at 1:27 pm, the Administrator said the MDS Coordinator was responsible for completing the resident assessments in the facility. She said she was not aware of Resident #27 having an assessment that was submitted late. She said, going forward, she would review the assessments monthly along with the DON and Regional Reimbursement Coordinator to ensure assessments were completed. She said they referred to the RAI manual for the timeframes on submitting the assessments. She said if the assessments were not completed timely, then the staff would not have a clear picture of what was going on with the residents, including the care plans and Kardex that the nurse aides used. She said she expected her staff to follow the RAI manual. She said the facility did not have a policy for MDS assessments.Record Review of the CMS RAI Version 3.0 Manual dated October 2025, indicated, in .Chapter 2.8, page 2-22: Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675835	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Trails Nursing Home	330 E Bagley Rd Rusk, TX 75785

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate MDS was completed for 1 of 4 residents reviewed for accuracy of assessments. (Resident #33). The facility failed to ensure the comprehensive MDS assessment dated [DATE] for Resident #33 wasn't miscoded for Parenteral/IV feeding (a method of delivering nutrients directly into the bloodstream for patients who cannot use their digestive system). This failure could place residents at risk of receiving inappropriate care and services.Findings included:Record review of a facility face sheet dated 5/19/26 for Resident #33 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of type 2 diabetes (uncontrolled blood sugar).Record review of a Comprehensive MDS assessment dated [DATE] for Resident #33 indicated section K (swallowing/nutrition) was incorrectly coded for Resident #33, indicating that he had received parenteral/IV feeding while a resident in the last 7 days (4/1/26 - 4/7/26).Record review of an electronic medical record for Resident #33 on 5/19/26 indicated no record of him receiving parenteral/IV feedings.During an interview on 05/20/2026 at 9:01 am, the Administrator said have a policy for MDS, they went by the RAI manual.During an interview on 5/19/26 at 3:45 pm, the MDS nurse said Resident #33 had not had parenteral or IV feedings. She said he was supposed to have had received IV antibiotics, but instead got them IM and it was just miscoded. She said she would do a modification.During an interview on 05/20/2026 at 10:20 am, the MDS nurse said Resident #33 was supposed to have received IV antibiotics, but instead ended up receiving IM antibiotics at a doctor's office, but she could not find the documentation. She said she wasn't sure how she clicked the wrong thing, but she said from then on she would pay more attention and question everyone else's recommendations to ensure they were completely accurate before submitting the MDS. She said it could negatively affect the resident care if the MDS was not coded correctly as the care plan was generated from the MDS assessments. During an interview on 5/20/26 at 10:45 am, the Regional Reimbursement Coordinator said she did not review each MDS assessment as she had too many buildings and did not have time to review each one. She said she did spot checks to ensure accuracy. She said assessments were completed by MDS nurse and sent to Precision (an asset management company) to review for recommendations. She said if assessments were not coded accurately, it could result in incorrect payments, incorrect quality measures and incorrect care plans. She said she would be implementing a PIP to ensure accuracy of assessments going forward. During an interview on 05/20/2026 at 11:06 am, the Administrator said if MDS assessments were not coded correctly, that it could present an inaccurate view of the resident, and could affect resident care. She said, going forward, she would be reviewing the 802 report and performing spot checks for accuracy. Record review of CMS's RAI Version 3.0 Manual, dated October 2025, read: .The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care.

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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 observations, interviews, and record review, the facility failed to establish and 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 4 residents (Resident #5) reviewed for infection control.The facility failed to ensure LVN F and CNA E wore the appropriate PPE when wound care was provided to Resident #5 who was on EBP on 5/20/2026.This failure could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:Record review of an admission Record for Resident #5 dated 5/20/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of hemiplegia following cerebral infarction (paralyzed on one side of his body following a stroke), hypertension, major depression (persistent sadness or loss of interest in doing things) and bipolar (extreme mood swings).Record review of a Quarterly MDS Assessment for Resident #5 dated 5/6/2026 indicated he did not have any impairment in thinking with a BIMS score of 13. He was not at risk of developing pressure ulcers/injuries and did not have any unhealed pressure ulcers.Record review of a care plan for Resident #5 dated 5/14/2026 indicated the resident had a wound to his right foot. Interventions included to clean bottom of his right foot everyday shift for 14 days. The care plan did not reflect Resident #5 required EBP.Record review of active physician orders for Resident #5 dated 5/20/2026 indicated an order for wound care to cleanse the bottom of his right foot with wound cleanser, pat dry, apply calcium alginate (dressing used to aid in wound healing) and cover with dry dressing every day shift for 14 days. There was no physician order for EBP.During an observation on 5/20/2026 at 9:54 am, Agency LVN F and CNA E were at the door of Resident #5 to perform wound care. Signage was noted on the door for EBP and PPE, that consisted of gowns and gloves, was in the hallway outside of the door. Both staff entered the room, washed their hands, and applied gloves. Neither staff donned (put on) a gown. Agency LVN F cleaned the overbed table of Resident #4, placed a piece of wax paper down on the table as a barrier, and placed the wound care supplies that consisted of: a bottle of wound cleanser, 4x4 gauze, calcium alginate, and an adhesive dressing on the wax paper. The Agency LVN F removed her gloves and placed them in the trash, sanitized her hands, and applied clean gloves. CNA E assisted by holding Resident #5's leg. Agency LVN F removed the dressing from Resident #5's foot that was dated 5/19/2026 and placed it in the trash. Agency LVN F sprayed wound cleanser and cleaned the wound with 4 x4 gauze and placed the gauze in the trash. Agency LVN F removed her gloves and placed them in the trash; sanitized her hands and applied clean gloves. Agency LVN F patted the wound dry with gauze and removed her gloves removed and placed them in the trash; sanitized her hands and applied clean gloves. Agency LVN F applied a piece of calcium alginate to the wound bed and covered it with a dry dressing. Agency LVN F removed her gloves and placed them in the trash and sanitized her hands. Agency LVN F applied clean gloves, removed the trash, and exited the room. CNA E removed her gloves and washed her hands.During an interview on 5/20/2026 at 10:12 am, LVN F said she worked for an agency and assisted in the facility as needed. She said during the wound care provided to Resident #5, she was supposed to wear a gown when wound care was provided. She said she just forgot. She said he had a wound infection on his foot. She said she did not see the sign on the door for EBP. She said EBP was for infection control to keep germs from spreading and others from getting it. She said infections could be spread to other residents if staff did not wear their gowns when care was provided. During an interview on 5/20/2026 at 10:16 am, CNA E said she had been employed at the facility since 2016. She said during the care that was provided to Resident #5, she forgot to put on a gown. She said PPE was outside in the hallway. She said she was aware Resident #5 was on EBP and should have worn a gown during the care provided. She said residents with signs on the doors and residents with wounds would be on EBP. She said staff could be at risk of spreading infections to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other residents if they did not wear the appropriate PPE when care was provided. She said she had been trained on EBP. She said she had a competency skills check off about a week ago. Record review of a Nursing Assistance Clinical Skills Checklist and Competency Evaluation for CNA E dated 5/7/2025 indicated she demonstrated competency on donning and removing PPE.During an interview on 5/20/2026 at 10:23 am, the ADON said she was responsible for infection control and was the IP for the facility. She said the interim DON conducted skills check offs about a week ago in the facility with staff. She said Resident #5 was on EBP for the wound to his foot. She said EBP was required for residents with wounds, urinary catheters, and any artificial openings with ports. She said staff should wear gowns, gloves, and masks when they provided care to residents on EBP. She said there should be a sign on the door and PPE in the hallways for the residents on EBP. She said there was a risk of spreading infections if staff did not wear the appropriate PPE for residents who were on EBP. During an interview on 5/20/2026 at 1:10 pm, the DON said she started at the facility on 5/18/2026. She said the ADON would be responsible for training staff on infection control and was the IP for the facility. She said EBP was required for residents who had wounds, g-tubes, IV's, tracheostomies (artificial opening in the neck with a tube to help breathe), PICC lines, urinary catheters, ostomies (a surgical opening in the abdomen that allows stool or urine to exit the body), and any openings from the body to the outside. She said Resident #5 was on EBP for his wound. She said staff should wear gowns and gloves when they were in the room providing care. She said if staff did not wear the appropriate PPE, then residents could be at risk of infections. During an interview on 5/20/2026 at 1:27 pm, the Administrator said the nursing managers were responsible for training staff on infection control, but she was responsible. She said the facility conducted monthly in-services that included infection control. She said EBP was in place to help prevent the spread of germs to one another. She said residents that required EBP were residents that had wounds or any artificial openings. She said staff should wear gowns and gloves when care was provided. She said if staff did not wear the appropriate PPE, then there was a risk of spreading germs. She said Resident #5 had a wound and was on EBP. Record review of the facility's policy titled Infection Prevention and Control Program revised 11/6/2024 indicated, .This facility has established and maintains 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 as per accepted national standards and guidelines. 6. Enhanced Barrier Precautions: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: b. Wounds and/or indwelling medical devices regardless of MDRO colonization status. During high-contact resident care activities: wound care: any skin opening requiring a dressing. Gloves and gowns prior to the high-contact activity .