STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676020	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menard Manor	100 Gay St Menard, TX 76859

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately notify and consult with the resident's physician when a significant change in a resident physical, mental, or psychosocial status (that was a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 3 residents reviewed for change in condition. The facility failed to immediately inform MD on 3/13/2026 of Resident #1's change in condition after she had a fall on 3/13/2026. This failure could place residents at risk of serious decrease in health due to delayed treatment. During a record review of Resident #1's face sheet dated 3/20/2026 revealed, [AGE] year old female (Resident #1) was admitted to facility on 5/16/2024 with diagnoses of unsteadiness on feet, muscle weakness, osteoporosis (a chronic bone disease characterized by decreased bone mass and density). During a record review of Resident #1's quarterly MDS dated [DATE] revealed, a BIMS score of 3 indicating severe cognitive impairment. Section GG of MDS revealed Resident #1 required substantial maximum assistance for transfers and used a wheelchair for mobility. Section P of MDS revealed Resident #1 used chair alarms and bed alarms daily. During a record review of Resident #1's care plan dated 2/20/2026 revealed, Resident #1 was at high risk for falls related to gait/balance problems Resident #1 would be free of falls through the review date. Follow facility fall protocol. During a record review of Resident #1's physician orders dated 3/20/2026 revealed, this resident is unable to understand and exercise rights related to dementia with an order date of 10/22/2022, no end date, self-release belt to wheelchair with a start date of 11/7/2024, no end date, smart quiet pressure pad alarm to bed for safety with a start date 11/8/2024, no end date. During a record review of Resident #1's progress notes generated by RN C dated 3/13/2026 at 6:00am revealed, at 4:50 am she heard a voice call out. RN C went down the hall and observed Resident #1 on the floor in the corner of her bedroom with her head and left shoulder propped up against the wall; Resident #1 was seated on her left hip. Neurological checks were initiated and were within normal limits. Resident #1 had a knot on her left forehead with a scrape. Wound was cleansed and left open to air. No other injuries were noted. Resident #1 complained of pain to the left side of her head and her left foot. Resident #1 rated the pain to her head and lower extremity at a 7 and PRN hydrocodone pain medication was administered. Administration was notified of fall at approximately 5:10.am. The responsible party was notified of fall at 7:01am. During a record review of Resident #1's progress notes generated by LVN W on 3/13/2026 at 6:57pm revealed PRN pain medication was administered due to Resident #1 complaining of severe head pain and left lower extremity pain with range of motion. On 3/13/2026 at 7:23pm Resident #1 was transferred to emergency room by her request due to pain and the responsible party agreed. At this time Resident #1 had a change in neurological checks of generalized weakness and slow to open eyes during assessment; grips weak.Prior to transferring Resident #1 to emergency room LVN W utilized on call system used after hours and notified MD on call of increased pain and MD gave orders to send to emergency room. Resident #1 returned from emergency room on 3/13/2026 at 11:53pm and CT scan (non-invasive medical imaging test that produces images of bones, blood vessels, and soft tissues) of head and x-ray (imaging test used to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visualize bones) of lower foot and ankle were clear. Attempted to interview LVN W 3 times and no return call. During an observation on 3/20/2026 at 9:35a.m, revealed, Resident #1 continued to have a raised area with bruising to the left side of her head. Fall equipment including bed alarm and fall mat was in place. Resident #1 was not interview able. During an interview on 3/20/2026 at 2:02 p.m., RN C stated she did not notify the MD at the time of the incident. RN C stated she did notify the responsible party and administration at the time of the incident. RN C stated she knew about the on-call system for notifying on-call physicians but failed to use it. RN C stated after the incident she received one on one training regarding utilizing the on-call system called Third Eye to notify the MD of events that occurred outside of normal business hours. RN C stated that the risk of not notifying the MD at the time of the incident could be an injury with delay in care. During an interview on 3/20/2026 at 4:04pm with the Administrator, she stated that the expectations for incidents were to notify administrative staff. She stated the nurse should have utilized the on-call system outside of normal business hours to notify the MD. Administrator stated the risk of not doing so could lead to injuries not being recognized. During an interview on 3/20/2026 at 4:07pm with Resident #1 MD he stated that he cannot be on call all the time because he was the only doctor in the area. The MD stated the facility has an on-call program for afterhours called Third Eye that the facility can utilize outside normal business hours. The MD stated that if there was an injury, he would expect them to notify him immediately. If there is no injury, the on-call system should be utilized and 2 hours after the incident would be a sufficient timeframe. The MD stated nurses have some autonomy in being able to decide when something needs to be addressed. The MD stated there is a risk to the residents anytime we misjudge a situation. The MD stated Resident #1 had no negative outcome from not notifying the MD after the incident.MD stated failing to notify him immediately if there was an injury could result in delay of care. During a record review of the facility's policy dated 11/5/2013 titled Incident/Accident Reporting Policy and Procedure revealed, 5. It is always necessary to notify family and physician no matter how insignificant an incident may seem. During a record review of the facilities policy dated 6/12/2024 titled Resident Rights Policy and Procedure revealed:Residents have the right to:Receive all care necessary for them to have the highest possible level of health. During a record review of facilities policy undated titled Managing Falls and Fall Risk did not include steps to take after a fall for notifying MD. Policy stated that the physician will help the staff reconsider possible causes that may not previously have been identified.