STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview and record review the facility failed to implement written policies and procedures that prohibit and prevent resident abuse for 1 of 4 (Resident #10) residents reviewed for abuse. The facility failed to ensure the housekeeping supervisor, per the facility's policy, immediately reported witnessed suspected roughness towards Resident #10 by CNA C on 09/07/24 to the Administrator, DON, or ADON. The housekeeper supervisor reported the allegation until 09/10/24. The housekeeper supervisor believed CNA C was rough with Resident #10 and wanted to see the video of the incident to see if CNA C was indeed abusive to the resident as she was not sure the incident occurred. Theses failures could place residents at risk for unsafe environment and further abuse. Findings included: Record review of the facility's policy and procedure, titled Abuse, neglect and exploitation policy dated 07/19/24 indicated in Part: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by: prohibiting and preventing abuse, neglect, exploitation and misappropriation of resident property, investigating any such allegations. Training new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures and dementia management and resident abuse prevention. Reporting/Response - Report all alleged violations to the Administrator, state agency and to all other required agencies (e.g. law enforcement, adult protective services, etc. when applicable) within specified timeframes: Immediately but not later than 2 hours after the allegation is made. Record review of Resident #10's admission record dated 09/12/2024 indicated she was admitted to the facility on [DATE] with diagnoses of weakness, stroke, and depression. She was [AGE] years of age. Record review of Resident #10's care plan dated 07/17/2024 indicated in part: Focus: Resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to vascular dementia. Goal: Resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions: Resident needs assistance/escort to activity functions. Record review of Resident #10's MDS dated [DATE] indicated in part: BIMS = 12 indicating resident was moderately impaired. (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: 676020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Menard Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Gay St Menard, TX 76859	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/11/2024 at 01:15 PM, Resident #10 was in her room sitting down in recliner awake and alert. Resident #10 was asked if she has had any issues with staff being rude or ugly to her and she said no that staff were very nice to her and she meant all staff and had no complaints about any of the staff. Resident #10 was asked if she had-had any problems with the staff being rude to her in the dining room some days ago, resident said no, resident then was asked specifically if she recalled an aide being rude or rough to her in the dining room due to her falling asleep at the dining room table. Resident #10 said that if she had fallen asleep then it was possible that staff had to really shake her up to get her to wake up as she was hard to arouse when asleep. Resident #10 said she did not feel like she had been mistreated by the aide and still had no complaints about the staff. During this interview Resident #10 did not appear to be in any distress and appeared to be at peace and comfortable at the facility. During a telephone interview on 09/11/2024 at 03:34 PM the housekeeping supervisor said she had witnessed the incident on Saturday September the 7th 2024 and waited until Monday September the 9th 2024 to report it in person to the Administrator. The housekeeping supervisor said unfortunately the Administrator was off on Monday, so she ended up not reporting it until Tuesday which was yesterday 09/10/2024. The housekeeping supervisor said she had not reported it right away because she first wanted to see the video of the incident to see if CNA C had indeed been abusive to Resident #10. The housekeeping supervisor said when she witnessed the incident on Sunday September the 7th it seemed that the CNA had been kind of rough with Resident #10 but that the resident had not cried out in pain or anything like that. The housekeeping supervisor said she was not sure if CNA C was indeed rough and the reason, she did not report it right away, she said the resident's family member was also present during the incident, but he had not said anything. The housekeeping supervisor said she had been trained to report abuse right away and she probably should have done that instead of waiting until Tuesday. The housekeeping supervisor said she had never seen CNA C being rude or rough to other residents and she had never heard of CNA C being abusive to residents. The housekeeping supervisor said if she did not report any type of abuse right away then the abuse could continue as the perpetrator would continue to have access to the residents. During a telephone interview on 09/12/2024 at 02:50 PM CNA C said on Saturday 09/07/2024 the residents were done with lunch, and the nursing staff were in the process of assisting the residents from the dining room back to their rooms. CNA C said Resident #10 would fall asleep in her wheelchair and could be hard to arouse at times. CNA C said she woke Resident #10 up and then wheeled her to her room. CNA C said at no time did she shake or talk ugly to the resident. CNA C said she would never mistreat any resident and that she loved her job and was very upset because she got suspended. CNA C said she had worked that Saturday 09/07/2024 and no one had said anything to her about being rude or rough with Resident #10. CNA C said she had also worked Sunday 09/08/2024 and was scheduled off for Monday and Tuesday 09/09/2024 through 09/10/2024 but that on Tuesday 09/10/24 the Administrator called her to come in and write a statement about what occurred and was then suspended and that currently she was still suspended. (continued on next page)

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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/2024 at 04:10 PM the Administrator said she was aware that housekeeper supervisor should have not waited until Tuesday 09/10/24 to report a suspected allegation of abuse that she believed she witnessed on Saturday 09/07/24. The Administrator said the housekeeper supervisor had just recently been re-trained on reporting abuse immediately and did not understand why the supervisor had waited until Tuesday to report the allegation. The Administrator said the housekeeper supervisor failing to report the abuse immediately could lead to the perpetrator still working at the facility. The Administrator said she had viewed the video of the alleged abuse was could not verify if the abuse had indeed occurred by CNA C but had still suspended the CNA.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on interview and record review, the facility failed to ensure allegations of abuse were reported immediately, but not later than 2 hours after the allegation was made, or if the events that caused the allegation did not involve abuse or result in bodily injury not later than 24 hours, to Administrator for 1 of 4 residents (Resident #10)reviewed for abuse in that: The housekeeper supervisor did not report that she thought she witnessed CNA C be rough with Resident #10 to the Administrator within 2 hours of the incident. This deficient practice could place residents at risk for not having all allegations of abuse and neglect reported to the State Survey Agency in a timely manner. Findings included: Record review of Resident #10's admission record dated 09/12/2024 indicated she was admitted to the facility on [DATE] with diagnoses of weakness, stroke, and depression. She was [AGE] years of age. Record review of Resident #10's care plan dated 07/17/2024 indicated in part: Focus: Resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to vascular dementia. Goal: Resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions: Resident needs assistance/escort to activity functions. Record review of Resident #10's MDS dated [DATE] indicated in part: BIMS = 12 indicating resident was moderately impaired. During an observation and interview on 09/11/2024 at 01:15 PM, Resident #10 was in her room sitting down in recliner awake and alert. Resident #10 was asked if she has had any issues with staff being rude or ugly to her and she said no that staff were very nice to her and she meant all staff and had no complaints about any of the staff. Resident #10 was asked if she had-had any problems with the staff being rude to her in the dining room some days ago, resident said no, resident then was asked specifically if she recalled an aide being rude or rough to her in the dining room due to her falling asleep at the dining room table. Resident #10 said that if she had fallen asleep then it was possible that staff had to really shake her up to get her to wake up as she was hard to arouse when asleep. Resident #10 said she did not feel like she had been mistreated by the aide and still had no complaints about the staff. During this interview Resident #10 did not appear to be in any distress and appeared to be at peace and comfortable at the facility. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 09/11/2024 at 03:34 PM the housekeeping supervisor said she had witnessed the incident on Saturday September the 7th 2024 and waited until Monday September the 9th 2024 to report it in person to the Administrator. The housekeeping supervisor said unfortunately the Administrator was off on Monday, so she ended up not reporting it until Tuesday which was yesterday 09/10/2024. The housekeeping supervisor said she had not reported it right away because she first wanted to see the video of the incident to see if CNA C had indeed been abusive to Resident #10. The housekeeping supervisor said when she witnessed the incident on Sunday September the 7th it seemed that the CNA had been kind of rough with Resident #10 but that the resident had not cried out in pain or anything like that. The housekeeping supervisor said she was not sure if CNA C was indeed rough and the reason, she did not report it right away, she said the resident's family member was also present during the incident, but he had not said anything. The housekeeping supervisor said she had been trained to report abuse right away and she probably should have done that instead of waiting until Tuesday. The housekeeping supervisor said she had never seen CNA C being rude or rough to other residents and she had never heard of CNA C being abusive to residents. The housekeeping supervisor said if she did not report any type of abuse right away then the abuse could continue as the perpetrator would continue to have access to the residents. During a telephone interview on 09/12/2024 at 02:50 PM CNA C said on Saturday 09/07/2024 the residents were done with lunch, and the nursing staff were in the process of assisting the residents from the dining room back to their rooms. CNA C said Resident #10 would fall asleep in her wheelchair and could be hard to arouse at times. CNA C said she woke Resident #10 up and then wheeled her to her room. CNA C said at no time did she shake or talk ugly to the resident. CNA C said she would never mistreat any resident and that she loved her job and was very upset because she got suspended. CNA C said she had worked that Saturday 09/07/2024 and no one had said anything to her about being rude or rough with Resident #10. CNA C said she had also worked Sunday 09/08/2024 and was scheduled off for Monday and Tuesday 09/09/2024 through 09/10/2024 but that on Tuesday 09/10/24 the Administrator called her to come in and write a statement about what occurred and was then suspended and that currently she was still suspended. During an interview on 09/12/2024 at 04:10 PM the Administrator said she was aware that housekeeper supervisor should have not waited until Tuesday 09/10/24 to report an allegation of abuse that she believed she witnessed on Saturday 09/07/24. The Administrator said the housekeeper supervisor had just recently been re-trained on reporting abuse immediately and did not understand why the supervisor had waited until Tuesday to report the allegation. The Administrator said the housekeeper supervisor failing to report the abuse immediately could lead to the perpetrator still working at the facility. The Administrator said she had viewed the video of the alleged abuse was could not verify if the abuse had indeed occurred by CNA C but had still suspended the CNA. Record review of the facility's policy and procedure, titled Abuse, neglect and exploitation policy dated 07/19/24 indicated in Part: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by: prohibiting and preventing abuse, neglect, exploitation and misappropriation of resident property, investigating any such allegations. Training new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures and dementia management and resident abuse prevention. Reporting/Response - Report all alleged violations to the Administrator, state agency and to all other required agencies (e.g. law enforcement, adult protective services, etc. when applicable) within specified timeframes: Immediately but not later than 2 hours after the allegation is made.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593 Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 8 residents (Resident #1 and Resident #2) reviewed for care plans. 1. The facility failed to have a care plan in place to accurately address Resident #1 diagnosis of diabetes. 2. The facility failed to ensure Resident #2's care plan accurately reflected her 1/2 side-rail use. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Resident #1 Record review of the admission record indicated Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had medical diagnoses that included Burn of unspecified degree of lower back, burn of third degree to left thigh, burn of third degree of right thigh, acquired absence of the right leg above the knee, acquired absence of the left leg above the knee, hypertension (high blood pressure), and type II diabetes. Record review of Resident #1's Annual MDS assessment dated [DATE] revealed his Cognitive Skills for Daily Decision Making to be Cognitively intact. He required maximum assistance with transfers and was independent for all ADL's except for bathing. He relied on electronic wheelchair for mobility. Under section I for Active diagnosis Diabetes was selected. Record review of Resident #1's order summary dated 9/12/24 included, Pioglitazone HCl Tablet 30 mg - give 1 tablet by mouth one time a day related to type 2 diabetes mellitus with unspecified complications. Record review of Resident #1's care plan dated 09/11/2024 revealed no care plan for Diabetes. Interview on 09/12/24 at 10:41 AM with the MDS coordinator stated anything out of the ordinary will be in a care plan like specific request or needs, anything triggered by MDS, diagnosis. For diabetes there would need to be care planned to monitor resident because the exposure to hot and colds, hypo/hyper glycemia side effects, clean feet daily, podiatrist, if they have any infection consult doctors, any wounds watch closely nail care by licensed nurses. The MDS coordinator stated that she does not believe there to be a negative outcome for this specific resident to not have diabetes care planned because he does not have any complications due to his diabetes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT #2 Review of Resident #2's Admission Record, dated 9/11/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stroke, paralysis affecting the right dominant side, and difficulty swallowing. Review of Resident #2's quarterly MDS Assessment, dated 8/15/24 revealed: Her mental status score was 9 of 15 (indicating moderate cognitive impairment). She needed substantial to maximum assistance with rolling to theft and right. She was incontinent of bowel and bladder. She was on an antidepressant, an antibiotic, an opiate, and a diuretic. Restraints were not identified as in use, including the use of side rails. Review of Resident #2's Care Plan updated 7/26/23 revealed: Resident #2 had an ADL self-care performance deficit related to Muscle Weakness (generalized), other lack of coordination, and need for assistance with personal care due to diagnosis of hemiplegia (paralysis), unspecified affecting right dominant side, Cerebrovascular Disease (stroke) and Major Depressive Disorder. The identified goal was Resident #2 will maintain current level of function in (ADLs) through the review date. Identified interventions included: Bed Mobility: Resident #2 required (substantial/maximum assistance) by (1-2) staff to turn and reposition and to move from lying to sitting on the side of the bed and sitting to lying, turn and reposition in bed every 2 hours, ensure proper padding and body alignment, keep heels off of the mattress. Bed Mobility: Resident #2 uses (1/4 rails) to maximize independence with turning and repositioning in bed. Observation and interview on 9/10/24 at 12:30 p.m. revealed Resident #2 sitting in her doorway watching the traffic. Resident #2 gave permission for surveyor to look in her room. Resident #2 had a 1/2 side rail that was positioned at the halfway point of her bed which would restrict Resident #2's movement. Resident #2 stated the side rail did not bother her and it did not keep her in the bed if she did not want to be in it. In an interview on 9/12/24 at 11:31 a.m. the MDS Coordinator stated she also did the care plans for the facility. The MDS Coordinator stated she care planed Resident #2 as having 1/4 side rails because that was what the staff told her (the MDS Coordinator) what Resident #2 had on her bed. The MDS Coordinator stated she updated Resident #2's care plan to reflect 1/4 side rails the most recent care plan cycle and prior to that she (Resident #2) was care planned for 1/2 side rails. The MDS Coordinator stated Resident #2 had the old fashioned kind of side rails that screwed into the bottom of the bed. The MDS Coordinator admitted she did not go to look at Resident #2's room but got all of Resident #2's resident interviews after Resident #2's therapy exercises. The MDS Coordinator stated, it was my understanding everyone had new bed. Review of facility policy titled Comprehensive Care Plans undated revealed, in part: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A comprehensive person-centered care plan is developed and implemented for each resident, consistent with the resident's rights, that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview and record review, the facility failed to ensure one Resident (Resident #32) of one reviewed for Percutaneous Endoscopic Gastrostomy - PEG (a tube inserted through the abdomen into the stomach for the purpose of administering liquid nutrition and medications) received the appropriate treatment and services to prevent complications and aspiration. LVN B failed to check PEG tube residual prior to administering Resident #32's medication as ordered by the physician. This failure could place residents receiving tube feedings at risk for aspiration pneumonia, dehydration, and metabolic abnormalities which could result in additional medical treatment and a decline in the resident's health. Findings include. Record review of Resident #32's admission record dated 09/10/2024 indicated he was admitted to the facility on [DATE]. Diagnoses included dysphagia (difficulty swallowing), dementia and stroke. He was [AGE] years of age. Record review of Resident #32's order summary report dated 09/11/2024 indicated in part: Check PEG placement with stethoscope prior to feedings. Check residual before each feeding, if greater than 60ml, hold feeding and re-check in one hour. If less than 60ml may resume feeding. Record review of Resident #32's care plan dated 07/16/2024 indicated in part: Focus: Resident requires tube feeding (PEG) r/t Dysphagia. Goal: Resident will maintain adequate nutritional and hydration status and weight will stabilize, with no signs and symptoms of malnutrition or dehydration through review date. Interventions: Check for tube placement with stethoscope and gastric contents/residual volume per facility protocol and record. Hold feed if greater than (60) cc aspirate., hold feeding for 1 hour, recheck and if less than 60cc may resume. Record review of Resident #32's MDS dated [DATE] indicated in part: Cognitive Skills for Daily Decision Making = Severely impaired - never/rarely made decisions. During an observation on 09/11/24 at 10:16 AM LVN B administered Resident #32's medication and feeding formula through the resident's PEG tube. LVN B placed the syringe without the plunger into Resident #32's PEG tube and did not check for residual by aspirating the stomach contents. LVN B then proceeded to administer the medications and the formula feeding through the resident's PEG tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 09:15 AM LVN B said that prior to administering Resident #32's medication she had checked for residual by placing the syringe in the resident's PEG tube and lowering the tube to see if any residual came up into the syringe. LVN B said she did not like to pull on the syringe plunger to check for residual because that would freak her out. LVN B said she thought that lowering the PEG tube to check for residual was a proper way to check for residual. LVN B said she was not aware of the facility's policy on how to check for PEG residual. LVN B said that it was her fault for not checking the residual correctly and should have aspirated for stomach contents. During an interview on 09/12/24 at 03:42 PM the DON was made aware of the observation of LVN B performing the PEG residual check for Resident #32. The DON said she had never heard of someone checking for PEG residual by lowering the PEG tube. The DON said the correct way was to place the syringe in the PEG tube and pull on the plunger to retrieve the stomach contents. The DON said the failure occurred because LVN B did not check for residual the correct way. The DON said she did rounds to monitor the nurses doing their job on a daily basis. During an interview on 09/12/24 at 04:12 PM the Administrator said LVN B was expected to follow the doctor's order and check for stomach contents before administering medications or feedings. The Administrator said she did not know why the LVN had not followed the orders. Record review of the facility's policy Gastrostomy tube procedure dated 05/28/98 indicated in part: Check tube placement and patency by aspirating stomach contents or by injecting 10 ml air into tube while listening with a stethoscope for a whooshing sound.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observations, interviews, and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail, assess the resident for risk of entrapment from bed rails prior to installation, and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 1 of 4 (Resident #2) residents reviewed for bed rails. The facility failed to ensure Resident #2's 1/2 side rail was installed correctly. The facility failed to correctly care plan Resident #2's side rails. These failures could place residents at risk of injury, hinder residents from getting out of bed, and/or cause a decline in resident's ability to engage in activities of daily living. Findings included: Review of Resident #2's Admission Record, dated 9/11/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stroke, paralysis affecting the right dominant side, and difficulty swallowing. Review of Resident #2's quarterly MDS Assessment, dated 8/15/24 revealed: Her mental status score was 9 of 15 (indicating moderate cognitive impairment). She needed substantial to maximum assistance with rolling to theft and right. She was incontinent of bowel and bladder. She was on an antidepressant, an antibiotic, an opiate, and a diuretic. Restraints were not identified as in use, including the use of side rails. Review of Resident #2's Care Plan updated 7/26/23 revealed: Resident #2 had an ADL self-care performance deficit related to Muscle Weakness (generalized), other lack of coordination, and need for assistance with personal care due to diagnosis of hemiplegia (paralysis), unspecified affecting right dominant side, Cerebrovascular Disease (stroke) and Major Depressive Disorder. The identified goal was Resident #2 will maintain current level of function in (ADLs) through the review date. Identified interventions included: Bed Mobility: Resident #2 required (substantial/maximum assistance) by (1-2) staff to turn and reposition and to move from lying to sitting on the side of the bed and sitting to lying, turn and reposition in bed every 2 hours, ensure proper padding and body alignment, keep heels off of the mattress. Bed Mobility: Resident #2 uses (1/4 rails) to maximize independence with turning and repositioning in bed. (continued on next page)

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Mobility Assessment, dated 8/15/24, revealed Resident #2's Ability to maintain normal head and trunk alignment was poor. Right side shoulder movement was poor. Left side shoulder movement was moderate. Right side elbow movement was poor. Left side elbow movement was moderate Right side wrist and elbow movement was poor. Left side wrist and elbow movement was moderate. Hip movement on the left and right side was poor. Knee movement of the left and right side were poor. Mobility and balance in all aspects was considered poor. Review of Resident #2's quarterly Restraint Evaluation, dated 8/8/24, revealed: contributing factors to the restraint were poor balance, confusion, short-term memory loss, and diagnosis contributing to increased risk of falls. The type of restraint in use was 1/2 side rails. The devices were indicated as an enabler and to promote greater functional independence. Review of the Restraint Consent, dated 7/28/22, revealed Resident #2's responsible party initialed for 1/2 bed rails as an enabler. Observation and interview on 9/10/24 at 12:30 p.m. revealed Resident #2 sitting in her doorway watching the traffic. Resident #2 gave permission for surveyor to look in her room. Resident #2 had a 1/2 side rail that was positioned at the halfway point of her bed which would restrict Resident #2's movement. Resident #2 stated the side rail did not bother her and it did not keep her in the bed if she did not want to be in it. In an interview on 9/12/24 at 11:31 a.m. the MDS Coordinator stated she also did the care plans for the facility. The MDS Coordinator stated she care planed Resident #2 as having 1/4 side rails because that was what the staff told her (the MDS Coordinator) what Resident #2 had on her bed. The MDS Coordinator stated she updated Resident #2's care plan to reflect 1/4 side rails the most recent care plan cycle and prior to that she (Resident #2) was care planned for 1/2 side rails. The MDS Coordinator stated Resident #2 had the old fashioned kind of side rails that screwed into the bottom of the bed. The MDS Coordinator admitted she did not go to look at Resident #2's room but got all of Resident #2's resident interviews after Resident #2's therapy exercises. The MDS Coordinator stated, it was my understanding everyone had new bed. Observation and interview on 9/12/24 at 12:11 p.m. the Maintenance Director stated the facility ordered 30 bed and he had so far put together 24 of them. He said he had to put them together and then inspect them. The Maintenance Director stated the old bed were operated by a crank or were a hospice provided bed. The Maintenance Director was shown Resident #2's rails which were now 75% of the way up the bed. The Maintenance Director looked at the rails and said that is not alright! The Maintenance Director checked the rail, and it was very loose. The Surveyor explained on 9/10/24 the rail was at the half- way point of the bed. The Maintenance Director said that will be changed as soon as possible. Someone tried to make these into rails. No one told me they were moving a rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/12/24 at 1:43 p.m. the DON stated the facility did not have a side rail policy. The DON stated the facility practice was to get a consent for half rails so if the facility decided it was needed as an enabler, they had the family sign for it. The DON admitted she had not been keeping up with the assessments to prove ongoing need for the side rails since she started working at the facility. The DON said the Maintenance Director, MDS Coordinator and her were talking about how Resident #2's side rail could get to the middle of the bed and the only thing they could think of was if the head of the bed was raised it might move the rail. The DON said Resident #2 was able to use the rail on one side and was able to hold onto it during incontinent care. The DON said she never considered the side rail a restraint. In an interview on 9/12/24 at 3:20 p.m. the Administrator stated the Maintenance Director informed her about the half rail. The Administrator said she did not know how it happened unless it wiggled that way and it loosened and maybe a CNA or housekeeper tightened it. The Administrator stated the Maintenance Director was swapping out beds.

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F 0800

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 26221

Based on observation, interview, and record review the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 2 of 4 residents (Resident #2 and Resident #3) reviewed for dietary services in that:

The residents with puree diet did not receive consistent portion sizes of the puree desert.

The facility served zero sugar pudding cups in place of the fortified pudding for lunch for Resident #2 and Resident #3.

These failures could place residents at risk for poor food intake, weight loss, and diminished quality of life.

Findings included:

Observation and interview of the noon meal on 9/11/24 at 11:25 a.m. revealed six 4 oz bowls of pureed dessert - three of the bowls were almost completely full, one approximately half full, and the last two were approximately 25% full. At 11:52 a.m. the first puree desert went out. The DM said the dessert bowls did not have the same portion sizes. The DM also saw the sugar free pudding left out for the fortified meal program and stated zero sugar pudding was not appropriate for a fortified program. The DM stated there was a weight loss problem in the building.

In an interview on 9/11/24 at 1:38 p.m. the DM stated she thought the kitchen observation went well. She stated fortified meal not being served was completely on her since she did not notice the sugar free pudding was laid out.

In an interview on 9/11/24 at 2:38 p.m. DM stated there were five residents on a fortified diet.

In an interview on 9/11/24 at 2:48 pm. the Administrator stated she expected to see fortified foods to have recipes. The Administrator said generally there was hot cereal for breakfast and pudding for lunch. The Administrator said there was usually something in the food to add calories or protein like butter, powdered milk. The Administrator stated zero sugar pudding cups would not be fortified. The Administrator said she had told the dietary department they could not just give residents a pudding cup and have it be considered a fortified diet.

RESIDENT #2

Review of Resident #2 Admission Record, dated 9/11/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stroke, paralysis affecting the right dominant side, and difficulty swallowing.

Review of Resident #2's quarterly MDS Assessment, dated 8/15/24 revealed:

(continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Her mental status score was 9 of 15 (indicating moderate cognitive impairment). She ate with set-up from staff. She weighed 150 pounds and had a weight loss of 5% or more in the last month or 10% or more in the last 6 months was no or unknown. Review of Resident #2's Care Plan, revised on 5/23/24 revealed Resident #2 had a nutritional problem or potential nutritional problem as evidenced by signs or symptoms or dehydration and history of skin break down, weight loss, and therapeutic diet of Regular with large egg portion with breakfast and fortified meal program. The goal was Resident #2 would maintain adequate nutritional status as evidenced by maintaining weight within (x)% of 130 pounds, no signs or symptoms of malnutrition and consuming at least 75% of at least 2 meals daily though the review date. Identified interventions included: provide and serve diet as ordered. Monitor and record each meal. Review of Resident #2's Order Summary revealed orders large egg portions with breakfast, fortified meal plan dated 1/9/23. Review of Resident #2's Nutrition/ Dietary Note, dated 6/11/24 revealed her weight had increased 12 pounds in the last three months. RESIDENT #3 Review of Resident #3's Admission Record, dated 9/12/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis, protein-calorie malnutrition, and stroke. Review of Resident #3's Annual MDS Assessment, dated 8/29/24, revealed: She had a mental status score of 15 of 15 (indicating she was cognitively intact). She needed set-up assistance from the staff to eat. She weighed 126 points and had significant weight loss not on physician-prescribed weight loss program. Review of Resident #3's Care Plan revised on 6/5/24 revealed Resident #3 had a nutritional problem or potential nutritional problem as evidenced by need for mechanically altered diet (pureed texture) and need for therapeutic diet of large egg portions with breakfast, and fortified meal plan due to weight loss and a stage II pressure ulcer (bed sore) to right gluteus (butt cheek). The identified goal was Resident #3 would maintain adequate nutritional status as evidenced by maintaining weight within 10% of 129 pounds, no signs or symptoms of malnutrition, and consuming at least 75% of at least two meals daily through the review date. Identified interventions included Resident #3 currently was eating tomato soup or soft/pureed soup with no texture related to pain in gums/mouth. Snacks with protein twice a day, chocolate milk twice a day. Review of Resident #3's Order Summary Report, dated 9/11/24, revealed diet orders of regular diet pureed texture, large egg portions with breakfast and fortified meal plan, start date 6/21/24. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's Nutrition Dietary Note dated 9/6/24 revealed she had gained 5 pounds in the last 30 days and the dietician felt her weight fluctations were likely due to medications. Review of portion sizes for the 9/11/24 menu revealed residents were to receive a #20 scoop (approximately 3 Tablespoons, or slight less than half the 4 oz bowl). Review of the Fortified Diet Program, undated, revealed: Foods/Snacks suggested to added calories and/or protein: cake, cheese/cottage cheese, chocolate/flavored milk, cookies, dry cereal, ice cream/ice cream bars, pies, pudding, snack crackers, yogurt. Food items/Ingredients to add additional calories: some individuals primary need to increase calories in the diet but have difficulty consuming additional volume. This may be the case for persons with decreased appetite, under nutrition, unintentional weight loss or other conditions. The following are suggestions of ways to increase calories by adding ingredients to foods already offered at the meal. Margarine or butter; mayonnaise; cream/ half or half, sour cream, honey, corn syrup, jam and jelly, cheese, non-fat dried milk, brown sugar and sugar, whipped cream. Recipe for fortified pudding: Portion sized 1/2 cup. Ingredients: Milk, whole, milk non-fat dry, pudding mix instant, any flavor; whipped topping dry, prepare according to package directions. Recipe for fortified soup. Portion size: 6 oz Ingredients: condensed soup, condensed cream, whole milk, shredded cheddar cheese.

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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. 26221 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen. The facility failed to ensure: Staff did not re-glove using the same single use glove. Staff did not cross contaminated the kitchen after touching the trash can lid and the did not immediately wash their hands. Staff did not handle food with their bare hands. Staff did not put food on cooking surfaces without ensuring they were covered. The walk-in refrigerator was maintained in a sanitary manner. These failures could affect residents who received meals prepared from the kitchen at risk for food borne illness and cross contamination. Findings included: Observation on 9/10/24 at 10:24 a.m. of the dry storage revealed a container of bullion on the floor underneath the shelves. The cook picked it up and put it on the shelf with the rest of the containers of bullion without wiping it down. Observation on 9/10/24 at 10:30 a.m. of the walk-in refrigerator revealed: the eggs used were not pasteurized. There was a dried puddle of dripped food on the floor. There was food debris shoved to the back of the corners of the wall and corners underneath the shelves. Observation of the noon meal preparation on 9/11/24 beginning at 9:53 a.m. revealed: At 10:04 a.m. [NAME] D took her glove off, pulled a spoon out of the drawer and pulled the same glove back on. At 10:50 a.m. [NAME] E lifted the lid of the trash can with her gloved hand, threw something out, went to the refrigerator opened it, put in a cup of fluid, picked up some unused cups off the table, returned them to the shelf placed them with the other clean, unused cups and then took off her gloves and washed her hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:30 [NAME] G cut open a bag of lettuce for the evening meal with his bare hands, emptied the lettuce into a large bowl and then evened the lettuce in the bowl by pushing it with his bare hands. At 11:52 a.m. [NAME] E opened the oven drawer to show surveyor that [NAME] G put potatoes on the rack in the oven with no foil and not on a pan. In an interview and observation on 9/11/24 at 1:38 the DM stated she thought the kitchen task went well until [NAME] G came in. The DM said usually when she told [NAME] G to correct something he did. The DM looked at the walk-in refrigerator and stated under the wire shelves were not clean and had food debris just pushed to the back. Surveyor reviewed other observations made through the cooking preparation. The DM stated when [NAME] E did not wash her hand after touching the trash can lid and then touched other surfaces was cross-contamination. The DM asked why someone would take off a single use glove and put it back on. The DM said it was not acceptable to handle food with a bare hand at any time because of the risk of contamination. In an interview on 9/11/24 at 2:48 p.m. the Administrator was informed of the kitchen observations. The Administrator asked for clarification that food was handled with bare hands and not by the packaging. The Administrator stated no one re-gloves when informed of the staff re-gloving to prepare food. The Administrator said she brought the foot pedal trash cans because the kitchen had so many problems with cross contamination prior to this survey. Review of the cleaning schedule for the kitchen revealed the evening dietary aide was responsible for cleaning refrigerators out inside and out daily and the last time this was done was 9/5/24. Review of in-service dated 7/10/24 revealed: Bare Hand Contact with Food and use of Plastic Gloves. Policy: single-use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited. Staff will use clean barrier such as single-use gloves, tongs, deli paper, and spatulas when handling food. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed: after handling garbage or garbage cans. (Cook D attended the in-service)

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48593 Based on interview and record review, the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. This failure could affect any resident in the facility, placing them at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. The findings included: Review of the PBJ Staffing Data Report CASPER Report 1705D for FY Quarter 3 2024 (April 1 - June 30) revealed the following dates to not have licensed nursing staff 04/07 (SU); 04/20 (SA); 04/21 (SU) 05/05 (SU); 05/19 (SU) 06/09 (SU); 6/15 (SA); 06/16 (SU). The facility was able to prove on the above listed dates to have at least one licensed nursing staff working. The facility provided actually working hours of staff. However , after an interview on 09/11/24 at 01:21 PM Payroll H revealed that he failed to submit approximately 155 different shifts worked by agency staff. Payroll H stated that he had made two separate PDFs of staff one for agency and one for core staff. Payroll H stated that he did not merge the document like he intended and failed to report these shifts worked. Payroll H is the person in charge of submitting staffing information. Payroll H stated he will ensure all information relating to staffing information. No policy in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #32 and Resident #1) of 5 residents reviewed for infection control. CNA A failed to change her gloves after they became contaminated during incontinent care while assisting Resident #32. CNA's I & J failed to use enhanced barrier precautions (EBP) during transferring Resident #1 from his bed to his wheelchair. (EBP - refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). These failures could place resident's risk for cross contamination and the spread of infection. Finding include: Record review of Resident #32's admission record dated 09/10/2024 indicated he was admitted to the facility on [DATE]. Diagnoses included dementia and stroke. He was [AGE] years of age. Record review of Resident #32's care plan dated 07/16/2024 indicated in part: Focus: Resident has incontinence r/t DX. Dementia, Cerebral infarction (stroke). Goal: Resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Resident uses (large) disposable briefs. Clean peri-area with each incontinence episode. Record review of Resident #32's MDS dated [DATE] indicated in part: Cognitive Skills for Daily Decision Making = Severely impaired - never/rarely made decisions. Urinary continence = Always incontinent. Bowel continence = Always incontinent. During an observation on 09/10/24 at 10:54 AM CNA A performed incontinent care for Resident #32. CNA A put gloves on and undid Resident #32's brief from the back and wiped his rectal area with some wet wipes. It was noted that the resident had some bowel movement. CNA A continued to wipe the resident's rectal area and then removed the soiled brief. While still wearing the same gloves, CNA A took a clean brief and placed it under the resident's buttocks. While still wearing the same gloves, CNA A then wiped Resident #32's penis with some wet wipes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/24 at 01:50 PM CNA A said she should have changed gloves after she wiped Resident #32's rectal which had some bowel movement. CNA A said she should have changed gloves before she wiped the resident's penis area as she was still wearing the same gloves, she used to wipe the bowel movement. CNA A said she normally changed her gloves before going from dirty to clean. CNA A said if she did not change her gloves that could lead to cross contamination. CNA A said she had gotten nervous and forgot to change her gloves before applying the new brief and cleaning Resident #32's penis area. During an interview on 09/11/24 at 05:45 PM the DON was made aware of the observation of incontinent care performed by CNA A. The DON said CNA A should have changed her gloves and washed her hands before touching the new brief and performed incontinent care to Resident #32's penis area. The DON said they monitored staff for incontinent care by performing competency checks. The DON said if the CNA did not change her gloves at the appropriate time that could lead to the spread of germs and infections. The DON said the failure probably occurred because the CNA got nervous. During an interview on 09/12/24 at 04:15 PM the Administrator said CNA A should have changed her gloves before going from dirty to clean. The Administrator said the CNA probably got nervous and did not change her gloves as indicated. The Administrator said the CNA not changing her gloves could lead to cross contamination. Resident #1 Record review of the admission record indicated Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had medical diagnoses that included Burn of unspecified degree of lower back, burn of third degree to left thigh, burn of third degree of right thigh, acquired absence of the right leg above the knee, acquired absence of the left leg above the knee, hypertension (high blood pressure), and type II diabetes. Record review of Resident #1's Annual MDS assessment dated [DATE] revealed his Cognitive Skills for Daily Decision Making to be Cognitively intact. He required maximum assistance with transfers and was independent for all ADL's except for bathing. He relied on electronic wheelchair for mobility. Under section H for Bowel and Bladder indwelling catheter was selected. Under section M - Skin conditions resident has a stage 1 or greater, a scar over a bony prominence, or a non-removable dressing or device. was selected. Record review of Resident #1's order summary dated 9/12/24 included, Enhanced Barrier Precautions every shift related to wounds/Foley catheter Observation of a Hoyer lift transfer on 09/11/24 at 04:00 PM with CNA I and CNA J for Resident #1 revealed Neither CNA I or CNA J donned EBP for the transfer of the resident. Both did wash hands and donned gloves prior to direct care. During the transfer both CNAs touched the resident's bed, bedding, clothes, wheelchair, and foley catheter tubing and bag. An interview on 09/11/24 at 04:30 PM with both CNA I and CNA J both revealed they did not believe they needed to don full enhanced barrier precaution PPE due to not directly touching the foley catheter. Both stated it was their understanding that unless they were directly cleaning or maneuvering the foley they do not have to have on extra PPE. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled perineal care/Incontinent care-male dated 09/20/2007 indicated in part: It is the policy of this facility to provide perineal/incontinent care on male residents as needed without contaminating the urethral area with germs from the rectal area. Properly clean hands before procedures. Wash rinse and dry the remaining area including the penis, scrotum and outward to the thighs. Turn resident on side. Wash, rinse and dry the remaining area including the rectum and buttocks without returning to the urethral area. Wash, rinse and dry from clean to dirty area leaving entire area clean and dry. Remove soiled linen and gloves and place in appropriate place. Wash hands or use hand sanitizer. Record review of the facility undated policy titled Handwashing policy and procedure indicated in part: Handwashing shall be regarded by this facility as the single most important means of preventing the spread of infections. All personnel shall follow our established handwashing procedure to prevent the spread of infection and disease to other personnel, residents and visitors. Employees must perform appropriate twenty (20) second handwashing procedure under the following conditions: After removing gloves. The use of gloves does not replace handwashing. Record review of the facility document titled Infection control guidelines for all nursing procedures dated 07/26/2016 indicated in part: Purpose - to provide guidelines for general infection control while caring for residents. Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. Employees must wash their hands for 10 to 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions - Before and after direct contact with residents; After removing gloves.