

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Merkel Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1704 N 1st Merkel, TX 79536	
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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's QAPI committee failed to implement an appropriate action plan to address identified quality deficiencies for 1 of 1 facility. The QAPI committee failed to implement the corrective actions outlined on the Plan of Correction, dated 8/29/2024, for deficient practice F695, F909, F941, F944, F949. This failure could place residents at risk for substandard quality of care due to the failure of the facility to take action on an identified problem affecting resident safety, respiratory treatment, and employee training. Findings included: Record review of a CMS 2567, dated 7/31/2025, reflected that based on observations, interviews, and record review, a deficient practice was cited at F695 (Respiratory/Tracheostomy Care and Suctioning) during the 7/31/2024 SSA recertification survey. Observations, interviews, and records reflected that the facility failed to have oxygen in use signs outside of resident's rooms that utilized oxygen. Record review of the facility's 9/5/2024 Plan of Correction which was submitted in response to the 7/31/2024 SSA recertification survey reflected the facility's plan as Weekly checks by the ADON or DON will be done to ensure the policy is enforced. Then their findings will be reported in the morning meetings which have Monday through Friday and at Monthly QAPI meetings. During an observation on 12/02/2025 at 09:30 a.m., Resident #3 was wearing a n/c and oxygen was being administered. There was no oxygen in use signs on her doorway leading into her room. During an observation on 12/2/2025 at 9:45 a.m., Resident #11 was sitting in a recliner in their room. Resident #11 was wearing a n/c and oxygen was being administered. There was no oxygen in use signs the doorway leading into the resident's room. During an observation on 12/2/2025 at 10:00 a.m., Resident #7 was lying in bed. Resident #7 was wearing a n/c and oxygen was being administered. There was no oxygen in use signs on her doorway leading into her room. During an observation on 12/02/2025 at 02:31 p.m., Resident #2 was lying in bed on her left side. Resident #2 was wearing a n/c and oxygen was being administered. There was no oxygen in use sign on the doorway leading into her room. Record review of a CMS 2567 dated 7/31/2025 reflected that based on observations, interviews, and record review, a deficient practice was cited at F909 (Resident Bed) during the 7/31/2024 SSA recertification survey. Observations, interviews, and records reflected that the facility failed to assess resident's beds that had bed rails for risk of entrapment. Record review of the facility's 8/20/2024 Plan of Correction submitted in response to the 7/31/2024 SSA recertification survey reflected the facility's plan as, The results of the routine checks will be made monthly at QAPI meetings or immediately if reasonable such as or emergency. The environmental supervisor will report at the monthly QAPI meeting. The Entrapment risks will be reviewed from the checklist generates based on state criteria. Record review of facility documents Bed Rail Appropriateness Checklist for Resident #2, Resident #3, Resident #7, Resident #9 and Resident #21 reflected no evidence that the assessment had been performed since 7/16/2025. Record review of a CMS 2567, dated 7/31/2025, reflected that based on interviews, and record review, a deficient practice was cited at F941 (Communication Training) during the 7/31/2024 SSA recertification survey. Interviews and record reviews reflected the facility failed to train staff on communication. Record review of the facility's 9/5/2024 Plan of Correction submitted in response to the 7/31/2024 SSA recertification (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 676053	If continuation sheet Page 1 of 26

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Further review of the personnel record provided by the AIT reflected RN C had no evidence she completed the required effective communication training upon hire or while working at the facility. Record review of the personnel records for LVN E reflected a hire date of 6/20/2025. Further review of the personnel record provided by the AIT reflected LVN E had no evidence she completed the required effective communication training upon hire or while working at the facility. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence she completed the required effective communication training upon hire or while working at the facility. Record review of the personnel records for NA H reflected a hire date of 2/28/2025. Further review of the personnel record provided by the AIT reflected NA H had no evidence she completed the required effective communication training upon hire or while working at the facility. Review of a CMS 2567, dated 7/31/2025, reflected that based on interviews, and record review, a deficient practice was cited at F944 (QAPI Training) during the 7/31/2024 SSA recertification survey. Interviews and record reviews reflected the facility failed to train staff on QAPI. Review of the facility's 9/5/2024 Plan of Correction submitted in response to the 7/31/2024 SSA recertification survey reflected the facility's plan as, Random audits of all trainings will be completed by the office manager and the results will be reported to the administrator during morning meetings which happen Monday through friday and at monthly QAPI meetings. Record review of personnel record for the DON reflected a hire date of 7/1/2025. Further review of personnel record provided by the AIT reflected the DON had no evidence she completed QAPI training upon hire or while working at the facility. Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of personnel record provided by the AIT reflected the DM had no evidence she completed QAPI training upon hire or while working at the facility. Record review of the personnel records for RN C reflected a hire date of 9/1/2025. Further review of the personnel record provided by the AIT reflected RN C had no evidence she completed QAPI training upon hire or while working at the facility. Record review of the personnel records for LVN E reflected a hire date of 6/20/2025. Further review of the personnel record provided by the AIT reflected LVN E had no evidence she completed QAPI training upon hire or while working at the facility. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence she completed QAPI training upon hire or while working at the facility. Review of a CMS 2567 dated 7/31/2025 reflected that based on interviews, and record review, a deficient practice was cited at F949 (Behavioral Health Training) during the 7/31/2024 SSA recertification survey. Interviews and records reflected the facility failed to train staff on behavioral health. Review of the facility's 9/5/2024 Plan of Correction submitted in response to the 7/31/2024 SSA recertification survey reflected the facility's plan as Random audits of all trainings will be completed by the office manager and the results will be reported to the administrator during morning meetings which happen Monday through friday and at monthly QAPI meetings. Record review of personnel record for the DON reflected a hire date of 7/1/2025. Further review of personnel record provided by the AIT reflected the DON had no evidence she completed behavioral health training upon hire or while working at the facility. Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of personnel record provided by the AIT reflected the DM had no (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided with such care consistent with professional standards of practice for 4 of 14 residents (Resident #2, Resident #3, Resident #7 and Resident #11) reviewed for oxygen therapy. The facility failed to provide Oxygen (O2) in use sign on resident doorways for Resident #2, Resident #3, Resident #7 and Resident #11. This failure could place residents who use oxygen at risk of injury from fire. Findings included: Record review of Resident #2's electronic face sheet, dated 12.04.2025, revealed the resident was a [AGE] year-old female admitted 12.21.2022 with diagnoses including heart failure, emphysema (chronic lung disease), tobacco use, type II diabetes mellitus. Record review of Resident #2's Quarterly MDS assessment, dated 09.04.2025, revealed Resident # 2 had a BIMS score of 09, meaning moderate cognitive impairment and received oxygen therapy. Record review of Resident #2's Care Plan, dated 09.04.2025, revealed Resident #2 was a smoker. Record review of Resident #2's physician's orders, dated 12.01.2025, revealed an order for oxygen via n/c at 3 lpm(liters per minute) PRN to keep oxygen saturation levels at 91% or greater. During an observation on 12.02.2025 at 02:31 p.m., Resident #2 was lying in bed wearing oxygen via N/C. Observation revealed there was not an oxygen in use sign on the doorway leading into Resident #2's room. Record review of Resident #3's electronic face sheet, dated 12.04.2025, revealed the resident was an [AGE] year-old female admitted 10.17.2017 with diagnosis including Chronic Obstructive Pulmonary Disease (lung disease), Dementia. Record review of Resident #3's Quarterly MDS assessment, dated 10.17.2025, Resident #3 had a BIMS score of 00 indicating severely impaired cognitive function and received oxygen therapy. Record review of Resident #3's Care Plan, dated 10.18.2025, revealed oxygen therapy as an intervention for COPD . Record review of Resident #3's physician orders, dated 12.01.2025, revealed two 2-4 LPM via n/c continuous to keep SPO2 (percent of oxygenated blood) greater than 90%[. During an observation on 12.02.2025 at 09:30 AM Resident #3 was lying in bed with O2 via N/C. There was no oxygen in use signs on her doorway. Record review of Resident #7's electronic face sheet on 12.04.2025, revealed a [AGE] year-old female admitted 12.26.2020 with diagnosis including Unspecified Dementia, and Wheezing, Hypoxemia (low levels of oxygen in the blood). Record review of Resident #7's annual MDS, dated 09.12.2025, revealed a BIMS score of 03 indicating severe cognitive impairment oxygen therapy. Record review of Resident #7's Care Plan, dated 09.13.2025, revealed a focus area of oxygen therapy related to shortness of breath. Record review of Resident #7's physician orders, dated 12.01.2025, revealed oxygen via nasal cannula at 2-4 LPM. During an observation on 12.02.2025 at 10:00 a.m., Resident #7 was lying in bed with O2 via N/C on and no oxygen in use signs on doorway. Record review Resident #11's electronic face sheet on 12.04.2025 revealed an [AGE] year-old female admitted 02.22.2021 with diagnoses including Disease of Upper Respiratory Tract and Obstructive Sleep Apnea (breathing disorder). Record review Resident #11's Quarterly MDS, dated 09.12.2025, revealed a BIMS score of 10 indicating moderately impaired cognition and oxygen therapy. Record review of Resident #11's Care Plan, dated 09.12.2025, revealed a focus area of altered respiratory status/difficulty breathing related to obstructive sleep apnea. Record review of Resident #11's physician orders, dated 12.01.2025, revealed O2 at 2L via N/C q (every) shift. During an observation on 12.02.2025 at 09:45 a.m. Resident #11 was sitting in a recliner with O2 via N/C at 3 LPM. There were no Oxygen in Use signs on doorway. During an interview on 02.04.2025 at 10:51 a.m. LVN A stated nursing staff and maintenance were responsible for ensuring the oxygen in use signs were in place for residents that used oxygen. LVN A stated not having the oxygen in use signs could lead to an accident if a cigarette was lit around the oxygen and the staff might not check to see if the resident was wearing oxygen when needed. LVN A stated she did not know who monitored the oxygen in use signs and did not know why this failure occurred. During an interview on 12.04.2025 at 11:45 a.m. the AIT (Administrator in Training) stated she was not aware (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the oxygen in use signs were not in place. She stated the negative effect of not using oxygen in use signage was not following state guidelines and the potential for fire. She stated the administrator and maintenance director were responsible for ensuring the oxygen signs were in place on the residents' doorways. During an interview on 12.04.2025 at 01:26 p.m. the Maint D stated he was not sure why the oxygen in use signs were not in place. He stated when he checked they needed new signs and felt like it just got forgotten. He stated not knowing oxygen was in the room could be potential for a fire. Record review of the facility's policy titled Oxygen Administration, dated October 2010, revealed: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. General Guidelines. Equipment and SuppliesThe following equipment and supplies will be necessary when performing this procedure.1. Portable oxygen cylinder (strapped to the stand);2. Nasal cannula, nasal catheter, mask (as ordered);3. Humidifier bottle4. No Smoking/Oxygen in Use signs;5. Regulator6. Personal protective equipment (i.e., gowns, gloves, mask, etc., as needed) . Steps in Procedures.2. Place an Oxygen in Use sign on the outside of the room entrance3. Place an Oxygen in Use sign in a designated place or over the resident's bed.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 3 (Resident #3, Resident #10, and Resident #24) of 3 residents reviewed for hospice services. The facility failed to maintain required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness to ensure Resident #3, Resident #10, and Resident #24 received adequate end-of-life care. The facility failed to have hospice care plans for Resident #3, Resident #10 and Resident #24. The facility failed to have Individual Election, Cancellation or Update forms for Resident #3, Resident #10 and Resident #24. The facility failed to have Physician Certification of Terminal Illness form for Resident #3, Resident #10 and Resident #24. This failure could place residents at risk of their hospice care needs being met. Findings included: 1. Record review of Resident #3's electronic face sheet, dated 12.04.2025, revealed the resident was an [AGE] year-old female admitted to the facility on 10.17.2017, with the following diagnoses Chronic Obstructive Pulmonary Disease (lung disease), Dementia, Ischemic Heart Disease. Record review of Resident #3's Quarterly MDS assessment, dated 10.17.2025, revealed Resident #3 had a BIMS score of 00 (meaning severely impaired cognitive function) and received oxygen therapy. Record review of Resident #3's Care Plan, dated 10.18.2025, revealed, Focus-Resident is on Hospice care. Record review of Resident #3's physician orders, dated 12.01.2025, revealed, Admit to hospice for end-of-life support and comfort care. During a record review [KA1] on 12.03.2025 at 01:30 p.m., the hospice care binder for Resident #3 revealed no evidence of the Individual Election, Cancellation or Update form, no Physician Certification of Terminal Illness Form and no updated hospice care plan. 2. Record review of Resident #10's electronic face sheet, dated 12.04.2025, revealed an [AGE] year-old male admitted 11.29.2024 with the following diagnoses CVA (cerebral vascular accident), encephalopathy (brain disease), type 2 diabetes mellitus (blood sugar changes). Record review Resident #10's Quarterly MDS, dated 11.14.2025, revealed Resident #10 had a BIMS score of 00 (meaning severely impaired), a life expectancy of less than six months, and received hospice care. Record review Resident #10's Care Plan, dated 10.10.2025, revealed: Focus-He may have pain medication therapy per Hospice comfort care. Record Review of Resident #10's physician orders, dated 12.01.2025, revealed admit to hospice care. During a record review [KA2] on 12.03.2025 at 01:30 PM the hospice care binder for Resident #10 revealed no evidence of Individual Election, Cancellation or Update form, no Physician Certification of Terminal Illness Form and no updated hospice care plan. 3. Record review of Resident #24's electronic face sheet dated 12.04.2025 revealed [AGE] year-old female admitted 08.06.2025 with diagnosis of Hypertensive Heart Disease, Essential Hypertension (high blood pressure), chronic kidney disease. Record review of Resident #24's Quarterly MDS, dated 11.19.2025, revealed a BIMS score of 07 meaning severely cognitively impaired, a life expectancy of less than six months, and received hospice care. Record review of Resident #24's Care Plan, dated 08.19.2025, revealed: Focus-has a terminal prognosis related to hypertensive heart disease on hospice care. Record review of Resident #24's physician orders, dated 12.01.2025, revealed, Admit to Nursing Center under care of Dr[KA3] . and hospice care. During a record review[KA4] on 12.03.2025 at 01:30 p.m., the hospice care binder for Resident #24 revealed no evidence of the Individual Election, Cancellation or Update form, no Physician Certification of Terminal Illness Form and no updated hospice care plan. During an interview on 12.04.2025 at 11:01 a.m., the ADON stated she was not sure why all the required documents were not in the hospice binders. She stated not having the hospice care plans did not cause harm to the residents because the facility staff communicated with hospice staff. She stated (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not know who was responsible for ensuring all documents from hospice were in the hospice binder. Review of the facility's policy titled Hospice Program (revised July 2017) revealed: Policy statement Hospice services are available to residents at the end of life. Policy Interpretation and Implementation 1. Our facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so. 5. Hospice providers who contract with this facility: must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency. 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. 12. Our facility has designated _____ to coordinate care provided to the resident by our facility staff and hospice staff. He or she is responsible for the following: d. Obtaining the following information from the hospice: 1. The most recent hospice plan of care specific to each resident. 2. Hospice Election form 3. Physician certification and recertification of the terminal illness specific to each resident 4. Names and contact information for hospice personnel involved in hospice care of each resident. 13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility. 14. The coordinated care plan will reflect the resident's goals and wishes, as stated in his or her advance directives and during ongoing communication with the resident or representative		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct regular inspections and maintenance of resident bed frames, mattresses, and bed rails, to identify areas of potential entrapment hazards for 4 (Resident #2, Resident #3, Resident #7, and Resident #9) of 14 residents reviewed for physical environment. The facility failed to conduct regular inspections of resident side rails, bed frames and mattresses to identify entrapment risks for Resident #2, Resident #3, Resident #7, and Resident #9. This failure could place residents at risk of injury resulting from equipment malfunction, entrapment, or falls. Findings included: Record review of Resident #2's electronic face sheet, dated 12/3/2025, reflected she was a [AGE] year-old female admitted [DATE] with diagnoses including history of falling and dementia. Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 9 which indicated she had moderate cognitive impairment. Further review of the MDS reflected Resident #2 needed partial to moderate assistance with bed mobility and used bed rail daily. Record review of Resident #2's care plan, dated 9/12/2024, reflected half rails up per physician's order for safety and to assist with bed mobility. Observe for injury or entrapment related to side rail use. Record review of Resident #2's electronic physician orders reflected an order, dated 6/26/2023, reflected Resident #2 may use half or quarter bed rail for bed mobility/positioning or to enable transfers. Record review of facility document Bed Rail Appropriateness Checklist dated 7/16/2025 for Resident #2 reflected no documentation in the Equipment Compatibility & Safety section. There were no other documents provided by facility showing that bed rail entrapment risk assessment had been performed for Resident #2. During an observation on 12/2/2025 at 2:35 p.m., Resident #2 was in her bed and the bed had quarter rails in the up position. She was lying on her left side, her eyes were closed with unlabored respirations, and she was wearing an oxygen nasal cannula. During an observation on 12/3/2025 at 8:12 a.m., Resident #2 was lying in her bed on her right side and the bed had quarter rails in the up position. She was lying on her right side, her eyes were closed with unlabored respirations, and she was wearing an oxygen nasal cannula. Record review of Resident #3's electronic face sheet dated 12/3/2025 reflected she was an [AGE] year-old female admitted on [DATE] and readmitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right sided weakness and right sided mobility issues after having a stroke), Alzheimer's disease (disease affecting the brain and interfering with the ability to think and causes memory deficits), and muscle weakness. Record review of Resident #3's quarterly MDS, dated [DATE], reflected a BIMS score of 0 which indicated she had severe cognitive impairment. Further review of the MDS reflected Resident #2 needed substantial assistance with bed mobility and used bed rail daily. Record review of Resident #3's care plan, dated 8/8/2024, reflected half rails up for safety and better mobility during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Record review of Resident #3's electronic physician orders reflected an order dated 6/26/2023 which stated Resident #3 may use half or quarter bed rail for bed mobility/positioning or to enable transfers. Record review of facility document Bed Rail Appropriateness Checklist dated 7/16/2025 for Resident #3 reflected documentation in the Equipment Compatibility & Safety section showing bed rails were compatible with mattress/bed frame and did not pose risk of entrapment. There were no other documents provided by facility showing bed rail entrapment risk assessment were performed for Resident #3. During an observation on 12/2/2025 at 9:30 a.m., Resident #3 was laying in her bed with quarter rail in the up position. She had her eyes open but could not respond to questions asked. Record review of Resident #7's electronic face sheet dated 12/03/2025 reflected she was a [AGE] year-old female admitted on [DATE] and readmitted [DATE] with diagnoses including dementia and muscle weakness. Record review of Resident #7's annual MDS, dated [DATE], reflected a BIMS score of 3 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Merkel Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1704 N 1st Merkel, TX 79536	
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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which indicated she had severe cognitive impairment. Further review of the MDS reflected Resident #7 needed substantial assistance with bed mobility and used bed rail daily. Record review of Resident #7's care plan, dated 5/27/2020, reflected she had half rails up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Record review of Resident #7's electronic physician orders reflected an order dated 8/8/2023 which stated Resident #7 may use half or quarter bed rail for bed mobility/positioning or to enable transfers. Record review of facility document Bed Rail Appropriateness Checklist dated 7/16/2025 for Resident #7 reflected documentation in the Equipment Compatibility & Safety section showing bed rails were compatible with mattress/bed frame and did not pose risk of entrapment. There were no other documents provided by facility showing bed rail entrapment risk assessment were performed for Resident #7. During an observation on 12/3/2025 at 8:13 a.m., Resident #7 was lying in her bed watching television. The bed had quarter rails in the up position. Record review of Resident #9's electronic face sheet dated 12/3/2025 reflected she was an [AGE] year-old female admitted on [DATE] with diagnoses including need for assistance with personal care, unsteadiness on feet, lack of coordination, multiple falls, and muscle weakness. Record review of Resident #9's quarterly MDS, dated [DATE], reflected a BIMS score of 12 which indicated she had moderate cognitive impairment. Further review of the MDS reflected Resident #9 needed substantial assistance with bed mobility and used bed rail daily. Record review of Resident #9's care plan, dated 8/11/2024, reflected she had half rails up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Record review of Resident #9's electronic physician orders reflected an order, dated 8/8/2023, which stated Resident #9 may use half or quarter bed rail for bed mobility/positioning or to enable transfers. Record review of facility document Bed Rail Appropriateness Checklist dated 7/16/2025 for Resident #9 reflected documentation in the Equipment Compatibility & Safety section showing bed rails were compatible with mattress/bed frame and did not pose risk of entrapment. There were no other documents provided by facility showing bed rail entrapment risk assessment were performed for Resident #9. During an observation and interview on 12/2/2025 at 9:32 a.m., Resident #9 was in her bed and had half rails in the up position. She stated she used the rails for bed mobility. She stated if the rails got loose, she told the nursing staff. She stated the nursing staff would inform the maintenance director and he would tighten the rails. She stated, at this time, the rails were not loose. During an interview on 12/3/2025 at 2:09 p.m., the Maint D stated he went to the rooms as needed to assess bed rails for entrapment risk. He stated he conducted room inspections and inspected the bed rails at that time. The Maint D stated he also performed assessments of bed rails if staff told him the rails were loose. He stated he worked as the Maintenance Director for approximately three months and never documented the entrapment risk assessments. He stated he would reach out to his supervisor to see where the entrapment risk assessments were kept prior to his taking over as Maintenance Director. He stated he was not told to document those assessments and did not have a schedule that he went by to assess the bed rails. During an interview on 12/3/2025 at 3:46 p.m., Maint D stated he was a CNA prior to taking on the maintenance position. He stated no one told him the bed rails should be assessed prior to today. He stated he reached out to his management and was told bed rails were to be assessed for entrapment risk monthly. He stated the assessment was to make sure bed rails were not loose and fit the bed. He stated it was important to help prevent residents becoming injured or entrapped on the bed rails. During an interview on 12/3/2025 at 3:14 p.m., the ADMN stated his expectation was for bed rails to be assessed for monthly for entrapment risk by the Maintenance Director. He stated poor oversight led to the failure of Maint D not performing scheduled assessments of the bed rails. He stated he was responsible for monitoring Maint D performed those assessments, and he could not remember the last time he looked for them. He stated Maint D worked in his current position for about three months and did not know if he was instructed to perform those monthly bed rail assessments. He did not state who trained him on maintenance duties. He stated not performing the assessments increased the risk (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of residents being entrapped and could cause them harm. Review of facility policy titled Proper Use of Side Rails, dated December 2016, reflected, The resident will be checked periodically for safety relative to side rail use. If side rail use is associated with symptoms of distress, such as screaming or agitation, the resident's needs and use of side rails will be reassessed. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used).		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 5 of 16 (ADMN, DON, DM, Maint.D, and NA G) staff reviewed training requirements. The facility failed to implement and maintain a training program that ensured the DON, DM, Maint.D, and NA G received required HIV training upon hire. The facility failed to implement and maintain a training program that ensured the ADMN received required annual HIV training. These failures could place residents at risk of being cared for by staff insufficiently trained on the mode of HIV transmission, HIV prevention, behaviors related to substance abuse, precautions, rights of an infected individual and behaviors associated with HIV transmission. Findings included:Record review of personnel record for the ADMN reflected a hire date of 8/17/2021. Further review of personnel record provided by the AIT reflected no evidence he completed required annual HIV training for the previous 12 months.Record review of personnel record for the DON reflected a hire date of 7/1/2025. Further review of personnel record provided by the AIT reflected no evidence she completed required orientation HIV training.Record review of personnel record for the Maint D reflected a hire date of 1/15/2025. Further review of personnel record provided by the AIT reflected no evidence he completed required orientation HIV training.Record review of personnel record for the DM reflected a hire date of 10/20/2025. Further review of personnel record provided by the AIT reflected no evidence she completed required orientation HIV training.Record review of personnel record for NA G reflected a hire date of 11/6/2025. Further review of personnel record provided by the AIT reflected no evidence she completed required orientation HIV training.gs upon hire. During an interview on 12/3/2025 at 3:50 p.m., the ADMN stated all new hires were given orientation for required training through a hyperlink. He stated required annual training was performed through in-services that were held monthly. He stated he would look for the training required for the employees in question.During an interview on 12/4/2025 at 2:25 p.m., the AIT stated each department head was responsible for ensuring training was completed by employees. If a manager or staff from administration, then the office manager was responsible for ensuring training was completed by employees. She stated the ADMN and office manager monitored the training was completed and updated. She stated HIV training was important to ensure employees were adequately trained in how to provide proper care to residents. She stated the ADMN completed a checklist for annual training, and the office manager completed a checklist for new hire training. She stated the training was not done due to an oversight by the ADMN.During an attempted interview on 12/4/2025 at 2:25 p.m., the office manager was not available for an interview on employee training.During a telephone interview on 12/4/2025 at 3:14 p.m., the ADMN stated he expected staff to have required orientation and annual training. He stated he was responsible for ensuring that training was completed for all employees. He stated he went through the training three months ago and monitored they were completed. He stated not receiving required training could lead to poor quality of care for the residents. The ADMN stated he implemented a detailed orientation training program and implemented that in-service trainings were done on pay day so that employees completed training to receive their paycheck to help ensure that the trainings were completed. During a telephone interview on 12/4/2025 at 3:24 p.m., the DM stated she did not remember getting any orientation training on HIV. She stated she was trained by the ADMN on other subjects but could not remember ever receiving training on HIV. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers, dated January 2008, reflected, All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment.A checklist is used to record materials reviewed with each employee/transfer/volunteer. A written record will be maintained of each employee's/volunteer's individual orientation program.Record review of facility policy titled [nursing facility name] Nursing Center Personnel Policies, dated July 2025, reflected no information on (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required personnel training on HIV during orientation or annually. Record review of facility policy titled Staff Development Program, dated December 2009, reflected, Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. All personnel are required to attend staff development classes. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): a. Hepatitis B; b. AIDS; c. Tuberculosis; d. Infection Control; e. Resident Rights; f. Resident Abuse; g. Fire Safety and Disaster Preparedness; Hazard Communication Plan (i.e., exposure to chemicals); i. Exposure Control (i.e., exposure to blood or body fluids; J. ____; and k. _____.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 6 of 16 (the DON, the DM, RN C, LVN E, NA G, and NA H) staff reviewed for training on effective communication. The facility failed to ensure communication training was provided to DON, DM, RN C, LVN E, NA G, and NA H upon hire. This failure could place residents at risk of not understanding their total health status and not effectively being provided notice of rights and services both orally and in writing in a manner that the resident understands. Findings were: Record review of the personnel record for the DON reflected a hire date of 7/1/2025. Further review of the personnel record provided by the AIT reflected the DON had no evidence that she had completed required effective communication training upon hire or while working at the facility. Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of the personnel record provided by the AIT reflected the DM had no evidence that she had completed required effective communication training upon hire or while working at the facility. Record review of the personnel records for RN C reflected a hire date of 9/1/2025. Further review of the personnel record provided by the AIT reflected RN C had no evidence that she had completed required effective communication training upon hire or while working at the facility. Record review of the personnel records for LVN E reflected a hire date of 6/20/2025. Further review of the personnel record provided by the AIT reflected LVN E had no evidence that she had completed required effective communication training upon hire or while working at the facility. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence that she had completed required effective communication training upon hire or while working at the facility. Record review of the personnel records for NA H reflected a hire date of 2/28/2025. Further review of the personnel record provided by the AIT reflected NA H had no evidence that she had completed required effective communication training upon hire or while working at the facility. During an interview on 12/3/2025 at 3:50 p.m., the ADMN stated all new hires were given orientation for required training through a hyperlink. He stated that required annual training was performed through in-services that were held monthly. He stated he would look for the training required for the employees in question. During an interview on 12/4/2025 at 2:25 p.m., the AIT stated each department head was responsible for ensuring training had been completed by employees. If a manager or staff from administration, then the office manager was responsible for ensuring training had been completed by employees. She stated the ADMN and office manager monitored that the training was completed and updated. She stated effective communication training was important to ensure employees were adequately trained on how to communicate with residents. She stated the ADMN was to complete a checklist for annual trainings, and the office manager completed a checklist for new hire training. She stated the training was not done due to an oversight by the ADMN. During an attempted interview on 12/4/2025 at 2:25 p.m., the office manager was not available for an interview on employee training. During a follow-up telephone interview on 12/4/2025 at 3:14 p.m., the ADMN stated he expected staff to have required orientation and annual training. He stated he was responsible for ensuring that training was completed for all employees. He stated he may have gone through the training 3 months ago and he does monitor that they were completed. He stated not receiving required training could lead to poor quality of care to the residents. The ADMN stated he had started providing a detailed orientation training program and implemented that in-service training to be done on pay day so that employees would complete to receive their paycheck to help ensure that the trainings were completed. During a telephone interview on 12/4/2025 at 3:24 p.m., the DM stated she did not remember getting any orientation training on effective communication. She stated she was trained by the ADMN on other subjects but could not remember ever receiving training on effective communication. Record review of facility policy titled (continued on next page)		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Orientation Program for Newly Hired Employees, Transfers, Volunteers with revision date of January 2008 reflected All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment.A checklist is used to record materials reviewed with each employee/transfer/volunteer. A written record will be maintained of each employee's/volunteer's individual orientation program.Record review of facility policy titled [nursing facility name] Personnel Policies revised on July 2025 reflected no information on required personnel training on effective communication during orientation or annually.Record review of facility policy titled Staff Development Program revised on December 2009 reflected Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. All personnel are required to attend staff development classes.The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): a. Hepatitis B; b. AIDS; c. Tuberculosis; d. Infection Control; e. Resident Rights; f. Resident Abuse; g. Fire Safety and Disaster Preparedness; Hazard Communication Plan (i.e., exposure to chemicals); i. Exposure Control (i.e., exposure to blood or body fluids; J. _____; and k. _____.		

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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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 4 of 16 (the DM, LVN E, NA G, and NA H) staff reviewed for training on resident's rights. The facility failed to ensure that the DM, LVN E, NA G, and NA H were educated on the rights of the resident, and the responsibilities of the facility to properly care for its residents upon hire. This failure could place residents at risk of their rights not being honored by uninformed staff. The findings were: Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of personnel record provided by the AIT reflected the DM had no evidence that she had completed required resident rights training upon hire or while working at the facility. Record review of the personnel records for LVN E reflected a hire date of 6/20/2025. Further review of the personnel record provided by the AIT reflected LVN E had no evidence that she had completed required resident rights training upon hire or while working at the facility. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence that she had completed required resident rights training upon hire or while working at the facility. Record review of the personnel records for NA H reflected a hire date of 2/28/2025. Further review of the personnel record provided by the AIT reflected NA H had no evidence that she had completed required resident rights training upon hire or while working at the facility. During an interview on 12/3/2025 at 3:50 p.m., the ADMN stated all new hires were given orientation for required training through a hyperlink. He stated that required annual training was performed through in-services that were held monthly. He stated he would look for the training required for the employees in question. During an interview on 12/4/2025 at 2:25 p.m., the AIT stated each department head was responsible for ensuring training had been completed by employees. If a manager or staff from administration, then the office manager was responsible for ensuring training had been completed by employees. She stated the ADMN and office manager monitored that the training was completed and updated. She stated resident rights training was important to ensure employees were adequately trained on how to honor resident rights. She stated the ADMN was to complete a checklist for annual trainings, and the office manager completed a checklist for new hire training. She stated the training was not done due to an oversight by the ADMN. During an attempted interview on 12/4/2025 at 2:25 p.m., the office manager was not available for an interview on employee training. During a follow-up telephone interview on 12/4/2025 at 3:14 p.m., the ADMN stated he expected staff to have required orientation and annual training. He stated he was responsible for ensuring that training was completed for all employees. He stated he may have gone through the training 3 months ago and he does monitor that they were completed. He stated not receiving required training could lead to poor quality of care to the residents. The ADMN stated he had started providing a detailed orientation training program and implemented that in-service training to be done on pay day so that employees would complete to receive their paycheck to help ensure that the trainings were completed. During a telephone interview on 12/4/2025 at 3:24 p.m., the DM stated she did not remember getting any orientation training on resident rights. She stated she was trained by the ADMN on other subjects but could not remember ever receiving training on resident rights. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers with revision date of January 2008 reflected All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment. A checklist is used to record materials reviewed with each employee/transfer/volunteer. A written record will be maintained of each employee's/volunteer's individual orientation program. Record review of facility policy titled [nursing facility name] Personnel Policies revised on July 2025 reflected no information on required personnel training on resident rights during orientation or annually. Record review of facility policy titled Staff Development Program (continued on next page)		

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised on December 2009 reflected Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. All personnel are required to attend staff development classes. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): a. Hepatitis B; b. AIDS; c. Tuberculosis; d. Infection Control; e. Resident Rights; f. Resident Abuse; g. Fire Safety and Disaster Preparedness; h. Hazard Communication Plan (i.e., exposure to chemicals); i. Exposure Control (i.e., exposure to blood or body fluids; j. _____; and k. _____.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 3 of 16 (the DM, RN C, and NA G) staff reviewed for training on abuse, neglect, and exploitation and training for dementia management. The facility failed to ensure that NA G was educated on abuse, neglect and exploitation & dementia management upon hire. The facility failed to ensure that the DM and RN C were educated on dementia management upon hire. These failures could place residents at risk of being abused, neglected, or exploited by uniformed staff and could delay the facility's investigation of abuse, neglect, or exploitation. Findings were: Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence that she had completed neither the abuse, neglect, and exploitation training nor the dementia management training upon hire or while working at the facility. Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of the personnel record provided by the AIT reflected the DM had no evidence that she had completed dementia management training upon hire or while working at the facility. Record review of the personnel records for RN C reflected a hire date of 9/1/2025. Further review of the personnel record provided by the AIT reflected RN C had no evidence that she had completed dementia management training upon hire or while working at the facility. During an interview on 12/3/2025 at 3:50 p.m., the ADMN stated all new hires were given orientation for required training through a hyperlink. He stated that required annual training was performed through in-services that were held monthly. He stated he would look for the training required for the employees in question. During an interview on 12/4/2025 at 2:25 p.m., the AIT stated each department head was responsible for ensuring training had been completed by employees. If a manager or staff from administration, then the office manager was responsible for ensuring training had been completed by employees. She stated the ADMN and office manager monitored that the training was completed and updated. She stated abuse, neglect, and exploitation & dementia management training were important to ensure employees were adequately trained on how to recognize and report abuse, neglect, and exploitation to the facility's abuse coordinator. She stated the ADMN was to complete a checklist for annual trainings, and the office manager completed a checklist for new hire training. She stated the training was not done due to an oversight by the ADMN. During an attempted interview on 12/4/2025 at 2:25 p.m., the office manager was not available for an interview on employee training. During a follow-up telephone interview on 12/4/2025 at 3:14 p.m., the ADMN stated he expected staff to have required orientation and annual training. He stated he was responsible for ensuring that training was completed for all employees. He stated he may have gone through the training 3 months ago and he does monitor that they were completed. He stated not receiving required training could lead to poor quality of care to the residents. The ADMN stated he had started providing a detailed orientation training program and implemented that in-service training to be done on pay day so that employees would complete to receive their paycheck to help ensure that the trainings were completed. During a telephone interview on 12/4/2025 at 3:24 p.m., the DM stated she was trained by the ADMN on many subjects but could not remember if she had been educated on abuse, neglect, or exploitation. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers with revision date of January 2008 reflected All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment. A checklist is used to record materials reviewed with each employee/transfer/volunteer. A written record will be maintained of each employee's/volunteer's individual orientation program. Record review of facility policy titled [name of facility] Personnel Policies revised on July 2025 reflected no information on required personnel training on abuse, neglect, and exploitation or dementia management at orientation or annually. Record review of facility (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Merkel Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1704 N 1st Merkel, TX 79536	
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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy titled Staff Development Program revised on December 2009 reflected Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. All personnel are required to attend staff development classes. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): a. Hepatitis B; b. AIDS; c. Tuberculosis; d. Infection Control; e. Resident Rights; f. Resident Abuse; g. Fire Safety and Disaster Preparedness; Hazard Communication Plan (i.e., exposure to chemicals); i. Exposure Control (i.e., exposure to blood or body fluids; J. ____; and k. ____.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 5 of 16 (the DON, the DM, RN C, LVN E, and NA G) staff reviewed for training on QAPI. The facility failed to ensure that the DON, the DM, RN C, LVN E, and NA G were educated on the facility's QAPI program upon hire. This failure could place residents at risk of their quality of care not being improved upon when a known issue had occurred from staff not being informed on the goals and various elements of the QAPI program. Findings were: Record review of personnel record for the DON reflected a hire date of 7/1/2025. Further review of the personnel record provided by the AIT reflected the DON had no evidence that she had completed QAPI training upon hire or while working at the facility. Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of the personnel record provided by the AIT reflected the DM had no evidence that she had completed QAPI training upon hire or while working at the facility. Record review of the personnel records for RN C reflected a hire date of 9/1/2025. Further review of the personnel record provided by the AIT reflected RN C had no evidence that she had completed QAPI training upon hire or while working at the facility. Record review of the personnel records for LVN E reflected a hire date of 6/20/2025. Further review of the personnel record provided by the AIT reflected LVN E had no evidence that she had completed QAPI training upon hire or while working at the facility. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence that she had completed QAPI training upon hire or while working at the facility. During an interview on 12/3/2025 at 3:50 p.m., the ADMN stated all new hires were given orientation for required training through a hyperlink. He stated that required annual training was performed through in-services that were held monthly. He stated he would look for the training required for the employees in question. During an interview on 12/4/2025 at 2:25 p.m., the AIT stated each department head was responsible for ensuring training had been completed by employees. If a manager or staff from administration, then the office manager was responsible for ensuring training had been completed by employees. She stated the ADMN and office manager monitored that the training was completed and updated. She stated QAPI training was important to ensure employees were adequately trained on how the facility's QAPI program works on its known areas that could be improved upon. She stated the ADMN was to complete a checklist for annual trainings, and the office manager completed a checklist for new hire training. She stated the training was not done due to an oversight by the ADMN. During an attempted interview on 12/4/2025 at 2:25 p.m., the office manager was not available for an interview on employee training. During a follow-up telephone interview on 12/4/2025 at 3:14 p.m., the ADMN stated he expected staff to have required orientation and annual training. He stated he was responsible for ensuring that training was completed for all employees. He stated he may have gone through the training 3 months ago and he does monitor that they were completed. He stated not receiving required training could lead to poor quality of care to the residents. The ADMN stated he had started providing a detailed orientation training program and implemented that in-service training to be done on pay day so that employees would complete to receive their paycheck to help ensure that the trainings were completed. During a telephone interview on 12/4/2025 at 3:24 p.m., the DM stated she did not remember getting any orientation training on QAPI. She stated she was trained by the ADMN on other subjects but could not remember ever receiving training on QAPI. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers with revision date of January 2008 reflected All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment. A checklist is used to record materials reviewed with each employee/transfer/volunteer. A written record will be maintained of each employee's/volunteer's (continued on next page)		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	individual orientation program.Record review of facility policy titled [name of facility] Personnel Policies revised on July 2025 reflected no information on required personnel training on QAPI at orientation or annually.Record review of facility policy titled Staff Development Program revised on December 2009 reflected Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. All personnel are required to attend staff development classes.The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): a. Hepatitis B; b. AIDS; c. Tuberculosis; d. Infection Control; e. Resident Rights; f. Resident Abuse; g. Fire Safety and Disaster Preparedness; Hazard Communication Plan (i.e., exposure to chemicals); i. Exposure Control (i.e., exposure to blood or body fluids; J. ____; and k. _____.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 4 of 16 (the DON, the DM, LVN E, and NA G) staff reviewed for training on infection control. The facility failed to ensure that the DON, the DM, LVN E, and NA G were educated on infection control upon hire. This failure could place residents at risk of contracting facility acquired infections from staff not being informed on proper infection prevention and control practices when performing resident care activities that pertain to that staff member's role. Findings were: Record review of personnel record for the DON reflected a hire date of 7/1/2025. Further review of the personnel record provided by the AIT reflected the DON had no evidence that she had completed infection control training upon hire or while working at the facility. Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of the personnel record provided by the AIT reflected the DM had no evidence that she had completed infection control training upon hire or while working at the facility. Record review of the personnel records for LVN E reflected a hire date of 6/20/2025. Further review of the personnel record provided by the AIT reflected LVN E had no evidence that she had completed infection control training upon hire or while working at the facility. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence that she had completed infection control training upon hire or while working at the facility. During an interview on 12/3/2025 at 3:50 p.m., the ADMN stated all new hires were given orientation for required training through a hyperlink. He stated that required annual training was performed through in-services that were held monthly. He stated he would look for the training required for the employees in question. During an interview on 12/4/2025 at 2:25 p.m., the AIT stated each department head was responsible for ensuring training had been completed by employees. If a manager or staff from administration, then the office manager was responsible for ensuring training had been completed by employees. She stated the ADMN and office manager monitored that the training was completed and updated. She stated infection control training was important to ensure employees were adequately trained on how to prevent infections. She stated the ADMN was to complete a checklist for annual trainings, and the office manager completed a checklist for new hire training. She stated the training was not done due to an oversight by the ADMN. During an attempted interview on 12/4/2025 at 2:25 p.m., the office manager was not available for an interview on employee training. During a follow-up telephone interview on 12/4/2025 at 3:14 p.m., the ADMN stated he expected staff to have required orientation and annual training. He stated he was responsible for ensuring that training was completed for all employees. He stated he may have gone through the training 3 months ago and he does monitor that they were completed. He stated not receiving required training could lead to poor quality of care to the residents. The ADMN stated he had started providing a detailed orientation training program and implemented that in-service training to be done on pay day so that employees would complete to receive their paycheck to help ensure that the trainings were completed. During a telephone interview on 12/4/2025 at 3:24 p.m., the DM stated she did not remember getting any orientation training on infection control. She stated she was trained by the ADMN on other subjects but could not remember ever receiving training on infection control. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers with revision date of January 2008 reflected All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment. A checklist is used to record materials reviewed with each employee/transfer/volunteer. A written record will be maintained of each employee's/volunteer's individual orientation program. Record review of facility policy titled [name of facility] Personnel Policies revised on July 2025 reflected no information on required personnel training on infection control at orientation or annually. Record review of 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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy titled Staff Development Program revised on December 2009 reflected Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. All personnel are required to attend staff development classes. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): a. Hepatitis B; b. AIDS; c. Tuberculosis; d. Infection Control; e. Resident Rights; f. Resident Abuse; g. Fire Safety and Disaster Preparedness; Hazard Communication Plan (i.e., exposure to chemicals); i. Exposure Control (i.e., exposure to blood or body fluids; J. _____; and k. _____.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 3 of 16 (the DON, the DM, and NA G) staff reviewed for training on behavioral health. The facility failed to ensure that the DON, the DM, and NA G were educated on behavioral health upon hire. This failure could place residents diagnosed with a mental, psychosocial, or substance use disorder at risk of not receiving the care specific to their individual needs. Findings were: Record review of personnel record for the DON reflected a hire date of 7/1/2025. Further review of the personnel record provided by the AIT reflected the DON had no evidence that she had completed behavioral health training upon hire or while working at the facility. Record review of the personnel records for the DM reflected a hire date of 10/20/2025. Further review of the personnel record provided by the AIT reflected the DM had no evidence that she had completed behavioral health training upon hire or while working at the facility. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence that she had completed behavioral health training upon hire or while working at the facility. During an interview on 12/3/2025 at 3:50 p.m., the ADMN stated all new hires were given orientation for required training through a hyperlink. He stated that required annual training was performed through in-services that were held monthly. He stated he would look for the training required for the employees in question. During an interview on 12/4/2025 at 2:25 p.m., the AIT stated each department head was responsible for ensuring training had been completed by employees. If a manager or staff from administration, then the office manager was responsible for ensuring training had been completed by employees. She stated the ADMN and office manager monitored that the training was completed and updated. She stated behavioral health training was important to ensure employees were adequately trained on how to prevent behaviors. She stated the ADMN was to complete a checklist for annual trainings, and the office manager completed a checklist for new hire training. She stated the training was not done due to an oversight by the ADMN. During an attempted interview on 12/4/2025 at 2:25 p.m., the office manager was not available for an interview on employee training. During a follow-up telephone interview on 12/4/2025 at 3:14 p.m., the ADMN stated he expected staff to have required orientation and annual training. He stated he was responsible for ensuring that training was completed for all employees. He stated he may have gone through the training 3 months ago and he does monitor that they were completed. He stated not receiving required training could lead to poor quality of care to the residents. The ADMN stated he had started providing a detailed orientation training program and implemented that in-service training to be done on pay day so that employees would complete to receive their paycheck to help ensure that the trainings were completed. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers with revision date of January 2008 reflected All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment. A checklist is used to record materials reviewed with each employee/transfer/volunteer. A written record will be maintained of each employee's/volunteer's individual orientation program. Record review of facility policy titled [name of facility] Personnel Policies revised on July 2025 reflected no information on required personnel training on behavioral health at orientation or annually. Record review of facility policy titled Staff Development Program revised on December 2009 reflected Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. All personnel are required to attend staff development classes. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): a. Hepatitis B; b. AIDS; c. Tuberculosis; d. Infection Control; e. Resident Rights; f. Resident Abuse; g. Fire Safety and Disaster Preparedness; h. Hazard Communication Plan (i.e., exposure to chemicals); i. Exposure Control (i.e., exposure to blood or body fluids; j. _____; and k. _____.		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurate for 1 (Resident #7) of 12 residents reviewed for resident records. The facility failed to ensure Resident #7's physician order and face sheet matched Resident #7's care plan for DNR. This failure could place residents at risk of having CPR when they or their representatives have requested no CPR treatment. Findings included: Record review of Resident #7's electronic face sheet, dated [DATE], reflected she was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including dementia (losing your memory and other thinking skills so much that it gets in the way of your daily life). Further review of face sheet reflected Resident #7 was a Full Code status, meaning she would receive CPR if her heart stopped beating, or she stopped breathing. Record review of Resident #7's annual MDS, dated [DATE], reflected a BIMS score of 03 indicating severe cognitive impairment. Further review of the MDS reflected Resident #7 did not have a disease that might result in a life expectancy of less than six months. Record review of Resident #7's care plan, dated [DATE], reflected she was a DNR code status and, if respirations and heart ceased to beat, she would not have CPR started, with last revision dated [DATE]. Record review of Resident #7's clinical record reflected an OOH DNR dated [DATE]. During an observation on [DATE] at 8:13 a.m., Resident #7 was lying in her bed watching television. The bed had quarter rails in the up position. During an attempted interview on [DATE] at 1:57 p.m., Resident #7's representative did not answer the telephone. During an interview on [DATE] at 9:53 a.m., the ADON stated she was responsible for updating care plans and verifying physician orders matched the resident's current code status. She stated she was not employed at the facility when the order for code status was placed in Resident #7's electronic record. The ADON stated she worked for the facility almost six months, and the DON started after her. She stated the DON was not in the facility. She did not state what system was in place for monitoring medical records to ensure orders were entered accurately and timely. During an interview on [DATE] at 10:48 a.m., LVN D stated she knew a resident's code status by the sticker on the outside of their door. She stated a red sticker was a DNR. She stated the code status was also found in the electronic medical record under the physician orders. She stated the care plan should match the code status. LVN D stated if the care plan and code status did not match it could cause confusion on whether CPR needed to be performed or not. She stated if there was conflicting information in a resident's chart, it could delay treatment or cause CPR to be performed on a resident that did not want CPR. During an interview on [DATE] at 10:50 a.m., LVN A stated she knew a resident's code status by looking in the Code Status binder at the nurses' station. She stated she also could look up code status in the electronic physician orders and a resident's care plan. She stated code status information should have been the same on the physician orders, care plan and face sheet to minimize confusion on what that resident's wishes were in an emergency situation where CPR may need to be performed. During an interview on [DATE] at 1:30 p.m., the ADON stated she found the OOH DNR for Resident #7. She stated Resident #7's care plan was correct that Resident #7 was not to have CPR treatment. She stated she was not sure why the electronic physician orders or the code binder at the nurses' station did not match the care plan, but she would get them corrected. She stated not having matching physician orders, care plan, face sheet, and code status binder could cause a resident to receive the wrong life saving treatment or delay in life saving treatment. She stated both her and the DON were responsible for monitoring that code status was correct. During an interview on [DATE] at 2:25 p.m., the AIT stated she expected physician orders to be updated immediately and updated in electronic medical record within 24 hours of an order being received. She stated the nurses were responsible for collecting the OOH DNR orders and should have placed those orders in a bin. She stated the office (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager would gather the OOHNR orders from the bin and scan them into the electronic chart for the appropriate resident. She stated if the electronic order in the resident chart did not match the OOHNR order document and care plan, resident's rights may be violated in an emergency event requiring CPR. She stated performing CPR to a resident that had an OOHNR could lead to a licensure issue for the nurse providing treatment in a situation where CPR would need to be performed. The AIT stated performing CPR on a resident that had chosen to not have that treatment could also have severe physical consequences for the resident. Record review of facility policy titled, Accurate Record Keeping with no date reflected, The nursing facility is committed to maintaining accurate, truthful, and complete records in all areas, including but not limited to clinical documentation, billing, resident assessments, staffing records, and financial reports. Any discrepancies or missing information must be reported immediately to a supervisor or the DON. The facility will conduct periodic internal audits of records to verify accuracy and compliance. Any identified errors or discrepancies will be reviewed, corrected and used for staff education. Record review of facility policy titled, Advanced Directives revised on [DATE], reflected, Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The resident has the right to refuse treatment, whether or not he or she has an advanced directive. A resident will not be treated against his or her own wishes.		

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 (NA G) staff reviewed for infection control. The facility failed to ensure NA G performed proper peri-care (incontinent care) for Resident #22. This failure could place residents at risk of infections from incontinent care. Findings included: Review of Resident #22's face sheet, dated 12/04/2025, revealed a [AGE] year-old female admitted on [DATE]. Resident #22's medical diagnoses included vascular dementia (impaired blood flow to the brain), insomnia (unable to sleep), local infection of the skin and generalized anxiety disorder. Record review of Resident #22's Annual MDS, dated [DATE], revealed in Section C - C0500, a BIMS score of 01 indicating the resident was severely cognitively impaired and unable to complete the interview. Further review of this MDS Section GG - Functional Abilities-revealed for toileting hygiene Resident #22 needed substantial/maximal assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Record review of Resident #22's Comprehensive Care Plan, dated 09/04/2024 and reviewed/revised 03/13/2025, revealed the following focused areas: The resident has an ADL self-care performance deficit r/t dementia, impaired mobility, bladder incontinence, decreased functional activity tolerance, lack of coordination, abnormal gait and mobility and frontotemporal neurocognitive disorder. She has a progressive decline due to her dementia, is frequently confused, and needs more physical assistance. During an observation on 12/02/2025 at 3:20 p.m., NA G performed peri care on Resident #22. NA G was observed wiping Resident #22 from back to front after having a BM. During an interview on 12/02/2025 at 3:45 p.m., NA G stated that was how she was taught to do peri care and did not feel she had done anything wrong. NA G stated she did not remember that she had wiped in the wrong direction. NA G stated she was nervous due to state being in the facility and being watched. She stated wiping and cleaning a resident in the wrong direction while performing peri care could cause an infection such as a UTI, especially after having a BM. She stated she was trained in peri care and infection control during this year (2025). NA G stated she felt confident she knew how to perform peri care correctly. Record review of NA G's Aide Checklist for Orientation/Evaluation, dated 11/06/2025, revealed: All newly employed nurses' aides will receive the orientation as listed. Personnel will be appointed to administer different portions of the orientation. Patients care Skills and Procedures: Incontinent Care. Record review of the personnel records for NA G reflected a hire date of 11/6/2025. Further review of the personnel record provided by the AIT reflected NA G had no evidence she completed infection control training upon hire or while working at the facility. Record Review of facility policy Perineal Care dated 2001 and revised August 2019 revealed: PurposeThe purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.Steps in the Procedure.8. b. Wash perineal area, wiping from front to back. Record Review of facility policy Diarrhea and Fecal Incontinence, dated 2001 and revised September 2010, revealed: Purpose: The purpose of this procedure is to provide guidelines that will aid in preventing the resident's exposure to feces.Steps in the Procedure.6. Wipe feces from the resident's skin with edge of brief or under pad. Wipe away from perineum (vaginal opening or scrotum).		