STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676143	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Medical Lodge	301 N Miller Rd Mansfield, TX 76063

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. 1. The facility failed to seal opened items in plastic bags in the dry pantry area on 09/23/25.2. The facility failed to seal opened items in plastic bags in the refrigerator area on 09/23/25.3. The facility failed to seal opened items in plastic bags and boxes in the freezer area on 09/23/25.4. The facility failed to ensure to have a use by date on items in zip loc bags in the freezer area on 09/23/25.5. The facility failed to ensure the dented can in the dry storage area with the other canned food were removed from the shelf on 09/23/25.These deficient practices could affect residents who received meals and/or snacks from the facility's only kitchen by placing them at risk for cross-contamination and other food-borne illnesses.Findings included:Observation of the facility's kitchen dry pantry, refrigerator, and freezer areas on 09/23/25 beginning at 9:25 AM, included the following food items were in unsealed packages and containers, and a dented can with other canned food: Dry pantry area:* 1 white plastic container of 11 lb. chocolate fudge icing was unsealed and exposed to air.* 1 plastic bag of brown sugar was unsealed in a zip loc bag and exposed to air.* 1 bag of 160 oz. pasta noodles was unsealed and exposed to air.* 2 bags of 10 lb. classic macaroni were unsealed and exposed to air.* 1 zip loc bag labeled, croutons was unsealed and did not have a use by date.* 2 packages labeled, tortilla was unsealed and exposed to air.* 1 box of instant food thickener was unsealed and exposed to air.* 1 dented 14 oz. can of sliced salad beans.Refrigerator area:* 1 clear plastic container of labeled, milk was unsealed and exposed to air.* 1 clear bowl of labeled, salad was unsealed and exposed to air.* 1 package of 5 lb. mozzarella cheese was unsealed and exposed to air.* 1 clear plastic cup labeled, milk was unsealed and exposed to air.* 1 clear plastic container labeled, orange juice was unsealed and exposed to air.* 2 bags of white sandwich bread were unsealed and exposed to air.Freezer area:* 1 box of chicken patties was unsealed and exposed to air.* 1 box of beef fritter patties was unsealed and exposed to air.* 1 box of flame broiled patties was unsealed and exposed to air.* 1 box of sugar frozen cookie dough was unsealed and exposed to air.* 1 plastic zip loc bag labeled, roast beef was dated 09/14 and did not have a use by date.* 1 plastic zip loc bag labeled, diced turkey was dated 09/21 and did not have a use by date.* 1 plastic zip loc bag labeled, sausage was dated 09/23 and did not have a use by date.* 1 plastic zip loc bag labeled, scrambled eggs was dated 09/23 and did not have a use by date.* 1 plastic zip loc bag labeled, m/s sausage was dated 09/23 and did not have a use by date.* 1 plastic zip loc bag labeled, cod fish was dated 09/23 and did not have a use by date.* 1 metal pan with 16 clear bowls labeled, cantaloupe was covered with parchment paper and exposed to air.* 1 white container of 5 oz. ricotta cheese was unsealed and exposed to air.In an interview with the Dietary Manager on 09/23/25 at 9:57 AM, reflected she had been employed at the facility for 7 months. The Dietary Supervisor stated that she supervised 11 employees in the kitchen, including 4 cooks and 7 Dietary Aides that work various shifts. She stated she was unaware there were unsealed items in the kitchen's dry storage, refrigerator, and freezer areas. The Dietary Manager stated she was unaware there was 1 dented can stored on the shelves with the other canned food in the dry pantry area. She (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated all kitchen staff were responsible for ensuring all food items in the kitchen's dry pantry, refrigerator, and freezer areas were sealed, labeled, and checked for expiration dates. The Dietary Manager stated that the dented can in the dry pantry area should have been removed from the shelves with the other canned foods and should be placed in her office where there was an area designated for dented cans. The Dietary Manager stated that there should not be any food items in the kitchen's dry pantry, refrigerator, and freezer areas that were not labeled, sealed, expired, including any dented cans in the dry pantry area. The Dietary Manager stated that all zip loc plastic bags need to include the date that the item was stored and the use by date to ensure the shelf life of the food. The Dietary Manager stated that she provided monthly reeducation and retraining via In-Service Trainings for all kitchen staff and the trainings included proper food storage, labeling, and ensuring that there were not any dented cans in the facility's dry pantry, refrigerator and freezer areas. The Dietary Manager stated that the monthly In-Service Trainings included proper food handling and sanitization to prevent food-borne illness and safety per the facility's policy. The Dietary Manager stated that her expectation for the kitchen staff to immediately throw away any food items that were expired, unsealed, and exposed to air that were found in the kitchen's dry storage, refrigerator, and freezer areas. The Dietary Manager stated that that she trusted her staff to do the right thing and immediately throw away the items and then notify her about the item(s) that were thrown away and the where the item(s) was located. The Dietary Manager stated then she could retrain and reeducate staff about the situation to correct the same thing from not occurring again. The Dietary Manager stated that all kitchen staff were responsible for ensuring that the food items in the kitchen were labeled, dated, sealed, and not expired. The Dietary Manager stated that he performs a monthly audit of the kitchen's dry pantry, refrigerator, and freezer areas to ensure everything in all areas were labeled, dated, and sealed, which included checking the expiration dates on the food items. [JM1] The Dietary Manager was unable to provide a date for the last monthly audit in the kitchen's dry pantry, refrigerator, and freezer areas were conducted. The Dietary Manager stated the items found in the kitchen by the state surveyor were things that she missed during her monthly audits. The Dietary Manager stated on 09/23/25, she would immediately retrain and reeducate all kitchen staff via In-Service Trainings on food storage, labeling, checking for expired items, proper sealing of containers, bags, and packages in the kitchen. The Dietary Manager stated that all the items that the surveyor found in the kitchen would be immediately thrown away. The Dietary Manager stated that she would continue to reeducate the kitchen staff to ensure everyone knew what her expectations were the kitchen and to follow the guidelines in the facility's Food Storage Policy so that everyone would be on the same page. The Dietary Manager stated the risk of someone, which included a resident, eating food that was unsealed, exposed to air and from dented cans in the facility kitchen's dry storage, refrigerator and freezer areas were that someone could become ill and become sick due to eating something that could cause food-borne illnesses. The Dietary Manager stated there were risks of food borne illness anytime someone ingested food items from the kitchen any items that had not been labeled and stored properly and from dented cans. The Dietary Manager stated the harm of someone, which included a resident ingesting food from the facility kitchen's dry storage, refrigerator and freezer areas, expired foods, eating something from a dented can could cause someone to have stomach aches, vomit and become ill.In an interview with [NAME] A on 09/23/25 at 10:33 AM, reflected she stated that she had been employed at the facility for 9 months. She stated she was unaware there were unsealed items in the kitchen's dry storage, refrigerator and freezer areas. She stated she was unaware there was 1 dented can on the shelves with the other canned food items. [NAME] A stated all the staff were responsible for storing the items on the shelf and checking the expiration dates, dented cans to make sure there were not any unsealed items in the kitchen's dry storage, refrigerator and freezer areas. [NAME] A stated that if she found any item(s) in the kitchen's dry storage, refrigerator and freezer areas, she would immediately throw them away and notify the Dietary Manager of her findings and inform the location of her finding(s). [NAME] A stated that during (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	her employment at the facility she had taken numerous In-Service training courses on food storage, labeling, dented cans, and ensuring that expired items are immediately thrown away. She stated that the In-Service Trainings included ensuring that dented cans are to be removed from the shelves and placed in the area labeled, dented cans in the Dietary Manager's office. She stated the In-Service training also included guidance on throwing away any food items in the kitchens dry pantry, refrigerator and freezer areas that are unsealed and cause the food become freezer burned. She stated that if anyone ingests food that unsealed packages or containers and that is not properly labeled and dated, their body could break down and become sick, vomit, have stomach issues and have an adverse reaction after ingesting the food. [NAME] A stated that if anyone ingests food from the kitchen from unsealed packages or containers, dented cans and they could be harmed by incontrollable vomiting and stomach cramps, which can make them ill.In an interview with the Dietary Manager on 09/23/25 at 12:35 PM, it was revealed that the sliced cantaloupe that was observed by the surveyor during the Initial Brief Tour of the kitchen was thrown away. The Dietary Manager stated that the sliced cantaloupe that was observed during the Dining Observation was prepared by the kitchen staff after the surveyor exited the kitchen for the Initial Brief Tour of the kitchen.Record review revealed that there was not any documentation in the kitchen of the Dietary Manager's monthly audits of the dry pantry, refrigerator and freezer areas.Record review of the facility's policy, Food Receiving and Storage, revised July 2014 reflected: Policy Statement:Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation1. Food Services, or other designated staff, will maintain clean food storage areas at all times.6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date).10. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing.12. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods.13.e. Other opened containers must be dated and sealed or covered during storage. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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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** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #38 and Resident #51) of five residents, reviewed for infection control. 1. The facility failed to ensure CNA B wore a PPE gown and performed hand hygiene during care for Resident #51.2. The facility failed to ensure CNA C performed hand hygiene during incontinence care for Resident #38 This failure placed residents at risk for healthcare associated cross contamination and infections.Findings included: 1. Review of Resident #51's Quarterly MDS Assessment, dated 08/14/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills were intact. The resident had diagnoses including neurogenic bladder (misfunctioning bladder) with a supra-pubic catheter (tube inserted directly into the bladder to drain urine), diabetes, and multiple sclerosis (disorder where the immune system attacks nerve cells and disrupt communication between the brain and the rest of the body). The resident was dependent on staff for toileting. The resident was occasionally incontinent of stool. Review of Resident #51's Care Plans reflected:06/28/24 - Resident was on EBP related to a wound and supra-pubic catheter.Facility interventions: Provide patient standard precautions using gowns and gloves during dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. An observation on 09/23/25 at 10:46 AM with Resident #51 revealed she had PPE outside of her door and a sign posted for EBP. CNA B was in the resident's room wearing gloves. CNA B was not wearing a gown. CNA B leaned over the bed and fastened the resident's brief. CNA B's clothes touched the resident's bed. CNA B removed the gloves, did not perform hand hygiene, put on new gloves and straightened the resident's blankets. An interview on 09/23/2025 at 10:53 AM with CNA B revealed she said Resident #51 was not on EBP. CNA B was outside the resident's room during the interview and standing next to the EBP sign on the wall. CNA B said she was only required to wear gloves to provide care for the resident. She said she did not have to wear a gown to provide care unless she was emptying the resident's catheter and near the resident's wound. CNA B said she was in-serviced on EBP about a month prior. CNA B said she was supposed to perform hand hygiene between glove changes. She said she did not do it this time because she forgot and got busy. CNA B said failing to wear the correct PPE and performing hand hygiene could lead to contamination. 2. Review of Resident #38's Annual MDS Assessment, dated 08/21/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills were intact. The resident had a Foley catheter and was occasionally incontinent of bladder. Her diagnoses included stroke and diabetes. The resident required substantial assistance with toileting. Review of Resident #38's Care Plans reflected:Revised 07/17/25 - Resident had an ADL self-care performance deficit.Facility interventions included:Resident was totally dependent on staff for personal hygiene. An observation on 09/24/25 at 2:05 PM of incontinence Care for Resident #38 by CNA C revealed she cleaned the resident's peri-area, changed gloves, and did not perform hand hygiene. The resident turned to her right side and CNA C cleaned the buttocks. The resident was dirty with a small amount of bowel movement. CNA C cleaned the bowel movement, changed her gloves, but did not perform hand hygiene. CNA C removed the soiled brief, did not change her gloves or hand hygiene, and placed a clean brief. CNA C applied barrier cream to the resident's buttocks, changed gloves, but did not perform hand hygiene. The resident turned to her back and CNA C fastened the brief. An interview on 09/24/25 at 2:20 PM with CNA C revealed she was supposed to perform hand hygiene between each glove change and had been trained to do so. She said she did not do it this time, because she forgot. CNA C said failure to perform hand hygiene could lead to infection. An interview on 09/25/25 at 11:10 AM with the DON revealed staff were supposed to perform hand hygiene between glove changes and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wear a gown while positioning a resident and fastening a brief who was on EBP. The DON said hand hygiene and proper PPE use was required to reduce the risk for infection. The DON said she made observations of staff during care to ensure they were performing hand hygiene and glove changes. Record review of the facility policy, Infection Control, revised October 2018, reflected: The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections.Record review of the facility policy, Hand Hygiene, revised 12/22/23, reflected: 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Residents #93) reviewed for accident hazards. CNA D did not ensure Resident #93, who required 1:1 meal assistance, was positioned correctly while eating. This failure could place residents at risk for aspiration and choking related to eating in an improper position.The findings included: Record review of Resident #93's quarterly MDS assessment, dated 09/04/25, revealed the resident was a [AGE] year-old male admitted on [DATE]. His BIMs score was 99. He was sometimes understood and sometimes able to make himself understood. His diagnoses included aphasia (aphasia impairs the expression and understanding of language, as well as reading and writing), Parkinson's disease, stroke, and hemiplegia, seizure disorder, difficulty swallowing, and respiratory failure. The resident required supervision to eat. The resident required maximum assist for positioning to sit upright. Record review of Resident #93's Care Plan reflected:1. Date Initiated: 01/13/25Risk for Malnutrition Parkinson's DiseaseFacility interventions included:Ensure resident was in proper position for eating.2. Revised on: 04/30/2025The resident had an ADL self-care performance deficit.Facility interventions included:Eating: Resident requires assistance with eating.3. Revised on: 09/11/2025The resident had a swallowing problem related to complaints of difficulty or pain with swallowing.Facility interventions included:1:1 assist feeding at this time.Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly.Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards. An observation and interview on 09/23/25 from 12:28 PM - 12:35 PM revealed Resident #93 was sitting in a custom wheelchair. His head and body were slumped over the left side of the wheelchair. The resident was non-verbal. CNA D fed the resident a chopped diet while Resident #93 was slumped over. CNA D fed the resident two bites while the resident was slumped over to the left side. CNA D said the resident was not supposed to be slumped over to the left side while eating to prevent risk of choking. CNA D and CNA E removed the resident from the table and repositioned him to sit upright. An interview on 09/23/25 at 1:15 PM with CNA D revealed Resident #93 was fed while leaning over to the left side because that was the way the resident's posture was. CNA D said he had been trained to feed the resident and fed him anytime he came to the dining room. CNA D said the resident was not supposed to be slumped over to his left side while eating. CNA D said the resident was at risk for choking if he ate while being slumped over to the left side. CNA D said therapy had told him 2-3 weeks ago that the resident was supposed to sit up straight to eat. An interview on 09/24/25 at 11:05 AM with the Director of Rehab Therapy revealed the best case scenario for Resident # 93 to eat was in the upright position in his wheelchair. The Director of Rehab Therapy said feeding the resident while slumped over to the left side placed him at risk for aspiration and choking. The Director of Rehab Therapy said she did not train the staff to feed the resident and would defer to facility staff to complete the training. An interview with the DON on 09/25/25 at 11:05 AM revealed it was not okay for staff to feed Resident #93 while he was slumped over to his left side. She said staff were trained to feed residents but was not aware if staff had been trained to feed Resident #93. The DON said if staff noticed a resident leaning over, they needed to notify the DON and involve therapy to find a solution. The DON said she made observations of residents at meal times and the resident had a history of leaning over to his left side. The DON said staff would need to reposition the resident into an upright position before they fed him. The DON said the resident was at risk of not being able to swallow properly if he was fed in a slumped over position. Review of the facility policy, Safety and Supervision of Residents, revised July 2017, reflected: Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined by the individual resident's assessed needs and identified hazards in the environment.3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.