

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 10 of 42 confidential residents. The facility failed to ensure 10 confidential residents were provided, the Grievance Procedure, information in regards to who the facility grievance officer was, their contact information, how to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings included: Interviews during Resident Council with 10 confidential residents, stated they did not have access to a Grievance form, they did not know they could file a Grievance anonymously, and they had not observed a posting of the Grievance procedure in prominent locations. Record Review of the facility Grievance policy updated April 2017 reflected a copy of the Grievance/complaint procedure should be posted on the resident bulletin board. Observed prominent postings in the lobby of the facility on 8/20/2025 at 11:45am. The facility postings did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available to Residents in the facility and there was no access to submit a Grievance anonymously. Interview with the ADM on 8/21/2025 at 3:15pm, the ADM stated she was the Grievance Officer for the facility. The ADM stated she was responsible for the review of Grievances and to assign them to department heads. The ADM stated there are currently no Grievance forms for Residents to complete. The ADM stated the staff complete a Grievance form if a resident has a complaint. The ADM stated there was no procedure for Residents to submit Grievances anonymously. The ADM stated the facility had a responsibility to resolve Grievances immediately with a final resolution being completed within 24 hours. The ADM stated she assigned the Grievance to the appropriate department, that department addressed the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated she will also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated the CNA supervisor, laundry supervisor, and the DON were responsible for ensuring staff were trained on the Grievance process. Record Review of the Grievance Policy updated April 2017 reflected the following: Policy Statement: Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or their representative. The Resident and/or the representative has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Policy Interpretation and (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
--	-------	-----------

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implementation: 1. Any resident, family member, or representative may file a grievance or complaint.2. Residents, family, and representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal.3. All grievances from resident or family concerning issues of residents' care in the facility will be considered. Actions will be responded to in writing.4. Upon admission residents are provided with written information on how to file a grievance. 5. Grievances may be submitted orally or in writing and may be filed anonymously.6. The contact information for the individual with whom a grievance may be filed is provided to the resident or representative upon admission.7. The ADM has delegated the responsibility of grievance investigation to the ADM.8. The grievance officer will review and investigate the allegations and submit the written report of such findings to the ADM with five working days of receiving the grievance.9. The grievance officer will coordinate actions with the appropriate state and federal agencies depending on the nature of the allegations. 10. The ADM and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated.11. The ADM will review the findings with grievance officer to determine what corrective actions need to be taken.12. The resident or person filing the grievance on behalf of the resident, will be informed (verbally or in writing) of the findings of the investigation and actions will be taken to correct any identified problems. A written summary of the investigation will be provided to the resident and a copy will be filed in the business office. 13. If the grievance is filed anonymously the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance and report the findings. 14. The results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision.15. This policy will be provided to the resident or the resident's representative upon request.		

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 4 of 16 residents (Resident #29, Resident #36, Resident #39, and Resident #42) reviewed for care plans. The facility failed to develop a care plan for Resident #29's, Resident #36's, Resident #39's and Resident #42's advanced directives. These failures could place residents at risk of not receiving the care required to meet their individualized needs. Findings included: Resident #29 Record review of the resident face sheet for Resident #29, dated 08/20/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: dysphagia (difficulty swallowing), acute pulmonary edema (difficulty breathing), and pneumonia (lung infection). The face sheet further revealed Resident #29 had advanced directives: Do Not Resuscitate (DNR). Record review of Resident #29's physician orders, dated 08/20/25, revealed an order: Resident is a DNR with a start date of 08/01/24. Record review of the current care plan for Resident #29, last reviewed on 06/11/25, revealed there was no specific care plan regarding advanced directives. Resident #36 Record review of the resident face sheet for Resident #36, dated 08/20/25 revealed an [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: unspecified dementia (decline in memory and cognitive skills), generalized anxiety disorder (mood disorder), and benign prostatic hyperplasia (urination problems caused by prostate). The face sheet further revealed Resident #29 had advanced directives: Do Not Resuscitate (DNR). Record review of Resident #36's physician orders, dated 08/20/25, revealed an order: DNR - Do Not Resuscitate with a start date of 05/16/25. Record review of the current care plan for Resident #36, last reviewed on 08/15/25, revealed there was no specific care plan regarding advanced directives. Resident #39 Record review of the resident face sheet for Resident #39, dated 08/20/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: quadriplegia (paralysis of all four limbs), pain, and dysphagia (difficulty swallowing). The face sheet further revealed Resident #39 had advanced directives: Do Not Resuscitate (DNR). Record review of Resident #39's physician orders, dated 08/20/25, revealed an order: Resident is a DNR with a start date of 07/30/25. Record review of the current care plan for Resident #39, last reviewed on 08/19/25, revealed there was no specific care plan regarding advanced directives. Resident #42 Record review of the resident face sheet for Resident #42, dated 08/20/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: gastro-esophageal reflux disease (a condition in which the stomach contents frequently flow back into the esophagus), depression (mood disorder), and hypothyroidism (thyroid gland does not produce enough thyroid hormones). The face sheet further revealed Resident #42 had advanced directives: Do Not Resuscitate (DNR). Record review of Resident #42's physician orders, dated 08/20/25, revealed an order: Resident is a DNR with a start date of 04/04/25. Record review of the current care plan for Resident #42, last reviewed on 07/15/25, revealed there was no specific care plan regarding advanced directives. During an interview on 08/21/25 at 2:14 PM, the DON stated she was responsible for ensuring the resident's code status was in the comprehensive care plan. The DON stated the facility was training her as I go. The DON stated it was an oversight regarding the comprehensive care plans for Residents' #29, #36, #39, and #42 not having their code status care planned. The DON stated a potential negative outcome to the residents was the staff would not know what to do or what to expect if there was a code. During an interview on 08/21/25 at 3:52 PM, the Admin stated the DON was responsible for ensuring a resident's code status was in their care plan. (continued on next page)		

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admin stated the DON had not been provided specific training for the code status being in a resident's care plan because she did not think about it. The Admin stated a potential negative outcome to the residents was a risk for their wishes to not be honored. Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, with a revised date of March 2022, reflected the following: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 7. The comprehensive, person-centered care plan: b describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) Services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the personal food policy was followed to maintain safe and sanitary storage of residents' food items for 4 of 16 residents rooms reviewed for food safety (room [ROOM NUMBER]A, #16B, #19B, and #21B) in that: The refrigerators located in room [ROOM NUMBER]A, #16B, #19B, and #21B were not being monitored for internal temperature and expiration/used by dates. These failures could place residents at risk for food borne illnesses. Findings include: During an observation on 08/19/2025 at 11:34 AM, Resident room [ROOM NUMBER]B contained a personal refrigerator. The refrigerator contained perishable food items such as a personal Ziplock package of summer sausage (expiration date 8/20/2025), 3 individual containers of Jello pudding, one bag of Doritos chips, two bags of Cheese It crackers, and a Ziplock bag of an unknown, unlabeled/undated food item. The refrigerator also contained numerous cans of unopened soda. During an observation on 08/19/2025 at 11:34 AM, Resident room [ROOM NUMBER]B contained a personal refrigerator. The refrigerator contained perishable food items such as 4 individual (undated) unknown white sauce containers, 1 individual, (undated) container of barbeque sauce, 1 container of tartar sauce, 1 jar of mayonnaise, 1 jar of salad dressing, a Ziplock bag containing a 1lb bag of sugar, a container of butter, and numerous cans and bottles of unopened sodas. The refrigerator also contained a to-go container from Rosa's Cafe (undated). During an observation on 08/20/2025 at 10:43 AM, Resident room [ROOM NUMBER]B contained a personal refrigerator. The refrigerator contained perishable food items such as yogurt (undated), an individual plate of cake (undated), an unlabeled/undated container of lunch meat, an unknown food item wrapped in a paper towel (undated), and a sour cream container labeled with yogurt (dated 8/19/2025). During an observation on 08/21/2025 at 11:54 PM, Resident room [ROOM NUMBER]B still contained an unknown food item wrapped in a paper towel (undated), a sour cream container labeled with yogurt (dated 8/19/2025), and an unlabeled/undated container of lunch meat. During an observation on 08/21/2025 at 12:54 PM, Resident room [ROOM NUMBER]A contained a personal refrigerator. The refrigerator contained perishable food items such as a container of ketchup, a jar of salsa, a container of mustard, a jar of jelly, a container of salad dressing, a homemade jar of jelly (undated), one avocado, one package of SPAM, a zip lock bag of sliced fresh tomatoes (undated), an opened, unwrapped (unknown) pastry, a bag of fresh grapes, one loaf of bread, an undated container of brownies, one package of hot dogs, an opened jar of queso, a package of Danishes, an unopened, packaged sandwich, and an undated to-go container from an unknown restaurant. During an observation on 08/21/2025 at 1:01 PM, Resident room [ROOM NUMBER]B still contained a personal Ziplock package of summer sausage (expiration date 8/20/2025), and a Ziplock bag of an unknown, unlabeled/undated food item. During an observation on 08/21/2025 at 2:13 PM, Resident room [ROOM NUMBER]B still contained 4 individual (undated) unknown white sauce containers, 1 individual (undated) container of barbeque sauce, and a to-go container from Rosa's Cafe (undated). During an interview on 08/21/2025 at 2:15 PM, CNA E stated the CNAs sometimes cleaned out resident's refrigerators, but it was not a regular task they were assigned to do. CNA E stated it was something she did as a courtesy to the residents, but the resident was usually responsible for doing it on their own. CNA E stated there was no log or way for the nursing staff to know when a resident's refrigerator had been cleaned out last, CNA E stated she threw out expired food for residents when they asked her to, but this was not a daily task she was assigned to complete. CNA E stated there was no system in place to check resident's refrigerators on a regular basis. CNA E stated she did not check the resident's refrigerators to ensure they were at an adequate temperature. CNA E stated she was not certain if the resident's refrigerator's contained thermometers. CNA E stated, if residents were unable to clean out their refrigerator on their own, the resident could have been at risk of eating expired foods. CNA E stated a resident could get sick if they ate old or expired foods. During an (continued on next page)		

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 08/21/2025 at 2:15 PM, the DON stated there was no current system or policy in place regarding resident's personal refrigerators. The DON stated there were no tasks assigned to any nursing facility staff to discard expired food items from resident's personal refrigerators. The DON stated this was a responsibility left to the resident, and there was not a way to ensure the resident's refrigerator did not contain expired food items. The DON stated CNAs may have helped a resident clean out their refrigerator at times, but there was no task assigned to the CNA to do this regularly. The DON stated, if a resident consumed expired or spoiled food items, the resident was at risk of getting sick or obtaining a food borne illness. During an interview on 08/21/2025 at 2:45 PM, the ADM stated the facility did not have a policy in place regarding resident's personal refrigerators. The ADM stated there was a policy regarding personal food brought in by family and visitors that residents and their families were made aware of upon admission. The ADM stated it was her expectation that all personal food items were dated with used by or expiration dates per the facility's Food Brought by Family/Visitors policy. The ADM stated the residents were responsible for discarding of any expired or spoiled food items themselves. The ADM stated there was not a way to ensure residents were discarding of expired or spoiled food items, as facility staff did not monitor this. The ADM stated the facility did not monitor resident's personal refrigerators to ensure they were working properly. The ADM stated CNAs discarded expired foods for residents weekly, but this was not a specific task assigned to the CNAs, and it was only a task they did to help the resident. The ADM stated there was not a way for the facility to track that this had been done, as there was no log kept verifying it. The ADM stated residents were at risk of food borne illness and they could get sick if they consumed expired or spoiled foods. The ADM stated the facility planned to develop a system to ensure residents' personal refrigerators were checked and cleaned regularly. Record review of the facility's policy titled Foods Brought by Family/Visitors, undated, revealed: Policy Statement: Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Policy Interpretation and Implementation 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food.a. Non-perishable foods are stored in re-sealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid.b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date.6. The nursing staff will discard perishable foods on or before the use by date.7. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 2 of 3 residents (Residents #39 and #29) reviewed for infection control. 1. CNA A failed to utilize proper hand hygiene between glove changes and failed to change gloves when going from dirty to clean when providing incontinence care and catheter care for Resident #39. 2. CNA A and RN B failed to follow enhanced barrier precautions (EBP) and wear a gown when providing incontinence care and catheter care for Resident #39. 3. CNA C failed to change her gloves when going from dirty to clean when providing incontinence care for Resident #29. These failures could place residents at risk for cross contamination and infection. The findings include: Resident #39 Record review of the resident face sheet for Resident #39, dated 08/20/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: quadriplegia (paralysis of all four limbs), pain, and dysphagia (difficulty swallowing). Record review of the comprehensive MDS for Resident #39, dated 03/05/25 revealed Resident #39 had an indwelling catheter. Record review of Resident #39's physician orders, dated 08/20/25, revealed an order: Foley catheter care every shift twice a day with a start date of 02/23/25. Record review of the current care plan for Resident #39, last reviewed on 08/19/25, revealed there was a problem area: I am at risk for UTI with an approach: Ensure good perineal care per infection control nurse treatment for peri care. During an observation on 08/20/25 at 10:27 AM, CNA A provided incontinence care and catheter care for Resident #39 with the help of RN B. CNA A and RN B did not put on a gown to provide care. CNA A washed her hands with soap and water and put on clean gloves. CNA A unfastened the brief for Resident #39 and cleansed his groin with wipes. CNA A removed her gloves and did not perform hand hygiene. CNA A then put on clean gloves. Resident #39 was turned on his side and CNA A wiped his buttocks with wipes. CNA A then placed a clean brief and pad under Resident #39 with the same gloves. CNA A and RN B then removed Resident #39's dirty brief and CNA A removed her gloves and did not perform hand hygiene. CNA A then put on clean gloves and Resident #39 was turned on his back. CNA A then cleansed Resident #39's foley catheter going outwards. CNA A then secured Resident #39's brief and repositioned him in bed with his bed sheets and placed a pillow and wedge under his legs with the same gloves. CNA A then removed her gloves and washed her hands with soap and water. During an interview on 08/20/25 at 4:46 PM, CNA A stated she had asked the DON if she needed to wear a gown when providing incontinence care for Resident #39. CNA A stated she was told wrong, or she got confused and she did not think she had to wear a gown when providing incontinence care for Resident #39. CNA A stated she knew to perform hand hygiene between glove changes, but she was nervous with people watching her. CNA A stated she recently had a check off by RN B for incontinence care and hand hygiene, but she could not remember the date exactly. CNA A stated she should have changed her gloves and performed hand hygiene before placing the clean brief under Resident #39 and after she cleaned his catheter. CNA A stated the resident had a risk for spreading bacteria and everything that could cause infection or sickness. During an interview on 08/21/25 at 3:44 PM, RN B stated she was helping the facility with infection control until the new IP started working next week. RN B stated she should have worn a gown when helping CNA A provide incontinence care to Resident #39. RN B stated she was nervous and got confused. RN B stated she was helping the facility with check off and the CNA's were trained on hand hygiene and glove changes recently. RN B stated the residents had a risk for infection and illness. Resident #29 Record review of the resident face sheet for Resident #29, dated 08/20/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: dysphagia (difficulty swallowing), acute pulmonary edema (difficulty breathing), and pneumonia (lung infection). Record review of the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive MDS for Resident #29, dated 12/07/24, revealed Resident #29 was always incontinent of bowel. Record review of the current care plan for Resident #29, last reviewed on 06/11/25, revealed there was a problem area: Urinary Incontinence with an approach: Provided incontinence care after each incontinent episode. Report any signs of complications/UTI During an observation on 08/20/25 at 11:00 AM, CNA C provided incontinence care for Resident #29. CNA C washed her hands with soap and water and put on clean gloves. CNA C then unfastened Resident #29's brief and cleansed his groin with wipes. Resident #29 was turned on his side and CNA C wiped his buttocks with wipes. CNA C then removed the dirty brief and placed a clean brief under Resident #29 without changing her gloves. CNA C then secured Resident #29's brief and removed her gloves. CNA C then used hand sanitizer to cleanse her hands. During an interview on 08/21/25 at 10:03 AM, CNA C stated she was trained to change her gloves and perform hand hygiene when going from dirty to clean during incontinence care. CNA C stated she realized she messed up yesterday when providing incontinence care to Resident #29 because she was nervous. CNA C stated she recently had check-offs regarding incontinence care and hand hygiene last week some time. CNA C stated a potential negative outcome to the residents was infection control concerns. During an interview on 08/21/25 at 2:14 PM, the DON stated she expects the staff to perform hand hygiene with soap and water or hand sanitizer between all glove changes. The DON stated she expects the staff to change their gloves and perform hand hygiene when going from dirty to clean when providing care to a resident. The DON stated she was confused on the EBP for Resident #39 but she understands now and she will have the staff wear a gown and gloves when changing his brief or providing catheter care. The DON stated the CNA's were recently trained with check-offs and RN B was assisting with that. The DON stated a potential negative outcome to the residents was a risk for spreading infection. During an interview on 08/21/25 at 3:52 PM, the Admin stated she expected the staff to perform hand hygiene between glove changes and to change their gloves when going from dirty to clean when providing care. The Admin stated the facility was confused on the rules for EBP but understands the importance. The Admin stated the CNA's are trained on hand hygiene and glove changes and thinks they got nervous and did not think about it. The Admin stated the facility hired RN B to help with infection control concerns until the new IP begins work at the facility next week. The Admin stated the residents had a risk for spreading infection. Record review of the facility document titled, Performance Skill #5 Perform Perineal Care, dated 06/12/25, revealed CNA A passed. Record review of the facility document titled, Performance Skill #5 Perform Perineal Care, dated 08/18/25, revealed CNA A passed. Record review of the facility document titled, Performance Skill #5 Perform Perineal Care, dated 07/17/25, revealed CNA C passed. Record review of the facility document titled, Performance Skill #5 Perform Perineal Care, dated 08/18/25, revealed CNA C passed. Record review of the facility policy titled, Infection Prevention and Control Program, with a revised date of December 2023 reflected the following: Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Record review of the facility policy title, Handwashing/Hand Hygiene, with a revised date of October 2023 reflected the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Indications for Hand Hygiene: 1. Hand Hygiene is indicated: g. immediately after glove removal. 5. The use of gloves does not replace hand washing/hand hygiene. Record review of the facility policy titled, Enhanced Barrier Precautions, with a revised date of December 2024 reflected the following: Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation: 1. Enhanced Barrier Precautions (EBPs) refers to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms during high contact resident care activities. 2. Enhanced barrier precautions apply when: b. A resident is not known to be infected or colonized with MDRO, has wound or indwelling medical (continued on next page)		

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	devices, and does not have secretions or excretions that are unable to be covered or contained.5. Indwelling medical devices include central lines, urinary catheters.8. examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: d. changing briefs or assisting with toileting.12. Enhanced barrier precautions are in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place them at higher risk.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 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 record reviews and interviews the facility failed to develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles for 6 out of 6 employees (RN F, CNA A, LVN H, CNA G, CNA I, and CNA J) reviewed for required training. The facility failed to ensure staff were properly trained in Fall Prevention, HIV, Restraints, Emergency Procedures and Dementia for 6 of 6 employees (RN F, CNA A, LVN H, CNA G, CNA I, and CNA J) reviewed for training at hire and annually. This failure could place residents at risk of receiving care from individuals who did not have the knowledge and skills to properly provide safety from adverse events or other resident life and health complications. Findings include: Record review of employee records for RN F reflected RN F was hired at the facility on 07/28/2025, and the facility was unable to provide documentation indicating RN F received training, through the facility, on Fall Prevention, HIV, Restraints, Emergency Procedures, and/or Dementia. Record review of employee records for CNA A reflected CNA A was hired at the facility on 05/27/2025, and the facility was unable to provide documentation indicating CNA A received training, through the facility, on Fall Prevention, HIV, Restraints, Emergency Procedures, and/or Dementia. Record review of employee records for LVN H reflected LVN H was hired at the facility on 02/17/2025, and the facility was unable to provide documentation indicating LVN H received training, through the facility, on Fall Prevention, HIV, Restraints, Emergency Procedures, and/or Dementia. Record review of employee records for CNA G reflected CNA G was hired at the facility on 07/21/2025, and the facility was unable to provide documentation indicating CNA G received training, through the facility, on Fall Prevention, HIV, Restraints, Emergency Procedures, and/or Dementia. Record review of employee records for CNA I reflected CNA I was hired at the facility on 01/17/2018, and the facility was unable to provide documentation indicating CNA I received training, through the facility, on Fall Prevention, HIV, Restraints, Emergency Procedures, and/or Dementia. Record review of employee records for CNA J reflected CNA J was hired at the facility on 11/05/2024, and the facility was unable to provide documentation indicating CNA J received training, through the facility, on Fall Prevention, HIV, Restraints, Emergency Procedures, and/or Dementia. During an interview with HR on 08/21/2025 at 5:05 PM, she stated the CCO of the hospital was supposed to pick up a training system to use for the facility, but nothing was in place and live at that time. HR stated the hospital will provide training through orientation and after that the facility was responsible for ensuring their staff completed the required training. The HR stated The ADM was responsible for ensuring facility staff completed their trainings. During an interview with the ADM on 08/21/2025 at 5:10 PM, she stated she has asked for a training program to be used at the nursing home, but she had not received approval yet. The ADM stated RN B was hired to help with specific infection control training, but she only started last week. The ADM stated the facility employees were responsible for ensuring their training was completed through their CEU's. The ADM stated the facility has not followed up enough on training for the employees. The ADM stated a potential negative outcome to the residents was staff not being able to react appropriately with dementia and behaviors with a lack of training. Record Review of the facility's policy titled, In-Service Training, All Staff, revised August 2022, revealed the following: Policy Statement: All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation: 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. 4. Training materials are provided at no cost to participating staff. 5. Training methods and teaching materials are appropriate to the level of (continued on next page)		

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	education and expected roles of those attending.6. Required training topics include the following:(3). dementia management and resident abuse prevention.7. Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. Based on the outcome of the facility assessment, additional training mayinclude: 8. Completed training is documented by the staff development coordinator, or his or her designee and includes:a. the date and time of the training;b. the topic of the training;c. the method used for training;d. a summary of the competency assessment; ande. the hours of training completed. Record Review of the facility's policy titled, On-the-Job Training, revised November 2023, revealed the following:Policy Statement:On-the-job training programs will be conducted when necessary to assist employees in performing their assigned tasks.Policy Interpretation and Implementation:1. On-the-job training is provided to train each employee in his/her respective job assignment and our methods of performing such tasks. Record Review of the facility's policy titled, Inspection of Orientation Records, revised December 2006, revealed the following:Policy Interpretation and Implementation2. All documents concerning employee orientation records are made available to federal and state surveyors upon request. Record Review of the facility's policy titled, Recordkeeping, Staff Development, undated, revealed the following:Policy StatementOur facility maintains recordkeeping data relative to in-service training programs conducted by the facility. Policy Interpretation and Implementation1. A record of all training classes will be maintained in the in-service training coordinator's office.2. The in-service training coordinator is responsible for assuring that appropriate records are completed by the department supervisor or instructor conducting the class.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 2 of 16 residents (Residents #27 and #28) reviewed for advanced directives, in that: Residents #27 and #28 was listed as a DNR (Do Not Resuscitate) but had Out-of-Hospital Do Not Resuscitate (OOH-DNR) forms that were incorrectly filled out or had missing required information. These failures could place residents at risk for not having their end of life wishes honored and their records being incomplete/inaccurate. Findings included: Resident #27 Record review of Resident #27's face sheet, undated, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (impairments of at least two brain functions), Hypothyroidism (thyroid gland does not produce enough thyroid hormones), and Hypertension (force of the blood against the artery walls is too high). The face sheet also revealed under the advance directive section - DNR-Do Not Resuscitate. Record review of quarterly MDS assessment dated [DATE] revealed Resident #27 had a BIMS of 6 which indicated the resident's cognition was severely impaired. Record review of Resident #27's physician order summary dated 8/21/25 revealed no order for Code Status. Record review of Resident #27's care plan, dated 07/8/25, revealed no care plan for DNR. Record review of Resident #27's Out of Hospital Do Not Resuscitate form dated 03/31/25 revealed under declaration by, statement no physician's signature, no physician's printed name, and no license number. In addition, under the acknowledgement of completed document there is no physician's signature and no Resident or Guardian's signature. Resident #28 Record review of Resident #28's face sheet, undated, revealed a [AGE] year-old-female who admitted to the facility on [DATE] with diagnoses to include Hypertension (force of the blood against the artery walls is too high), Gastro-esophageal reflux (stomach acid flows back into the esophagus), Altered mental status (deviation from a normal level of alertness), and Anemia (lack of healthy red blood cells and hemoglobin). Record review of quarterly MDS assessment dated [DATE] revealed Resident #28 had a BIMS of 0 which indicated the resident's cognition was severely impaired. Record review of Resident #28's physician order summary dated 08/21/25 revealed no order for Code Status. Record review of Resident #28's care plan dated 06/10/25, revealed no care plan for Resident #28's code status. Record review of Resident #28's Out of Hospital Do Not Resuscitate form dated 02/17/25 revealed under physician statement no physician printed name and no license number. During an interview on 08/21/25 3:15PM with the ADM, she stated the OOH DNR was not valid if not filled out correctly. She stated the Social Worker was responsible for making sure the OOH DNR was completed accurately. She stated they do not have a system in place to monitor OOH DNR for accuracy. She verified missing information on OOH DNR for Resident #27 and #28. She stated she does not know why the information is missing; it was a human error. She also stated the DNR audits should improve once a full time Social Worker is obtained. She stated the potential negative outcome could be the residents' end of life requests may not be honored. She stated her expectations were that the OOH DNR was done correctly to make sure they are valid. Record review of the Social Services Policies and Procedures Advanced Directives (Revised March 2021) reflected the following: Policy Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. A DNR order form must be completed and signed by the attending physician and resident or resident's legal surrogate and placed in the front of the resident's medical record. Should the resident be transferred to the hospital, a photocopy of the DNR order form must be provided to the personnel transporting the resident to the hospital. The DNR orders will remain in effect until the resident or legal surrogate provides the facility with a signed and dated request to end the DNR order. The interdisciplinary care planning team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such (continued on next page)		

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: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directives. The resident's attending physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes to clarify and adhere to the resident's wishes. Inquiries concerning do not resuscitate orders/requests should be referred to the administrator, director of nurses, or the social services director.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 10 out of 90 days (01/11/25, 01/12/25, 01/25/25, 01/26/25, 02/08/25, 02/09/25, 02/15/25, 02/16/25, 02/22/25, and 02/23/25) reviewed for RN coverage. The facility failed to ensure they had RN coverage 8 hours a day, 7 days a week for the following weekend days: 01/11/25, 01/12/25, 01/25/25, 01/26/25, 02/08/25, 02/09/25, 02/15/25, 02/16/25, 02/22/25, and 02/23/25 This failure could place residents at risk for inconsistency in care and services. Findings include: Record review of the facility's PBJ Staffing Data Report for the Fiscal Year Quarter 2 2025 (January 1 - March 31) dated 08/15/25 revealed there were no RN hours for the dates 01/11/25, 01/12/25, 01/25/25, 01/26/25, 02/08/25, 02/09/25, 02/15/25, 02/16/25, 02/22/25, and 02/23/25. During an interview on 08/21/25 at 12:11 PM, the Admin stated the DON was hired at the end of 2024 and has worked Monday through Friday 8 am to 5 pm and sometimes more than that. The Admin stated the DON was salary and does not clock in for work. The Admin stated the facility did not have an RN to cover the weekends during the months of January 2025 and February 2025. The Admin stated the weekend RN began working weekends in March 2025 and the facility has not had any issues since then. The Admin stated the facility had problems hiring an RN to cover the weekends and that was why the facility went without an RN to cover the weekends during January and February. The Admin stated the Nurse Practitioner for the facility lived nearby and would be able to be at the facility quickly if help was needed. The Admin stated a potential negative outcome to the residents was an LVN not getting assistance from an RN if needed. Record review of the facility policy titled, Departmental Supervision, Nursing with a revised date of August 2022 reflected the following: Policy Statement: The nursing services department shall be under the direct supervision of a registered or licensed practical/vocational nurse at all times. Policy Interpretation and Implementation: 2. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RN's may be scheduled more than eight (8) hours depending on the acuity needs of the resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 212 NW 10th St Seminole, TX 79360	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to prepare food in a form to meet individual needs in 1 of 1 kitchen reviewed for dietary services in that: The facility failed to ensure puree meat, puree vegetables, and puree pasta were prepared to a smooth uniform texture. This failure could place residents at risk for choking. Findings include: During an observation on 08/20/2025 at 12:10 PM, the test tray sampled revealed the pureed broccoli had small chunks of broccoli and strings in it and was not a smooth uniform texture. The puree pasta had chunks of dough and was not a smooth uniform texture. During an observation on 08/21/2025 at 11:55 AM, the test tray sampled revealed the pureed pork had small grains of pork and was not a smooth uniform texture. The puree carrots had chunks of carrots and were not a smooth uniform texture. The puree potatoes had chunks of potatoes and were not a smooth uniform texture. During an interview on 08/21/2025 at 12:05 PM, the DM stated she was responsible for the puree food items served to the residents. The DM stated she was not certain which dietary staff completed the puree task on 08/20/2025 or 08/21/2025. The DM stated she would ensure all pureed food items were pureed herself, to a consistent, smooth texture on 08/21/2025 before they were served to residents. The DM stated all food served to nursing facility residents was prepared at the connected hospital. The DM stated it was her responsibility to prepare food and check it before it was served at the nursing facility. The DM stated her expectation was that all pureed food was served at a smooth texture. The DM stated she was not aware the pureed food was not being served at a smooth texture. The DM stated there was one resident receiving a puree diet at this time. The DM stated all dietary staff were trained on pureed food standards and would receive updated training as soon as possible. The DM stated it was important for pureed food to be at a smooth, creamy texture to prevent choking hazards for residents who may have trouble swallowing. During an interview on 08/21/2025 at 2:26 PM, the DON stated the dietary staff were responsible for preparing and serving pureed foods to residents receiving a puree diet. The DON stated she was unsure of how many residents received a puree diet, but she could confirm one resident received a puree diet. The DON stated it was her expectation that pureed foods were at a soft, baby food consistency, without chunks. The DON stated she was not aware the puree foods were not a smooth form and contained chunks. The DON stated if the puree contained chunks and was not at a smooth, baby food consistency, it could have placed residents who required a pureed diet, at risk of choking. During an interview on 08/21/2025 at 3:11 PM, the ADM stated the DM, and dietary staff were responsible for ensuring puree foods were served adequately to residents with a pureed diet. The ADM stated pureed form should have been a smooth baby food consistency, with no chunks. The ADM stated she was no aware the pureed food items were not at a consistent smooth form. The ADM stated it was her expectation for all dietary and nursing staff to ensure the food served to residents was consistently prepared for the resident's dietary needs. The ADM stated it was important for pureed food to be prepared properly since residents with a pureed diet may be at risk for pocketing food and/or choking due to difficulty swallowing. Record review of facility document titled, Puree Diet, undated, revealed the following: Description: The diet is soft in texture and mechanically nonirritating. Foods prepared on the Pureed Diet follow the [NAME] Healthcare/[NAME] Senior Dining Puree program. Select foods are allowed in their natural state provided they do not require additional mastication (e.g., Cottage cheese, scrambled eggs, etc.). Instructions: The Pureed diet is used for patients who have problems chewing and swallowing and patients who have esophageal inflammation or varices.		