

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: 675201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Hillside Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S. Highway 36 Bypass Gatesville, TX 76528	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure assessments accurately reflected the resident's status for three (Residents #16, #28, and #91) of eight residents reviewed for accuracy of assessments. 1. The facility failed to ensure Resident Residents #16's Comprehensive MDS assessment dated [DATE] accurately reflected that the resident was on a CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open). 2. The facility failed to ensure Resident Residents #28's Comprehensive MDS assessment dated [DATE] accurately reflected that the resident was on a BiPAP (bilevel positive airway pressure: normalizes breathing by delivering pressurized air into the upper airway leading into the lungs). 3. The facility failed to ensure Resident Residents #91's Comprehensive MDS assessment dated [DATE] accurately reflected that the resident was on a CPAP. These failures could place the resident at risk for not receiving care and services to meet their needs, diminished function of health, and regression in their overall health. Findings included: 1. Record review of Resident #16's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Record review of Resident #16's Comprehensive MDS Assessment, dated 10/24/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 14. The Comprehensive MDS Assessment did not indicate the resident was using a CPAP. Record review of Resident #16's Comprehensive Care Plan, dated 09/29/2025, reflected the resident had sleep apnea and one of the interventions was to assist with CPAP equipment each time. Record review of Resident #16's Physician Order, dated 12/01/2025, reflected CPAP = Resident to wear CPAP @ bedtime, set at 6. Check placement, setting and functioning daily. Record review of Resident #16's Physician Order on 12/10/2025 reflected that the resident had been with CPAP since April 2025. An observation on 12/10/2025 at 9:02 AM, revealed Resident #16 was not inside her room. A CPAP machine was observed behind the resident's recliner chair. In an interview on 12/10/2025 at 9:36 AM, LVN M stated Resident #16 started using a CPAP maybe for 6 months. She said the resident would usually put her CPAP behind her chair. In an interview on 12/10/2025 on 1:36 PM, Resident #16 stated she had been using a CPAP for about five to six months. She said she used it every night. 2. Record review of Resident #28's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea. Record review of Resident #28's Comprehensive MDS Assessment, dated 09/22/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident was using a BiPAP. Record review of Resident #28's Comprehensive Care Plan on 12/09/2025, reflected the resident did not have a care plan for BiPAP. Record review of Resident #28's Physician Order, dated 04/21/2025, reflected BiPAP = Resident to wear BiPAP at night set at 14/7. Check placement, setting and functioning daily. every night shift. Observation on 12/09/2025 at 9:15 AM, revealed Resident #28 was not inside the room. It was observed that the resident had a BiPAP machine at his side table. In an interview on 12/09/2025 at 9:27 AM, LVN B stated Resident #28 had been using a BiPAP for almost six months. In an interview (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 12/10/2025 at 10:09 AM, Resident #28 stated he had been using his BiPAP for months but he cannot remember the exact number of months. 3. Record review of Resident #91's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea. Record review of Resident #91's Comprehensive MDS Assessment, dated 10/24/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident was using a CPAP. Record review of Resident #91's Comprehensive Care Plan on 11/18/2025, reflected the resident did not have a care plan for CPAP. Record review of Resident #91's Physician Order, dated 12/01/2025, reflected CPAP = Resident to wear CPAP at night, 13/16. Check placement, setting and functioning daily. every night shift. Record review of Resident #91's Physician Order on 12/10/2025 reflected that the resident had been using a CPAP since June 2025. Observation on 12/10/2025 at 9:42 AM, revealed Resident #91 was not inside her room. A CPAP machine was observed on top of the resident's side table. In an interview on 12/10/2025 at 9:48 AM, Resident #91 said she had been using a CPAP since June if she was not mistaken. During an observation and interview on 12/10/2025 at 11:47 AM, MDS Nurse K stated that she was the one responsible in doing the residents' MDS. She said she did not know that Residents #16, #28, and #91 were using CPAPs and a BiPAP. She checked the resident's orders and saw that Resident #28 had an order for BiPAP and both Resident #16 and Resident #91 both had orders for CPAP. She checked the residents' MDS and saw that the residents was not coded for CPAP and BiPAP. She said she could not click CPAP and BiPAP because they were grayed out. She then pulled an RAI Guidelines. She said she would do the corrections and would re-submit the MDS. She said the MDS was for reimbursement but also to assess the residents' medical status. She said she would fix her oversight. In an interview on 12/11/2025 at 9:10 AM, ADON A stated she was not familiar with the MDS but if some residents was using CPAPs and a BiPAP, then it should be reflected in the residents' MDS. She said the MDS Coordinator was responsible for doing the MDS and if the assessment in the MDS was not accurate, the care given to the residents might not be accurate. In an interview on 12/11/2025 at 9:34 AM, the DON stated if the residents was using a BiPAP and CPAPs, their MDS should reflect that they were using them because sometimes the MDS was the basis of what should be included in the care plan. She said she would coordinate with the MDS Coordinator to fix the issue and audit the MDS of the residents. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated if the MDS needed to reflect that a resident had a CPAP or a BiPAP, then the residents MDS should display it. She said she would coordinate with the DON on how to go through the issue. Record review of the facility policy, Accuracy of Assessments undated, reflected The assessment must accurately reflect the resident's status. Record review of the facility policy, Use of the Comprehensive Assessment undated, reflected The results of resident comprehensive assessments shall be used to develop, review, and revise each resident's plan of care.		

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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 observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Residents #28, #46, and #91) of twelve residents reviewed for respiratory care. 1. The facility failed to ensure Resident #28's mask for BiPAP (bilevel positive airway pressure: normalizes breathing by delivering pressurized air into the upper airway leading into the lungs) was properly stored when not in use on 12/09/2025. 2. The facility failed to ensure Resident #46's breathing mask was properly stored when not in use on 12/09/2025. 3. The facility failed to ensure Resident Residents #91's CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) was properly stored when not in use on 12/10/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #28's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea. Record review of Resident #28's Comprehensive MDS Assessment, dated 09/22/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident was using a BiPAP. Record review of Resident #28's Comprehensive Care Plan on 12/09/2025, reflected the resident did not have a care plan for BiPAP. Record review of Resident #28's Physician Order, dated 04/21/2025, reflected BiPAP = Resident to wear BiPAP at night set at 14/7. Check placement, setting and functioning daily. every night shift. Record review of Resident #28's Progress Notes on 12/09/2025, reflected that there was no documentation that the resident was refusing to put his BiPAP in a plastic bag. Observation on 12/09/2025 at 9:15 AM, revealed Resident #28 was not inside the room. It was observed that the resident had a BiPAP machine on top of his bedside table with a mask connected to it, the mask was not bagged. In an interview on 12/09/2025 at 9:27 AM, LVN B stated Resident #28's BiPAP mask should be bagged to prevent respiratory infection. She said the resident was peculiar with his things and wanted it placed in certain areas. In an interview on 12/10/2025 at 10:09 AM, Resident #28 stated that nurses would put on his BiPAP and they were the one taking it off. He said he was quadriplegic and it would be difficult for him to put his BiPAP on or took it off. He said he would sometimes refuse to put on his BiPAP but he never told them to not bag his mask. 2. Record review of Resident #46's Face Sheet, dated 12/09/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with respiratory failure. Record review of Resident #46's Comprehensive MDS Assessment, dated 10/07/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had respiratory failure. Record review of Resident #46's Comprehensive Care Plan on 10/22/2025, reflected the resident used oxygen therapy and one of the interventions was to administer bronchodilators as ordered. Record review of Resident #46's Physician Order, dated 09/25/2025, reflected Ipratropium-Albuterol Solution 0.5 - 2.5 (3) MG/3ML 1 unit inhale orally via nebulizer three times a day for Medical Condition related to ACUTE AND CHRONIC RESPIRATORY FAILURE WITH HYPOXIA (insufficient amount of oxygen in the body). Document V/S, lung sounds, and minutes spent prior to and post administration. During an observation and interview on 12/09/2025 at 9:11 AM, revealed Resident #46 was in her bed, awake. A nebulizer machine was on top of the resident's side table with a breathing mask attached. It was observed that the breathing mask was not bagged. Resident #46 said the nurse put it on every morning and the nurse also took it off. In an interview on 12/10/2025 at 9:27 AM, LVN B stated she administered Resident #46's breathing treatment and she was the one who took it off. She said she place the breathing mask on top of the nebulizer and did not bag it, she said it should be bagged to keep it clean. She said she would get a plastic bag for the resident's breathing (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mask. She said she would also clean the mask before putting it inside a plastic bag. 3. Record review of Resident #91's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea. Record review of Resident #91's Comprehensive MDS Assessment, dated 10/24/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident was using a CPAP. Record review of Resident #91's Comprehensive Care Plan on 11/18/2025, reflected the resident did not have a care plan for CPAP. Record review of Resident #91's Physician Order, dated 12/01/2025, reflected CPAP = Resident to wear CPAP at night, 13/16. Check placement, setting and functioning daily. every night shift. Observation on 12/10/2025 at 9:42 AM, revealed Resident #91 was not inside her room. A CPAP machine was observed on top of the resident's side table with a mask attached to it, the CPAP mask was not bagged. During an observation and interview on 12/10/2025 at 9:44 AM, ADON L stated the CPAP mask should be inside a bag to prevent infection and to prevent it from falling to the floor. She went inside Resident #91's room and saw that the resident's CPAP was not bagged. She said the resident would sometimes take off her CPAP mask but the staff should be monitoring more if the CPAP was bagged. She said she would get a bag for the resident's CPAP mask. In an interview on 12/10/2025 at 9:48 AM, Resident #91 said she had been using a CPAP since June if she was not mistaken. She said she would sometimes take it off because no one would take it off. She said nobody told her to put it inside a bag. The resident then asked if she was the one responsible for putting her mask inside a bag. In an interview on 12/10/2025 at 10:04 AM, LVN E stated she should monitor if Resident #91's CPAP mask was bagged or not. She said the CPAP mask should be bagged when not in use to prevent any infection. In an interview on 12/11/2025 at 9:10 AM, ADON A stated the breathing mask, CPAP mask, and BiPAP mask should be bagged when not in use to prevent any respiratory infection and prevent cross contamination. She said the staff were responsible in bagging the masks. She said if the residents would sometimes take it off, the more the staff should check it. She said the expectation was for all the masks to be bagged when not in use. She said they already started an inservice about bagging the masks when not in use. In an interview on 12/11/2025 at 9:34 AM, the DON stated the breathing mask, CPAP mask, and BiPAP mask should be inside a plastic bag when not in use and not just hanging around or on top of the table, to maintain its cleanliness as well as its patency. She said bagging the masks was important to prevent the development of infections. She said she was responsible for making sure the staff was bagging the masks. She said the expectation was for the staff to bag the mask after taking it off and to monitor if the masks was bagged. She said she already started an in-service about bagging the masks when not in use. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated that the masks should be bagged when not in use to prevent cross contamination and respiratory infection. She said the expectation was that the staff would be compliant in bagging the masks of the residents. She said she would coordinate with the DON and the ADONs to make sure that the staff was following the in-service about bagging the masks. Policy for bagging the masks requested via email on 12/10/2025 at 11:20 AM and on 12/11/2025 at 11:15 AM but was not provided prior to date and time of exit.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #80) of eighteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident 80's room was in a position that was accessible to the resident on 12/09/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Record review of Resident #80's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness, hemiplegia (paralysis of one side of the body), and hemiparesis (weakness on one side of the body). Record review of Resident #80's Comprehensive MDS Assessment, dated 10/27/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 05. The Quarterly MDS Assessment indicated the resident required maximal assistance for shower, dressing, bed mobility and transfer. Record review of Resident #80's Comprehensive Care Plan, dated 11/03/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach. During an observation and interview on 12/09/2025 on 9:38 AM, revealed Resident #80 was in her bed, awake. It was observed that the resident's call light was on top of the resident's side table along with the resident's leg rest for her wheelchair. When asked where her call light was, the resident looked at her side and then shrugged her shoulders. During an observation and interview on 12/09/2025 at 9:43, LVN C stated the call lights should be with the residents at all times in case the residents needed to call the staff for assistance. She checked on Resident #80 and saw the resident's call light on the side table below the resident's leg rests for the wheelchair. She took the call light and placed where the resident could reach it. She said the resident was transferred after eating breakfast and the aides maybe forgot to place it where the resident could reach it. She said she would talk to CNA F about the call light. In an interview on 12/09/2025 at 9:52 AM, CNA F stated she and CNA G transferred Resident #80 to her bed after breakfast. She said she left the room after the transfer and left CNA G with the resident. She said she should have made sure that the call light was with the resident before leaving the room or at least reminded CNA G to place the resident's call light within reach. She said the call lights should be within reach in case the resident needed something. She said the call lights were for all the residents. she said the CNAs and the nurses were responsible in ensuring the call lights were with the residents. In an interview on 12/09/2025 at 12:08 PM, CNA G stated he did transfer Resident #80 to her bed after breakfast and he cannot remember if he placed the resident's call light when he left the room. He said the call lights should be with the residents because the residents used the call lights to call the staff if they needed assistance. In an interview on 12/11/2025 at 9:10 AM, ADON A stated the call lights should always be with the residents in case they needed assistance with something like a refill of water or the resident needed a pain medication. She said when a resident was already in the wheelchair, the call light should be on top of the bed so the resident could still call the staff if needed. She said the staff should make sure that the call lights were with the residents before they left the room. She said they already started an in-service about call light within reach at all times. In an interview on 12/11/2025 at 9:34 AM, the DON stated call lights were inside the residents' rooms so they can call the staff for assistance, for pain medication, or because they wanted to get up. The DON said if the call lights were not within reach, their needs would not be met and the residents might get upset because there was no way to call the staff. The DON said all the staff were responsible for the call lights. The DON said the expectation was for the staff to scan the residents' room when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. she said she already started an in-service about call lights within reach. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated call lights (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be with the residents all the time in case they need help. She said the call lights were for all the residents whether dependent or independent. She said the aides where primarily responsible for the call lights but everybody was responsible in making sure the call lights were with the residents to prevent any falls. She said she would coordinate with the DON and the ADONs to make sure that the staff were following the in-service about call lights. Record review of the facility's policy, Call Lights undated reflected Purpose: To respond to a resident's call light for their needs . Procedure . 9. The call light must always be within resident's reach before you leave the room.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident had a right to confidentiality of his or her personal and medical records for one (Resident #84's) of ten residents reviewed for privacy and confidentiality. The facility failed to ensure LVN B would not disclose Resident #84's medical treatment to her roommate on 12/09/25. This failure could place the residents at risk of their medical information or treatment being disclosed to unauthorized individuals. Findings included: Record review of Resident #84's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). The Face Sheet did not indicate that Resident #84's roommate was her responsible party. Record review of Resident #84's Comprehensive MDS Assessment, dated 10/08/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated that the resident had diabetes mellitus and was receiving insulin. Record review of Resident #84's Comprehensive Care Plan, dated 11/24/2025, reflected the resident had diabetes mellitus and one of the interventions was to administer diabetes medication as ordered. Record review of Resident #84's Physician Order, dated 12/01/2025, reflected Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject 3 unit subcutaneously before meals for DM2 (adult-onset diabetes). Record review of Resident #84's Physician Order, dated 12/01/2025, reflected FINGERSTICK BLOOD SUGAR . Document results. An observation on 12/09/2025 at 11:12 AM, revealed that LVN B was about to check Resident #84's blood sugar. She prepared the things needed for blood sugar and went inside the resident's room. Resident #84 was in her wheelchair and had a roommate that was still in her bed. LVN B pulled the privacy curtain between the two residents. When she was about to start to prick Resident #84, the roommate coughed, LVN B pulled the curtain a little bit to check on the roommate. The roommate said she was ok. At that point, the roommate asked LVN B what was she doing, LVN B replied, I am getting her blood sugar. LVN B proceeded to check the blood sugar. LVN B did not ask Resident #84 if it was ok to tell her roommate what treatment she was currently getting. In an interview on 12/09/2025 at 11:24 AM, LVN B stated, She should have not answered the roommate. She said getting the blood sugar is medical treatment and should not be disclosed when asked by anybody that did not have anything to do with Resident #84's care. She said it would not be an issue if it was Resident #84 who replied to the roommate. She said she should be mindful before replying casually to questions about a resident's medical condition or treatment because their medical information should be confidential. In an interview on 12/11/2025 at 9:10 AM, ADON A stated getting a blood sugar was a medical procedure and Resident #84's roommate was not her responsible party. She said LVN B should have just replied that she was just doing something. She said it did not matter if the resident's roommate already knew that Resident #84 was receiving insulin but the mere fact that a staff disclosed a medical procedure to somebody that had nothing to do with the resident's care could be a HIPAA violation. She said even though the facility was a close-knitted facility, there should be a line drawn between being familiar with each other and what should be disclosed. She said they already started an in-service regarding HIPAA. In an interview on 12/11/2025 at 9:34 AM, the DON stated personal and medical information about a resident should not be disclosed to anybody that had nothing to do with the resident's care. She said the Resident #84's roommate was not her responsible party and the staff should not have told the roommate what she was doing. She said the staff should have not answered or should have replied that she was just doing something. She said it was just like leaving the computer open and somebody, who was unauthorized, saw that the resident needed her blood sugar to be checked. She said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said all employees were expected to provide full privacy and confidentiality of information for all residents. (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated she already started an in-service about HIPAA. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated the staff should not disclose any medical information about a resident to another resident or other individuals that had nothing to do with a resident's care. She said, maybe, the staff and the residents in the facility became like family and it did not don on the staff that she was releasing information that was not supposed to be disclosed. She said she knew an in-service about HIPAA was already initiated but she would coordinate with the DON and the ADONs to monitor the staffs' compliance in providing privacy and confidentiality. Record review of the facility's policy, General Staff Responsibilities undated reflected, All staff are responsible for safeguarding the privacy of resident health information. Specific staff responsibilities under these privacy policies and procedures will be listed in the staff member's job description All staff members must . 1. Use and disclose protected health information only as authorized in their job description or as authorized by a supervisor . 2. Conduct oral discussions of personal health information with other staff or with patients and family members in a manner that limits the possibility of inadvertent disclosures.		

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NAME OF PROVIDER OR SUPPLIER Hillside Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S. Highway 36 Bypass Gatesville, TX 76528	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interviews, and record review, the facility failed to develop a complete care plan that meets all of a resident's needs, with timeframes and actions that can be measured for two (Resident #28 and #91) of twelve residents reviewed for care plans. 1. The facility failed to ensure Resident #28 was care planned for a BiPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) on 12/09/2025. 2. The facility failed to ensure Resident #91 was care planned for a CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) on 12/09/2025. These failures could place the residents at risk of not receiving the necessary care and services required. Findings include: 1. Record review of Resident #28's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea. Record review of Resident #28's Comprehensive MDS Assessment, dated 09/22/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident was using a BiPAP. Record review of Resident #28's Comprehensive Care Plan on 12/09/2025, reflected the resident did not have a care plan for BiPAP. Record review of Resident #28's Physician Order, dated 04/21/2025, reflected BiPAP = Resident to wear BiPAP at night set at 14/7. Check placement, setting and functioning daily. every night shift. Observation on 12/09/2025 at 9:15 AM, revealed Resident #28 was not inside the room. It was observed that the resident had a BiPAP on top of his bedside table. In an interview on 12/09/2025 at 9:27 AM, LVN B stated Resident #28 had been using a BiPAP for almost six months. In an interview on 12/10/2025 at 10:09 AM, Resident #28 stated he had been using his BiPAP for months, but he cannot remember the exact number of months. 2. Record review of Resident #91's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea. Record review of Resident #91's Comprehensive MDS Assessment, dated 10/24/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident was using a CPAP. Record review of Resident #91's Comprehensive Care Plan on 11/18/2025, reflected the resident did not have a care plan for CPAP. Record review of Resident #91's Physician Order, dated 12/01/2025, reflected CPAP = Resident to wear CPAP at night, 13/16. Check placement, setting and functioning daily. every night shift. Record review of Resident #91's Physician Order on 12/10/2025 reflected that the resident had been with CPAP since June 2025. Observation on 12/10/2025 at 9:42 AM, revealed Resident #91 was not inside her room. A CPAP machine was observed on top of the resident's side table. In an interview on 12/10/2025 at 9:48 AM, Resident #91 said she had been using a CPAP since June if she was not mistaken. During an observation and interview on 12/10/2025 at 11:47 AM, MDS Nurse K stated that she was the one responsible in doing the care plans of the residents. She opened the profile of Residents #28 and Resident #91 and saw that the residents had orders for a BiPAP and CPAP. She then checked the residents' care plans and saw that the residents did not have a care plan for CPAP and BiPAP. She said a care plan is a reflection of a resident's care and services being provided by the staff. She said it indicated the observations done by the staff to be able to provide the best care possible. She said if there was no care plan, the staff might miss something and the residents' needs will not be addressed. She said it was an oversight on her part that the said residents was not care planned for CPAP and BiPAP. She said she would add the needed care plans. In an interview on 12/11/2025 at 9:10 AM, ADON A stated everything done for the residents should be care planned to make sure the residents were being taken care for and were receiving the care needed. She said if residents had a CPAP and a BiPAP, then there should be a care plan for the CPAP and BiPAP. She said care plans should be in place so that the staff were in sync with the care being provided to the (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Hillside Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S. Highway 36 Bypass Gatesville, TX 76528	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. In an interview on 12/11/2025 at 9:34 AM, the DON stated care plans should be in place so that the staff caring for the resident would be on the same page. She said if the resident had a CPAP and a BiPAP, then there should be a care plan for CPAP and BiPAP. She said every resident needed a comprehensive care plan to ensure the residents received the care needed and appropriate to their current conditions and functionality. She said the care plans reflect the resident's problem lists, the goals, and the interventions. She said without the care plan, there could be confusion with the care needed by the residents. She said the expectation was every resident had detailed care plans and they should be reflected on their profile. She said she would coordinate with the MDS Nurse to audit the care plans of the residents. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated the expectations was the residents should be care planned accordingly to make sure the needed care were provided. She said she would coordinate with the DON about the issue. Record review of facility's policy, Comprehensive Person-Centered Resident Care Planning undated, reflected A comprehensive person-centered care plan is developed and implemented for each resident . to include measurable short-term and long-term objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one (Resident #8) of two residents reviewed for feeding tube (a way of providing nutrition directly to the stomach). The facility failed to ensure LVN D would flush the g-tube (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach) before administering medications and flush after with the amount indicated in the physician order on 12/10/2025. This failure could place residents with g-tubes at risk for blockage, aspiration, discomfort, and overhydration. Findings included: Record review of Resident #8's Face Sheet, dated 12/10/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #8's Comprehensive MDS Assessment, dated 07/28/2025, reflected the resident had a severe impairment in cognition with a BIMS score. The Comprehensive MDS Assessment indicated the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #8's Comprehensive Care Plan, dated 07/28/2025, reflected the resident required a peg-tube (a flexible feeding tube inserted directly to the stomach) and one of the goals was the resident would not experience adverse effects. Record review of Resident #8's Physician Order, dated 12/01/2025, reflected every shift G-TUBE (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) - MED ADMINISTRATION = Flush w/30cc H2O BEFORE med administration. Give EACH medication separately, mixed w/small amount H2O to mix/dissolve. Flush BETWEEN EACH MED w/5 - 30 ml H2O. Flush w/30cc H2O AFTER med administration. Record review of Resident #8's Physician Order, dated 12/09/2025, reflected Dantrolene Sodium Oral Capsule 25 MG (Dantrolene Sodium). Give 2 capsule via PEG-Tube three times a day for muscle relaxer. Record review of Resident #8's Physician Order, dated 12/09/2025, reflected Baclofen Oral Tablet 20 MG (Baclofen) Give 1 tablet via PEG-Tube three times a day for contractures (tightening or shortening of the muscles). During an observation and interview on 12/10/2025 at 1:09 PM, revealed LVN D was about to administer Resident #8's medication via g-tube. She said she would be administering two medications for the resident. LVN D sanitized her hands and put on a pair of gloves. She placed the medications in a cup separately, crushed one of the medications, and returned the crushed medication to its respective small plastic cup. One of the medications was a capsule, she opened it and placed its content in a cup. She placed what she prepared on a tray, went inside the room, and placed the tray on top of the resident's overbed table. She also brought with her a cup of water and placed it on the tray. She put on a gown, raised the resident's bed and took the g-tube from the abdominal binder. She then pulled the plunger (movable part of the syringe that pulls or pushes liquid into the syringe) of a 60 ml piston syringe and connected it to the g-tube. She pushed the plunger to check the placement of the g-tube and then pulled the plunger to check for the residual. She disconnected the syringe and pulled the plunger all the way and connected the syringe without the plunger. She then put approximately 10 ml of water on each medication and stirred them using the plastic spoon. She then started to administer the first medication and then flushed it with 15 ml of water. she did not flush the g-tube before administering the first medication. She then gave the second medication and flushed it with 15 ml of water. After flushing with 15 ml of water, she said she would flush it again. She flushed the g-tube with 30 ml of water for four times totaling to 120 ml. After flushing the g-tube, she put back on the abdominal binder, washed her hands, and cleaned the syringe. During an observation and interview on 12/10/2025 at 1:32 PM, LVN D stated she was supposed to flush the g-tube with warm water before medication administration to make sure that the tube was not clogged. She said she was not sure why she forgot to flush it before administering the first medication. She opened Resident #8 profile (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and saw the order to flush 30 ml before medication administration. She also saw to flush 30 ml after medication administration. She said she flushed 120 ml. She said she needed to follow the order to prevent aspiration. She said too much water could also cause fluid overload and bloating of the stomach. In an interview on 12/11/2025 at 9:10 AM, ADON A stated it was important to flush the g-tube to prevent clogging the tubing and to make sure that the medications administered went through. She said there was certain amounts of water ordered for flushing before and after medication administration and in between medications. She said more than or less than the ordered amount of water could have an effect on the resident. She said less fluid could cause dehydration and more water could cause fluid overload, vomiting, and aspiration. She said flushing a medication with more than 100 ml of water was not right. She said an in-service was already initiated regarding medication administration via g-tube and about following the physician's order. In an interview on 12/11/2025 at 9:34 AM, the DON stated there was a specific amount of water incorporated during medication administration via g-tube to avoid dehydration, overhydration, and aspiration. Too much water given for one flushing could lead to aspiration. She said the g-tube should be flushed before giving the medications to make sure the tube was not clogged. She said the expectation was that the staff would flush the g-tube before medication administration and to use the required amount of water for flushing. She said she already started an in-service about g-tube focusing on flushing before administering medications and about using the amount of water for flushing as ordered. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated the expectation was for the staff to follow the right procedure in administering medications via g-tube and to follow the physician's order. She said she was not a clinician and would let the DON and the ADONs take the lead in educating the staff about the issue. Record review of the facility's policy Tube (Medication Administration) undated, reflected Purpose: To safely and accurately administer medications to residents who receive their entire oral intake via enteral feeding tube . 10. Flush tube with at least 5cc of water prior to medication administration . 15. Flush the tube with water and clamp to prevent medication from clogging tube.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for one (Resident #100) of twenty residents reviewed for pharmaceutical services. The facility failed to ensure MA J did not leave Resident #100's Arginine inside the room for the resident to take by herself on 12/09/2025. This failure could place residents at risk of not receiving medications as ordered, potential overdose, and adverse effects. Findings include: Review of Resident #100's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hyponatremia (lower than normal level of sodium in the bloodstream). Review of Resident #100's Comprehensive MDS Assessment, dated 12/11/2025, reflected the resident had a severe impairment (requires significant assistance and support in daily life) in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had hyponatremia. Review of Resident #100's Comprehensive Care Plan, dated 12/08/2025, reflected the resident had a potential for weight loss and one of the interventions was to administer supplement as ordered. Record review of Resident #100's Physician Order, dated 12/08/2024, reflected Arginine Supplement Powder two times a day for RISK OF PROTEIN CALORIEMALNUTRITION/PROMOTE WOUND HEALING 1pkt mixed in 4-6 oz H2O. Observation and interview on 08/17/2025 at 7:09 AM, revealed Resident #100 in her wheelchair, awake. It was observed that a cup of colored liquid was on top of the resident's overbed table. During an observation and interview on 12/09/2025 at 10:19 AM, LVN B stated the cup of colored liquid might be the protein supplement for Resident #100. She said the resident said she did not like it. She said the liquid was a supplement administered for weight loss and also to promote healing of wounds. She said it should not be left inside the room and whoever administered it should have waited for the resident to take it before leaving the room. She said other resident might consume it and might have an allergic reaction to it. She took the cup of colored liquid and threw it in the sink. In an interview on 12/09/2025 at 12:53 PM, MA J stated she was the one who left the arginine supplement inside Resident #100's room. She said she should have waited for the resident to drink it before leaving the room to make sure that the resident was the one who drank the supplement and not other residents. She said she would also know if the resident was drinking it or was refusing to drink it or had difficulty in swallowing. In an interview on 12/11/2025 at 9:10 AM, ADON A stated leaving any form of medication inside the room was a no-no because a lot of things could happen. She said the resident might choke and nobody would be there to help her. She said the staff should wait for the resident to be done taking the medication before leaving the room. She said arginine was a protein supplement that was being administered by the staff meaning the staff was responsible in making sure that the resident took it. She said confused residents might enter other residents' rooms and take the medication. She said the DON already initiated an in-service about medication administration and she already a one-on-one in-service with MA J. In an interview on 12/11/2025 at 9:34 AM, the DON stated the staff should never leave any form of medication inside the resident's room for them to take unsupervised. She said the resident might not take them, hide them, or take them with them along with the next dose. She said the resident could overdose or their underlying conditions were not getting well because they were not taking the medications. He said the staff should make sure that the medications, or even supplements, were consumed before leaving the room. She said she already initiated an in-service pertaining to not leaving any medication with the resident to take unsupervised. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated no medications should be left inside the room for the resident to take unsupervised because the resident might overmedicate, not (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take it, or just throw it. She said the expectation was for the staff not to leave any medication inside the room for the resident to administer by himself. She said the DON already started an in-service about not leaving the medications with the resident, but she would closely coordinate with them that this incident would never happen again. Policy for not leaving medications inside the rom unattended requested via email on 12/10/2025 at 11:20 AM and on 12/11/2025 at 11:15 AM but was not provided prior to date and time of exit.		

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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 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 two (Resident #8 and Resident 100) of twelve residents reviewed for infection control. 1. The facility failed to ensure CNA F and CNA G wore gowns and gloves while transferring Resident #8, who had a g-tube, on 12/10/2025. 2. The facility failed to ensure LVN C performed hand hygiene while connecting Resident #100's IV on 12/09/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #8's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia. Review of Resident #8's Comprehensive MDS Assessment, dated 09/18/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube and was dependent on staff for transfer. Review of Resident #8's Comprehensive Care Plan, dated 10/01/2025, reflected the resident required a PEG tube and one of the interventions was to give enteral formula as ordered. The Care Plan indicated that the resident was dependent with ADLs and one of the interventions was to transfer via mechanical lift (a device used to lift, transfer, or position an individual with limited mobility). Observation on 12/10/2025 at 10:23 AM, revealed that CNA F and CNA G was about to transfer Resident #8 to his wheelchair via mechanical lift. The CNAs sanitized their hands before going inside the room. Upon entering, both CNAs went straight to the resident's bedside and started to prepare the resident for transfer. Neither of the CNAs put on gowns and gloves. Without any gloves and gowns on, CNA F went to the resident's left side and CNA G went to the right side. CNA G rolled the resident towards CNA F while CNA F assisted in rolling the resident. CNA G put the mechanical sling under the resident while CNA F was holding the resident. After putting the sling underneath the resident, both CNAs was about to roll the resident to the other side when Lead CNA N, who was also inside the resident's room, stopped them and told them to repeat the process. At this point the CNAs already had contact with the resident. It was observed that there was sign outside the resident's door that the resident was on enhanced barrier protection. It was also observed that there was a PPE cart inside the resident's room. In an interview on 12/10/2025 at 10:27 AM, Lead CNA N stated she stopped the transfer because the CNAs did not have any gloves and gowns on. She said she reviewed the process with the CNAs before transferring Resident #8 and they still forgot. She said the CNAs should be wearing gloves and gowns because the resident was on EBP due to his g-tube. She said there was also a sign outside indicating EBP should be practiced. She said PPE should have been worn to prevent any cross contamination. In an interview on 12/10/2025 at 10:39 AM, CNA G stated he should have worn a gown and gloves because Resident #8 had a g-tube and there was a sign outside the resident's door to remind them to put on a PPE. He said gloves and gowns was required to prevent cross contamination. In an interview on 12/10/2025 at 10:41 AM, CNA F stated she forgot to put on a pair of gloves and a gown before touching the resident because the resident was on EBP and required PPE when having contact with the resident. She said the resident had a g-tube and she should have worn a gown and gloves to prevent any transfer of microorganism. 2. Review of Resident #100's Face Sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with infection due to left internal hip prosthesis. Review of Resident #100's Comprehensive MDS Assessment, dated 12/11/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had an infection due to left hip prosthesis. Review of Resident #100's Comprehensive Care Plan, dated 12/08/2025, reflected the resident was receiving IV antibiotics and one of the interventions was to administer medications as ordered. Record review of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #100's Physician Order, dated 12/08/2024, reflected Vancomycin HCl in NaCl Intravenous Solution 1.25-0.9 GM/250ML-% (Vancomycin HCl-Sodium Chloride) Use 1.25 gram intravenously one time a day for INFECTED THA until 12/30/2025 08:59 RUN OVER 90 MINUTES . Administer Vanc between 830 and 840 on those days. Observation and interview on 08/17/2025 at 7:09 AM, revealed Resident #100 in her wheelchair, awake. It was observed that the resident had a PICC line to right upper arm. The resident said she had a PICC line because she was receiving an antibiotic for her infection due to her prosthesis. Observation on 12/09/2025 at 10:07 AM, revealed LVN B was about to connect Resident #100's IV. She washed her hands before putting on a pair of gloves and a gown. She then incorporated 250 ml of normal saline to the vancomycin powder to reconstitute it. She placed the antibiotics and the IV administration set in a tray and placed the tray on the resident's overbed table. She then realized the trash can was far from her. She took the trash can and placed it near her. She removed her gloves and put on a new pair of gloves. She did not sanitize her hands before putting on a new pair of gloves. She proceeded to connect the IV. In an interview on 12/09/2025 at 10:19 AM, LVN B stated hands should be sanitized before putting on a new pair of gloves, especially that she touched a trash can. She said sanitizing hands was to prevent any cross contamination and probable infection. In an interview on 12/11/2025 at 9:10 AM, ADON A stated staff must do hand hygiene before putting on a new pair of gloves to make sure that their hands was clean before touching the new pair of gloves, especially if the staff touched the trash can. She said the resident was being treated for infection and the staff should make sure that nothing could cause additional contamination. She said in transferring a resident with a g-tube, the CNAs should wear gowns and gloves. She said she did not even know why the CNAs did not even put on any gloves. She said there was a sign outside the door that Resident #8 was on EBP and required PPE when handling the residents. She said, even though somebody stopped the procedure, the CNAs already touched the resident without any gloves and gown. She said deviation from the said procedures could result to cross contamination and development of infection. She said the expectation was for the staff to be mindful and compliant with the policy of infection control. She said they already started an in-service about infection control, enhanced barrier precaution, and hand hygiene as soon as they heard the issues. In an interview on 12/11/2025 at 9:34 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said hands should be sanitized before donning a new pair of gloves to make sure the hands was clean when touching the new pair of gloves, especially after handling something soiled. She said a trash can was always deemed dirty so after touching it, the staff should have sanitized her hands before putting a pair of gloves. She said when transferring a resident with g-tube, the staff should wear a PPE, specifically gowns and gloves. She said the resident was on EBP and there was a sign outside to remind the staff to wear gowns and gloves when handling the resident. She said she heard that the process of transferring was halted but it was too late because the CNAs already touched the resident. She said the issues discussed could contribute to cross contamination, development of infection, and spread of infection. She said the expectation was for the staff to take the in-services seriously and compliant with it. She said the staff should do better to ensure they were providing the best care. She said she already started an in-service about infection control. She said she would do a check-off about infection control. In an interview on 12/11/2025 at 9:50 AM, the Administrator stated the expectation was for the staff to follow to the guidelines of infection control. She said hand hygiene should be done before putting on a new pair of gloves and PPE should have been worn when required. She said the staff should always make sure that not following the policy for infection control could be disadvantageous for the residents. She said she knew an in-service about infection control was already initiated but she would coordinate with the DON and ADONs to do monitor the staffs' compliance to the policy of infection control. Record review of the facility's policy, ENHANCED BARRIER PRECAUTIONS (EBP) INFECTION PREVENTION AND CONTROL PROGRAM undated, reflected EBP are indicated for residents with any of the following . indwelling medical device . Indwelling medical device examples include . feeding (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Hillside Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S. Highway 36 Bypass Gatesville, TX 76528	
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	tubes. Record review of the facility's policy, Handwashing INFECTION PREVENTION AND CONTROL PROGRAM undated, reflected Policy: and washing is required before and after a procedure that involves direct or indirect contact with a resident, after contact with any wastes or contaminated materials, before handling any food or food receptacle, or at any time the hands are soiled.		