

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: 675282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Amarillo Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 9 Medical Dr Amarillo, TX 79106	
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission for 4 (Resident #40, Resident #76, Resident #86, and Resident #97) of 19 residents reviewed for baseline care planning.1. The facility failed to include dialysis in Resident #40's baseline care plan.2. The facility failed to include a central line in Resident #76's baseline care plan.3. The facility failed to include a central line and a life vest in Resident #86's baseline care plan.4. The facility failed to include a PICC line in Resident #97's baseline care plan. These failures could place newly admitted residents at risk of not receiving safe, effective, person-centered care. Findings Included: 1. Record review of Resident #40's admission record dated 03/11/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, end stage renal disease (kidney failure) and dependence on renal dialysis (process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Record review of Resident #40's EHR under the MDS tab revealed an admission MDS assessment with an ARD of 02/27/26 that was labelled export ready. Resident #40 had a BIMS score of 13 which indicated intact cognition. Record review of Resident #40's baseline care plan initiated on 02/23/26 revealed no mention of dialysis except in the list of diagnoses at the bottom of the care plan where she was noted to have dependence on renal dialysis. The care plan included the following focus area: [Resident #40] Has nutritional problem or potential nutritional problem r/t . ESRD My current diet is LIBERALIZED RENAL diet . Record review of Resident #40's order summary report dated 03/11/26 revealed the following orders with corresponding order dates: 02/23/26 LIBERALIZED RENAL diet. 02/23/26 DIALYSIS COMMUNICATION FOMR TO BE COMPLETED AND FILED/SCANNED IN CHART ON DIALYSIS DAYS 02/24/26 [Name address and phone number of dialysis clinic] 02/23/26 HEMODIALYSIS 3X/WEEK EVERY T-TH-SAT @12PM. Record review of Resident #40's progress notes dated 02/09/26-03/12/26 revealed the following notes with corresponding dates and times: 02/23/26 at 05:45 PM . Genitourinary: Dialysis - while a Resident. 02/24/26 at 04:41 PM Res was taken to Dialysis, no new issues noted. During an observation and interview on 03/10/26 at 09:34 AM Resident #40 was seated in her wheelchair in her room. Her left upper wrist had what appeared to be lumpy bruising. When asked about the bruising, she stated, That is where I get dialysis. Resident #40 stated she went for dialysis three times a week on Tuesdays, Thursdays, and Saturdays. 2. Record review of Resident #76's admission record dated 03/11/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic osteomyelitis with draining sinus right ankle and foot (persistent bone infection that often requires surgical intervention and long-term antibiotic therapy), type 2 diabetes mellitus with foot ulcer (insufficient production of insulin, causing high blood sugar with a foot ulcer caused by nerve damage, poor circulation and high blood sugar), and non-pressure chronic ulcer of other part of right foot with unspecified severity (an ulcer on the right foot not caused (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 - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #42 and Resident #73) of 18 residents reviewed for accuracy of assessment. 1. The facility coded Resident #42 as not using tobacco when he was a smoker. 2. The facility coded Resident #73 as not using tobacco when he was a smoker. These failures to accurately assess residents could result in residents not receiving correct care and services. Findings Included: Resident #42 Record review of Resident #42's admission record dated 03/10/26 revealed a [AGE] year-old male most recently admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), muscle weakness (a lack of muscle strength), and shortness of breath. Record review of Resident #42's admission MDS assessment completed 12/27/25 revealed a BIMS score of 12 which indicated moderate cognitive impairment, Resident #42 was independent with most of his ADLs, and was listed as not using tobacco at this time. Record review of Resident #42's care plan completed on 12/23/25 revealed the following focus areas with corresponding initiation dates: 12/23/25 [Resident #42] has potential for injury r/t Smoking d/t impaired vision. Record review of Resident #42's Smoking Evaluation dated 12/23/25 revealed he smoked 6 times a day. Record review of Resident #42's Activity - admission Evaluation dated 12/26/25 revealed Smoking - Current. Description - resident attends smoke breaks that are monitored by staff. During an observation and interview on 03/10/2026 at 8:47 AM Resident #42 was observed in bed dressed well and in the process of transferring to his wheelchair. Resident #42 reported he was transferring to his wheelchair because the next smoke break was at 9:00 AM and he did not want to miss it. Resident #73 Record review of Resident #73's admission record dated 03/11/26 revealed a [AGE] year-old male most recently admitted to the facility on [DATE] with diagnoses that included, but were not limited to, impulsiveness, need for assistance with personal care, lack of coordination, and muscle weakness. Record review of Resident #73's quarterly MDS completed 12/22/25 revealed a BIMS score of 13 which indicated intact cognition. Resident #73 required set up/clean up assistance to supervision/touching assistance across all ADLs. (This MDS assessment does not require the facility to address the residents use of tobacco) Record review of Resident #73's EHR under the MDS tab revealed an admission MDS with ARD of 08/09/25. Record review of Resident #73's admission MDS completed 08/12/25 revealed he was not coded as using tobacco. Record review of Resident #73's care plan completed on 12/22/25 revealed the following focus areas with corresponding initiation dates: 08/07/25 [Resident #73] Has Oxygen Therapy r/t Ineffective gas exchange and Smoking 08/14/25 [Resident #73] has potential for injury r/t Smoking d/t impaired vision and cognitive deficit. Record review of Resident #73's Smoking Evaluation dated 05/21/25 revealed he smoked 6 times a day. Record review of Resident #73's Smoking Evaluation dated 08/14/25 revealed he smoked 5 times a day. During an observation on 03/10/26 at 11:10 AM Resident #73 placed a finished cigarette into a lidded ashcan offered to him by staff member. Staff member then handed him a new cigarette and lit the cigarette for him. Resident #73 proceeded to smoke the new cigarette. During an interview on 03/11/26 at 09:40 AM Resident #73 stated he started smoking when he was [AGE] years old and had been an active smoker the whole time he had been in the facility. During an interview on 03/12/26 at 08:45 AM RN A stated tobacco use should absolutely be included in comprehensive MDS assessments. She stated not including tobacco use in the MDS assessment could place residents at risk of injury. During an interview on 03/12/26 at 08:52 AM ADON B stated MDS LVN was responsible for completing MDS assessments. She stated tobacco use should be included in comprehensive MDS assessments. She stated if a new staff member was not aware a resident smoked the resident would be at risk of burns. During an interview on 03/12/26 at 09:21 AM the DON stated MDS LVN was responsible for completing MDS assessments. She stated tobacco use (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be included in comprehensive MDS assessments. She stated the only negative outcome of an inaccurate MDS assessment was the effect it could have on reimbursement. She stated funding effects would not negatively impact resident care. During an interview on 03/12/2026 at 9:33 AM the MDS LVN reported he based the tobacco part of the MDS assessment on the activity admission assessment completed at admission. The MDS LVN reviewed the activity admission assessment and found Resident #42 was marked for smoking and stated, I just missed that. The MDS LVN reported tobacco use should have been marked on the MDS assessment. The MDS LVN stated, other than accuracy, I do not think the inaccuracy of the MDS assessment will affect a residents care and it will not affect the reimbursement. During an interview on 03/12/26 at 09:41 AM the MDS LVN stated he was responsible for completing MDS assessments. He stated he utilized the RAI as his policy when completing MDS assessments. MDS LVN stated he was not sure why Resident #73 was not coded as using tobacco, but he knew he (the MDS LVN) had a new partner working with him at the time of Resident #73's comprehensive assessment. He stated residents could be negatively impacted by inaccurate MDS assessments but did not elaborate on how. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.11, dated October 2025 (RAI Manual) revealed the following: SECTION J: HEALTH CONDITIONS-J1300: Current Tobacco Use Steps for Assessment Ask the resident if they used tobacco in any form during the 7-day look-back period.If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes.If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Coding Instructions Code 0, no: if there are no indications that the resident used any form of tobacco.Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.		

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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, interview and record review, the facility failed to implement a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #42) of 18 Residents reviewed for comprehensive care plans. -The facility failed to address the use of a catheter in Resident #42's care plans. This failure could result in residents not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Record review of Resident #42's admission record dated 03/10/26 revealed a [AGE] year-old male most recently admitted to the facility on [DATE] with diagnoses to include neuromuscular dysfunction of the bladder (the nerves and muscles of the bladder do not work well resulting in the bladder not filling or emptying well), and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that commonly affects men as they age, often causing bothersome urinary symptoms). Record review of Resident #42's admission MDS completed 12/27/25 revealed a BIMS score of 12 which indicated moderate cognitive impairment, Resident #42 required supervision/touch assistance with his toileting hygiene, and was listed as having an Indwelling catheter. Record review of Resident #42's care plan created on 12/23/25 revealed Resident #42 had no care plans for his catheter and catheter care. Record review of Resident #42's Order Summary with Active Orders As of 3/10/26 revealed the following order:- CHANGE FOLEY CATHETER MONTHLY ON 17 DAY OF EACH MONTH. REINSERT PRN FOR ACCIDENTAL REMOVAL, DISLODGE, OBSTRUCTION OF URINE FLOW one time a day starting on the 17th and ending on the 17th every month Phone Active 12/23/2025. During an observation on 03/10/2026 at 8:47 AM Resident #42 was observed in bed dressed well and in the process of transferring to his wheelchair. Resident #42 had a catheter bag present on his bed that had dark urine in the bag. Resident #42 reported he was having some trouble with bleeding from his bladder and the facility was keeping an eye on it. Resident #42 reported the facility does a good job of taking care of all his catheter needs. During an interview on 03/12/2026 at 8:54 AM the DON reviewed Resident #42's chart and reported Resident #42 did have a catheter, and he was admitted with the catheter. The DON reviewed Resident #42's care plan and reported he had a care plan for urinary retention but no care plan to address his catheter or his catheter needs. The DON reported the catheter does need to be care plan, but she did not feel it would affect his care with it missing from the care plan since they usually address that and Resident #42 has orders for his catheter care so his catheter care would have been provided. The DON reported the MDS Coordinator was responsible for completing the care plans. During an interview on 03/12/2026 at 9:37 AM the MDS LVN reported he completes portions of the care plans and verified that if a catheter was marked on an MDS then he would complete that on the care plan. The MDS LVN reviewed Resident #42's admission MDS and reported Resident #42 was marked as having a catheter. The MDS LVN then reviewed Resident #42 care plan and reported he did not include the catheter in his care plan and should have. The MDS LVN stated, It would be ideal for the catheter to be in his care plan, but we did have his orders, so his care was still provided, and nothing was missed. The MDS LVN stated, We have his orders and as long as we follow his orders, I do not think his care would be affected. During an interview on 03/12/2026 at 10:19 AM LVN D (the nurse responsible for Resident #42 this shift) reported she did not review the residents care plans, but she felt all aspects of their care to include a catheter should be covered in the care plan. LVN D stated, I know management monitored all the care plan information and passes anything we need to know to use and vice versa. If we see something that changes or needs to be included, we let them know. LVN D reported that if the care plan did not address the residents' care and needs then (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who required respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #46) of 18 residents reviewed for quality of care. Resident #46 was left on 03/10/26 unsupervised by LVN E during breathing treatment. This failure had the potential to place residents at risk for respiratory compromise due to incomplete administration of ordered respiratory treatments and lack of monitoring, which could result in shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings included: Record review of Resident #46's face sheet, dated 03/10/26, revealed a 67-year-old female admitted to the facility on [DATE] with diagnoses which included: chronic obstructive pulmonary disease (progressive, long-term long disease that makes it difficult to breathe due to damaged, inflamed airways and destroyed air sacs), pleural effusion (abnormal accumulation of fluid in the thin membrane that covers the lungs), pulmonary hypertension (increased blood pressure in the arteries of the lungs), Non-ST elevation myocardial infarction (NSTEMI) (heart attack), and heart failure. Record review of Resident #46's quarterly MDS resident assessment, dated 12/15/2026 revealed she had a BIMS score of 13 indicating her cognition was intact. Record review of Resident #46's care plan with admission date, 04/25/25, revealed the resident had COPD with interventions/tasks including: give aerosol or bronchodilators as ordered, monitor/document any side effects and effectiveness, monitor for difficulty breathing on exertion, and monitor for s/sx of acute respiratory insufficiency: anxiety, confusion, restlessness, SOB at rest, cyanosis (change of tissue color to a bluish-purple hue as a result of decrease of oxygen), somnolence (sleepiness/drowsiness for unusually long periods of time). Record review of Resident # 46's active order summary report revealed the following order: Monitor for s/sx of shortness of breath when resident attempted to lie flat and/or resident avoided lying flat due to shortness of breath. Albuterol Sulfate Nebulization Solution (2.5 mg/3 ml) 0.083% 3 ml inhale orally via nebulizer every 6 hours for shortness of breath. During an interview on 03/10/26 at 10:15 a.m., Resident #46 stated she administered nebulizer treatments herself frequently and staff were never present during those treatments. Resident #46 stated they filled the nebulizer mask with medication and left the room. The resident stated this occurred every day. During an observation on 03/10/26 at 11:52 a.m., a medication cart was observed outside the resident's room with no nurse present. Resident #46 was observed sitting on her bed with the head of bed elevated and a nebulizer mask in place with medication visible in the bottom of the mask. The resident was alone in the room. During an observation on 03/10/26 at 11:58 a.m., Resident #46 remained alone in the room with the nebulizer mask in place. The medication cart remained outside the room and no nurse was observed in the area. During an observation on 03/10/26 at 12:05 p.m., Resident #46 continued to be alone in the room with nebulizer mask in place. The medication cart remained outside of Resident #46's room and no nurse was observed in the area. During an observation on 03/10/26 at 12:14 p.m., LVN E and ADON C were observed entering Resident #46's room and were heard asking the resident if she had completed her breathing treatment. Resident #46 was heard answering yes to staff and no vitals observed being taken. During an interview on 03/10/26 at 12:17 p.m., LVN E stated she worked at the facility for 1 1/2 years. When asked how she knew Resident #46 received the full breathing treatment medication, she stated that she returned to the room to check and the medication was gone from the mask. LVN E stated she stood outside the door and monitored Resident #46 during the treatment, and that was the expectation from management. LVN E stated a possible negative outcome of a resident not being monitored or staff not knowing if the resident had completed the treatment could be an adverse reaction. During an interview on 03/10/26 at 12:24 p.m., the surveyor stated she observed ADON C and LVN E enter Resident #46's room after the breathing treatment. ADON C stated that during breathing treatments, the expectation of staff was that they should be (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Amarillo Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 9 Medical Dr Amarillo, TX 79106	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside the door and monitor the resident during the entire treatment. The surveyor stated she observed several instances where LVN E was not present outside the resident's room during the breathing treatment. ADON C stated that was incorrect practice. ADON C stated a negative outcome of residents not being monitored during breathing treatments could be that the residents may not receive medication correctly. During an interview on 03/11/26 at 11:28 a.m., CNA F stated she worked at the facility for 3 years and observed nurses remain with residents during breathing treatments until they were completed. She stated she believed that was the expected practice. During an observation and interview on 03/12/26 at 9:44 a.m., Resident #46 was observed with an empty nebulizer mask on the bedside table. The resident stated she completed her first breathing treatment of the day at approximately 9:15 a.m. and no staff were with her during the treatment. Resident #46 stated the night-shift nurse left the medication in the mask and she administered it herself after waking up. Resident #46 stated that if she experienced shortness of breath during a breathing treatment, she would place her oxygen on and attempt to relax. She stated staff were not present and she had to manage the situation herself. Resident #46 stated that she believed she was stable, but felt she should be monitored during treatments because anything could happen. The resident further stated nurses had never taken her vital signs after breathing treatments. During an interview on 03/12/26 at 9:54 a.m., RN A stated she had worked at the facility for about 13 months and worked on the hallway where Resident #46 resided. RN A stated that the policy of the facility, during breathing treatments, was to remain within line of sight of the resident. If the resident was stable, staff could leave the room, but vital signs were to be taken before and after treatment. RN A stated she was not aware Resident #46 administered a breathing treatment at 9:15 AM because she did not administer the medication. RN A stated a potential negative outcome of not monitoring a resident during a breathing treatment could include adverse reactions, heart palpitations, and increased heart rate. RN A stated if a breathing treatment medication was prepared at 5:00 AM but not administered until 9:00 a.m., it could pose a safety concern because another resident could access the medication. During an interview on 03/12/26 at 10:03 a.m., the DON stated staff were expected to ensure breathing treatments were administered correctly. She stated, for stable residents, staff should ensure the breathing treatment was running and check on residents before, during, and after treatment. The DON stated vital signs were to be taken before and after treatment, and staff were expected to remain in the hallway during the treatment. She stated a possible negative outcome of a resident not being monitored could be that a resident may not receive their full breathing treatment. Review of the undated facility's policy, Oxygen Therapy Policy, revealed the following: Purpose: This policy establishes procedures for the safe and effective administration, monitoring and documentation of oxygen therapy in accordance with Texas Health and Human Services Minimum Licensing Standards, CMS Requirements of Participation and accepted clinical practice. 6. Administration Procedures Set up oxygen equipment and/or nebulizer according to manufacturer instructions. Ensure correct flow rate, medication and delivery device. Frequently monitor the resident based on clinical stability. Document assessments and resident response. Educate the resident and family on oxygen safety. 7. Monitoring and Documentation Nursing staff will frequently monitor the resident based on clinical stability, provider orders, and changes in condition. Monitoring includes oxygen saturation levels, respiratory assessment, resident tolerance, equipment function, adverse reactions, and interventions or notifications. Residents requiring continuous oxygen or those with unstable respiratory status will receive more frequent monitoring, with documentation reflecting the resident's condition and clinical judgement. 10. Care planning The resident's care plan will include diagnosis requiring oxygen, flow rate, delivery method, safety needs, monitoring frequency, and resident preferences or goals.		