

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: 675959	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Songbird Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Songbird Cir Brownwood, TX 76801	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies, and skills set to carry out the functions of the food and nutrition service for 1 of 3 dietary staff (DS G) reviewed for qualified dietary staff. The facility failed to ensure the facility's DS G met the requirements for a certified dietary manager. This failure could place residents at risk of not having their nutritional needs met and place them at risk for food born illnesses. Record review of DS G on 12.10.2025 revealed no evidence of a food handler's certificate. During an interview on 12.09.2025 at 05:40 p.m. the DM stated one of the dishwashers did not have a food handler's certificate. She stated he only washed dishes and did not handle any food for the residents. She stated she was not sure why he had not gotten the certificate. She stated she did not feel like this could cause any harm to the residents. She stated she was responsible for monitoring the staff to ensure that they had the proper training to work in the kitchen. During an interview on 12.10.2025 at 12:22 p.m. the ADMN stated that all dietary staff should have a food handler's certificate. She stated there could be a potential for infection to the residents who eat out of the kitchen if the staff had not had the food handler's course. She stated the DM should be monitoring that all kitchen staff have completed the food handler's course. She stated she did not know who this failure occurred. During a telephone interview on 12.10.2025 at 01:03 p.m. the Dietician stated her expectations were that all kitchen staff have a food handler's certificate. She stated any staff that did not have a food handler's certificate should be monitored by the DM. She stated she did not feel that a dishwasher not having a food handler's certificate would pose any harm to the residents. On 12.11.2025 before exit conference at 08:00 p.m. was conducted, the facility did not provide a policy regarding dietary staff requirements for a food handler's certification.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure kitchen staff (DS F) did not prepare food with an active infection. This deficient practice could place residents at risk for infection and cross contamination. Findings include: During an observation on 12.09.2025 at 05:30 p.m. observed dietary aide F in the kitchen with a mask below his nose and only covering his mouth. Dietary aid F had on gloves and was lying out tortillas on a plate and placing cheese on top of the tortillas. During an interview on 12.09.2025 at 05:32 p.m., Dietary aid F stated he had a note from his doctor stating for him to not work due to a respiratory infection. He stated he had given the note to his DM, and she told him had to work and he could not leave. During an interview and record review on 12.09.2025 at 05:35 p.m. observed a return to work/school note from a local medical center that stated the dietary aid F was seen on 12.09.2025 and may return to work on 12.15.2025. The note was signed by a local PA (Physician's Assistant). The DM stated that Jesus (dishwasher) did not have a food handler's certificate. She stated he only washes dishes and did not handle any of food for the residents. She stated she was not sure why he had not gotten the certificate. She stated she did not feel like this could cause any harm to the residents. During an interview on 12.09.2025 at 05:40 p.m. DM stated she thought since the dietary aid F was wearing a mask it was okay for him to work. She stated if a kitchen staff member was sick and served food to the residents, it could cause the residents to get sick. During an interview on 12.10.2025 at 12:22 p.m. the ADMN stated when she was informed a dietary aid F was working in the kitchen and had an infection, she asked dietary aid F to leave the facility. The ADMN stated this failure could cause a potential for infection for any resident that eats out of the kitchen. The ADMN stated she did not know what caused this failure. The ADMN stated the DM is responsible for ensuring the kitchen staff are not infectious and working in the kitchen. During a telephone interview on 12.10.2025 at 01:03 p.m. the Dietician stated her expectations were that kitchen staff that come to work sick should have been told to leave. She stated it was not appropriate for a kitchen staff member to work sick. She stated the staff member should not have been in the building. She stated the DM had not informed her of a staff member being sick. She stated this failure could have been potential for residents to become sick if food was being prepared and served by a person who was sick. She stated the DM should have been monitoring the kitchen staff daily. She stated she comes to the facility two times a month to monitor the kitchen. Review of the facility's policy titled, Guidelines For Work Restrictions For Persons With Infectious Diseases (not dated) revealed: Disease/Problem Group A streptococcal disease-Relieve from direct resident contact-Yes, Partial work restriction blank Duration Until 24 hours after adequate treatment is started.		

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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 that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 17 residents (Residents #2, Resident #7, and Resident #64) reviewed for care plans. The facility failed to ensure Resident #2 had a care plan in place that included fluid restriction. The facility failed to ensure Resident #7, and Resident #64 had a care plan in place that included a fall mat. These failures could place residents at risk of not receiving individualized care and services to meet their needs. Findings included: 1. Record review of Resident #2's electronic face sheet, dated 12/08/2025, reflected he was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic kidney disease (inability of kidneys to filter toxins out of the blood) and dependence on renal dialysis (having to have blood filtered by a machine due to kidneys not working correctly). Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 07 indicating severe cognitive impairment. Further review of the MDS reflected he needed setup assist with eating, he was on a therapeutic diet and received dialysis while a resident. Record review of Resident #2's physician orders, electronically accessed on 12/08/2025, reflected an order, dated 12/2/2025, reflecting a fluid restriction no greater than 32 oz a day related to renal dialysis. Record review of Resident #2's care plan, electronically accessed on 12/08/2025 reflected a focus area, dated 5/29/2025, Resident #2 had potential for fluid deficit. The interventions included encouraging the resident to drink fluids of choice, inviting the resident to activities that promoted additional fluid intake, and informing the nurse if the resident refused to drink fluids. Further review of the care plan reflected a focus area, dated 9/10/2025, Resident #2 needed hemodialysis (having blood filtered by a machine due to kidneys not working correctly) related to renal failure (inability of kidneys to filter blood to get rid of waste) with no interventions for fluid restriction. During an observation and interview on 12/07/2025 at 2:26 p.m., Resident #2 was sitting up in a recliner with his foot elevated. There was a prothesis beside his chair and a wheelchair in reach. He stated he had a left below the knee amputation. He stated he had no complaints with the staff at the facility. He stated she was supposed to be on a fluid restriction, but he drank what he wanted. Resident #2 did not state if he was able to obtain fluid himself or if the staff had educated him on complying with physician ordered fluid restrictions. He stated he continued to receive dialysis treatments. During an interview on 12/09/2025 at 1:47 p.m., LVN D stated she was Resident #2's charge nurse and Resident #2 went to dialysis on Monday, Wednesday, and Friday. She stated sometimes he went more often if he had too much fluid intake. LVN D stated fluid restrictions should be on the resident's care plan and did not know why it was not. She stated not putting fluid restriction on the care plan could cause Resident #2 to receive too many fluids causing him to go into fluid overload (body has too much fluid (mostly water) in it. This extra fluid can build up in places it shouldn't, like your lungs, legs, or belly.) She stated she did not know who was responsible for updating the care plans. She did not state whether she knew of about Resident #2's fluid restrictions or what system was in place for monitoring Resident #2's fluid intake. During an interview on 12/09/2025 at 2:00 p.m., the interim DON stated fluid restrictions should have been on a resident's care plan. She stated if the fluid restrictions were not care planned, staff could have given Resident #2 too much fluid. She stated if Resident #2 received too much fluid, he could have gone into fluid overload and would have required an extra day of dialysis. She stated the DON should have monitored the care plan to ensure it was accurate. 2. Record review of Resident #7's electronic face sheet, dated 12/09/2025, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including unsteadiness on feet and muscle weakness. Record review of Resident #7's (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Kardex (a quick-reference summary of a resident's essential information in a long-term care or nursing facility managed through the electronic record system) electronically accessed on 12/09/2025 reflected no evidence of a fall mat was to be placed beside the bed. Record review of Resident #7's care plan, electronically accessed on 12/09/2025, reflected a focus area, dated 12/27/2024, indicating she was at risk for falls, and refused to wear shoes. The goal was for Resident #7 to not sustain serious injury through the review date. Target date listed was 9/08/2025. There was no evidence that the fall mat was addressed in the care plan. Record review of Resident #7's quarterly MDS, dated [DATE], reflected a BIMS score of 03 which indicated she had severe cognitive impairment. Further review of the MDS reflected she needed supervision or touching assistance with transfers from the bed to a chair and had two or more falls with no injuries. Record review of Resident #7's physician orders accessed on 12/09/2025 reflected an order, dated 6/18/2025, for fall mat to bedside for injury prevention related to falls. Record review of Resident #7's incident note documentation dated 11/17/2025 reflected Resident #7 was observed lying on floor beside bed. On 11/18/2025 note written by the interim DON which reflected keep bed in lowest position and fall mat in place. During an observation on 12/07/2025 at 10:39 a.m., Resident #7 was sitting in a chair in her room with the call light attached to the chair. Observed between the chair and her bed was a fall mat lying on the floor to the left of her bed. Resident #7 had her eyes closed and no distress was observed. During an attempted telephone interview on 12/08/2025 at 3:29 p.m., Resident #7's RP did not answer the telephone. 3. Record review of Resident #64's electronic face sheet, dated 12/08/2025, reflected she was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including epilepsy (seizure activity) and failure to thrive (inability to maintain body weight). Record review of Resident #64's Kardex (a quick-reference summary of a resident's essential information in a long-term care or nursing facility managed through the electronic record system) electronically accessed on 12/08/2025 reflected no evidence that a fall mat was to be placed beside bed. Record review of Resident #64's care plan on 12/08/2025 reflected focus, dated 10/29/2025, reflecting she was at risk for falls. The goal was for Resident #64 to not sustain serious injury through the review date. Target date listed as 1/07/2026. There was no evidence the fall mat was addressed in the care plan. Record review of Resident #64's quarterly MDS, dated [DATE], reflected a BIMS score of 02 which indicated she had severe cognitive impairment. Further review of the MDS reflected she needed substantial assistance with transfers from the bed to a chair and had no falls since the prior assessment. During an observation and interview on 12/07/2025 at 10:39 a.m., Resident #64 was lying in bed. The bed was in the low position and there was a fall mat to the left of the bed. She smiled when being talked to and stated she had no concerns with her care. She did not have any skin issues such as bruising or wounds. During an interview on 12/10/2025 at 2:12 p.m., CNA H stated she looked up a care plan on the kiosk. She stated she had never noticed a fall mat on any resident's care plans. She stated a fall mat helped prevent injury by cushioning a resident during a fall. She stated she knew who needed a fall mat by the mat being in the resident's room or a nurse told her. She stated Resident #64 should have a fall mat beside her bed but stated the fall mat was not in the care plan. During an interview on 12/11/2025 at 3:00 p.m., the RRN stated fall mats should have been on the care plan if they were being utilized. She stated the DON, ADON, and MDS coordinator were responsible for maintaining the care plans. She stated the care plans were monitored by the same staff during morning meetings. She did not know why fall mats were not on the care plans. During an interview on 12/11/2025 at 5:38 p.m., the DON in training stated she started working for the facility on 12/08/2025. She stated a fall mat should have been on the care plan if it was being utilized. She stated she expected the intervention to be put on the care plan as soon as possible. She stated she did not know why the fall mats were not on the care plans. She stated failure to put on the care plan could prevent direct care staff knowing that a fall mat was to be used. She verified that herself, the ADON, and the MDS coordinator all updated the care plans and monitored that they were accurate. Facility policy titled Comprehensive Care Planning, undated, reflected, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Comprehensive care plans may include but are not limited to resident Kardex records, baseline care plans, and task listings. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care planning drives the type of care and services that a resident receives. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to not use any individual working in the facility as a nurse aide for more than four months on a full-time basis unless that individual has completed a training and competency evaluation program for 3 (SNA M, SNA N, and SNA O) of 4 student nurse aides reviewed for nursing services. The facility failed to ensure SNA M, SNA N, and SNA O were certified within the required time. This failure could place residents at risk for receiving inappropriate care from individuals whose skill level was not known. Findings included: Record review on 12/09/2025 of the facility's employee files revealed: -SNA M had a hire date of 4/18/2023 and worked full time as of 12/11/2025. An employability status check dated 12/11/2025 indicated SNA M had a CNA certification expiration date of 5/22/15. -SNA N had a hire date of 4/18/2023 was currently working full time. An employability status check dated 12/11/2025 indicated SNA M had no CNA certification. -SNA O had a hire date of 3/26/2025 was currently working full time. An employability status check dated 12/11/2025 indicated SNA O had no CNA certification. During an interview on 12/10/2025 at 11:00 a.m. the RCN stated her expectation was when NAs were hired, they were enrolled in classes within 30 days and were certifiable at 60 days. She stated the facility had no policy on NA's and that there was no time limit other than what the NATCEP requirements were, being 4 months after hire, NA's should have been hired and certified with their CNA. The RCN stated she felt the failure was due to the previous DON who was no longer there. During an interview on 12/11/2025 at 10:51 AM the ADMN stated as of yesterday she changed three of the SNAs to Hospitality Aides because they worked for four months or more. During an interview on 12/11/2025 at 5:29 PM, the ADMN stated SNAs should have been certified within 4 months of hire. She stated the DON was not keeping up with monitoring and tracking of the certification. She stated they had been performing direct care with residents even after the 4-month allotted time frame. The ADMN stated the DON had been responsible for monitoring the nurse aides, but she was no longer at the facility. The ADMN stated she felt the failure occurred with the previous DON not following up and completing the task she was given. She stated there was potential harm for residents if staff were not trained properly in not knowing what out of the range signs and/or symptoms to look for. Record review of the document provided by the DON titled Job Description for a SNA dated 2010, and signed on 4/18/23 by SNA M stated the following [in part] :Knowledge Base - Must provide written proof of the completion of 16-hour ADL training by authorized school instructor. Only perform patient care areas that they have been trained for, accountable for personal care (grooming, dressing, personal care, catheter care, peri care, and dressing), basic computer knowledge, identifies and reports any condition requiring management attention, ambulate and transfer residents utilizing appropriate assistive devices and body mechanics. Applicant declaration: I have read the qualifications and requirements of the position of student nurses' aide; I understand this position is not permanent but limited to 120 days in which I am required to test and obtain certification. I understand and certify that the foregoing is a non-exhaustive criterion that is consistent with the needs of this facility and is a legitimate measure of the qualifications for a Certified Nursing assistant and relates to the functions essential to a certified nursing assistant. Record review of the document provided by the ADMN titled Job Description for a SNA dated 2014, and signed on 2/6/25 by SNA N stated the following [in part] :Knowledge Base - Must provide written proof of the completion of 16-hour ADL training by authorized school instructor. Only perform patient care areas that they have been trained for, accountable for personal care (grooming, dressing, personal care, catheter care, peri care, and dressing), basic computer knowledge, identifies and reports any condition requiring management attention, ambulate and transfer residents utilizing appropriate assistive devices and body mechanics. Applicant declaration: I have read the qualifications and requirements of the position of student nurses aide; I understand this position is not permanent but limited to 120 days in which I am required to test and (continued on next page)		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtain certification. I understand and certify that the foregoing is a non-exhaustive criterion that is consistent with the needs of this facility and is a legitimate measure of the qualifications for a Certified Nursing assistant and relates to the functions essential to a certified nursing assistant. Record review of the document provided by the ADMN titled Job Description for a SNA dated 2010, and signed on 4/18/23 by SNA O stated the following [in part] :Knowledge Base - Must provide written proof of the completion of 16-hour ADL training by authorized school instructor. Only perform patient care areas that they have been trained for, accountable for personal care (grooming, dressing, personal care, catheter care, peri care, and dressing), basic computer knowledge, identifies and reports any condition requiring management attention, ambulate and transfer residents utilizing appropriate assistive devices and body mechanics .Applicant declaration: I have read the qualifications and requirements of the position of student nurses aide; I understand this position is not permanent but limited to 120 days in which I am required to test and obtain certification. I understand and certify that the foregoing is a non-exhaustive criterion that is consistent with the needs of this facility and is a legitimate measure of the qualifications for a Certified Nursing assistant and relates to the functions essential to a certified nursing assistant.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the menu was followed for 1 of 5 halls (B hall) reviewed for food and nutrition services. The facility failed to ensure 68 of 68 residents receiving a lunch meal from the kitchen received pecan pie as posted on the weekly menu for lunch on 12/07/2025. The facility failed to ensure 3 of 18 residents receiving a meal from the kitchen on B hall received lunch menu items roasted pork loin and mashed sweet potatoes on 12/07/2025. These failures could place residents at risk of poor intake from being disappointed they did not receive the menu items listed. Findings include During an observation on 12/07/2025 at 12:02 p.m., the lunch menu written on the white board outside the kitchen reflected roasted pork loin, gravy, mashed sweet potatoes, parmesan brussel sprouts, honey roll, and vanilla pudding. Weekly menu posted at the rear of the dining area reflected roasted pork loin, gravy, mashed sweet potatoes, parmesan brussel sprouts, honey roll, and pecan pie. During an observation on 12/07/2025 at 1:00 p.m., kitchen staff were plating food for the last three residents. There were mashed potatoes being served and Italian sausage on the last 3 trays. During an observation on 12/07/2025 at 1:15 p.m., the last of the hall trays were being passed out to residents on B hall. Three of the trays were observed having mased potatoes instead of mashed sweet potatoes. Three of the trays were observed having a different protein product instead of the roasted pork. During an interview on 12/07/2025 at 1:19 p.m., [NAME] I stated when she was prepping the sweet potatoes, a lot of them were bad so she could not use them. She stated she thought she had enough of them prepped but had ran out and that was why she substituted with instant mashed potatoes. During an interview on 12/07/2025 at 1:25 p.m., the DM stated the pecan pie was not served because the items were not received on the shipment truck. She stated sometimes the kitchen had to make changes due to what was delivered on the truck. She stated the residents were notified of the substitution. She stated some residents had not gotten mashed sweet potatoes because the kitchen had run out of sweet potatoes. During a follow-up interview on 12/08/2025 at 12:36 p.m., the DM stated sometimes the kitchen had to make changes due to what was delivered on the truck. She stated the residents were notified of the substitution by writing on the whiteboard outside of the kitchen. She stated she did not know how the residents that did not get out of their room for meals had been notified of dessert change. She stated she did not know if residents had been notified of potato and protein substitutions. She stated she did not notify the dietician of the potato and protein substitution. She stated both she and the dietician had been working with [NAME] I to make sure she was preparing the right amount of food product, not too much or not enough. She stated some of the issues were not all the sweet potatoes were usable but had no idea of why the kitchen ran out of protein item. She stated not providing residents with menu items could cause them to be unhappy after having an image of one food on their mind then being served another. She stated she monitored the kitchen staff and food service during meals. She stated the cook was responsible for making sure enough products had been prepared. During a telephone interview on 12/10/2025 at 12:57 p.m., the dietician stated she expected menus to be followed. She stated mashed potatoes had the same nutritional value as mashed sweet potatoes. She stated different proteins would have the same nutritional value as roasted pork loin. She stated different desserts had the same nutritional value. She stated the negative outcome would be that residents could have been upset the food they were served was different than what they had expected. She stated the DM was responsible for making sure the menus were followed. She stated she had not been notified of the food substitutions. She stated she monitored the food served at the facility twice a month and the DM was ultimately responsible for monitoring that all menu items were served. During a confidential group meeting at a confidential time, 8 of 8 residents voiced they were unhappy that items served during meals were not the items that were posted. 8 of 8 residents stated no one informed them of the menu changes when the items were different then what was posted. 8 of 8 (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents stated the DM had come to the confidential meeting in the past to go over their concerns but nothing changed after that meeting. Record review of facility policy titled Menu Approval and Honoring Resident Special Requests, and Food Brought to the Facility From Unapproved Sources with no date reflected Every attempt will be made to honor resident food preferences. The facility has a five-week cycle menu that can be modified by the dietary manager to meet the preferences of the majority of the residents. There was no evidence on following menus.		

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NAME OF PROVIDER OR SUPPLIER Songbird Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Songbird Cir Brownwood, TX 76801	
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and records review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to implement an appropriate action plan to address identified quality deficiencies for 1 of 1 facility. The QAPI committee failed to implement the corrective actions outlined on the Plan of Correction dated 03/14/2025 for deficient practice F728 for 3 (SNA J, SNA M, and SNA N) of 4 SNAs reviewed. This failure placed residents at risk for substandard quality of care due to the failure of the facility to act on an identified problem affecting resident safety. Findings include: Review of a CMS 2567 dated 03/14/2025 revealed that, based on observation, interviews, and record review, a deficient practice was cited at F728 (Facility Hiring and use of a Nurse) during an abbreviated survey that began on 03/13/2025. Interviews and records revealed that the facility failed to ensure SNA A (SNA M) was certified within the required time. Review of the facility's 03/15/2025 Plan of Correction which was submitted in response to the 03/14/2025 abbreviated survey revealed the facility's plan as: Corrective Action for Affected Residents: On 3/13/25, Area Director of Operations in-serviced Administrator and HR on auditing and tracking the compliance of Student Nurse Aide certifications. SNA A (SNA M) had completed the certification program. Since 3/14/25, SNA A (SNA M) has received additional support in preparation. Systemic Changes to Prevent Recurrence: On 3/13/2025, the facility implemented a monthly monitoring and tracking system for the SNA certification process to ensure SNAs are aware of the certification requirements and deadlines, and to help monitor their progress for facility compliance. Monitoring of Corrective Actions: HR/ADMN/DON designee will report to QAPI as needed for 3 months any concerns. During an interview on 12/11/2025 at 6:50 PM, the ADMN stated she had followed up during QAPI meetings and were supposed to have been followed up with the DON, but she failed to do so. She stated that SNA M had taken her exam and failed it and has one more time to take it before she would be unable to continue to take it. The ADMN stated there was a continued monitoring log for SNAs and NAs had monitoring for 90 days, and the DON and HR were going to do the tracking afterwards but did not follow through. She stated that her DON and HR changed in the middle of that. The ADMN stated that she was to monitor the tracking but had not. During an interview on 12/11/2025 at 6:58 PM the RDO stated her expectations were to inspect and monitor staff where needed. She stated she felt the ultimate failure occurred because the previous DON had not followed through with the policy and protocols. She stated her ADMN would have followed through verbally but felt the DON was not up front with her about this situation. Review of the facility's policy revised 9/2022, titled, Quality Assurance Policy and Procedure Purpose: The Quality Assurance and Performance Improvement Program is a data driven and proactive approach to quality improvement. All members of our organization, including residents, are involved in continuously identifying opportunities for improvement. Gaps in systems are addressed through planned interventions with the goal of improving the overall quality of life and quality of care and services delivered to nursing home residents. 5. Systematic Analysis and Systematic Action: Root cause analysis will be used to determine when in depth analysis is needed to fully understand a problem/event, its causes, and the implications of a change. The committee will review all involved systems to prevent future events and promote sustained improvement. The facility will focus on continued training, learning and continuous improvement. QAA Meeting: In addition to the QAA Meeting the Facility conducts Quality Reviews daily, weekly, and periodically throughout the month. The Interdisciplinary Team will report its findings to the QAA Committee for review. The QAA Committee may assign the QAPI Sub-Committee(s) to address specific areas as needed. Training/Competency. QAPI Plan Follow-up and Oversight: The Facility QAA Committee under the direction of the Administrator is responsible for verify Action Plans and Performance Improvement Plans are in place for areas that require improvement. The Administrator will notify the Area Director of Operations, and Area Compliance Nurse of concern or need for assistance as needed.		

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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 interview and record review, the facility failed to ensure the comprehensive assessment accurately reflected the resident's status for 1 (Resident #32) of 17 reviewed for accuracy of assessments. The facility failed to ensure the MDS dated 11.27.2025 reflected Resident #32 did not have a diagnosis of pneumonia. This failure could place residents at risk of inaccurate assessments and not receiving appropriate care according to their status. Findings included: Record review of Resident #32's electronic face sheet, dated 12.09.2025, revealed a [AGE] year-old female admitted [KA1] on 11.23.2024, readmitted 12.08.2025, with diagnoses of pneumonia, unspecified organism, history of falling, unspecified dementia, hypertension (high blood pressure), iron deficiency anemia (blood disorder), presence of cardiac pacemaker. Record review of Resident #32's Annual MDS, dated 11.27.2025, revealed: Section C - Cognitive Patterns Resident #32 had a BIMS score of 03 (meaning severely impaired cognition). Section I-Active Diagnosis revealed Resident # 32 had pneumonia during the past seven days of the look back period. Record review of Resident #32's physician orders, dated 12.01.2025, revealed no current orders for antibiotic therapy for a diagnosis of pneumonia. Record review of Resident #32's care plan, dated 09.11.2025, revealed no evidence of a focus, goal or intervention for the diagnosis of pneumonia. During an interview on 12.10.2025 at 02:10 p.m. the Regional Reimbursement Nurse stated her expectation was all MDSs were accurate for the residents. She stated if the resident did not have a current diagnosis of pneumonia, it should not have been triggered (checked)by the MDS. She stated she did not know how the failure occurred and that she was responsible for monitoring MDSs for accuracy. She did not know how often she monitored the MDSs. During an interview on 12.10.2025 at 02:20 p.m. the Regional Nurse stated her expectation was the MDSs were completed and accurate. She stated if a resident did not have a diagnosis of pneumonia in the last seven days, then it should not have been on the MDS. She stated she did not know how this failure occurred, except for human error. She stated this failure would not have affected the care of the residents. She stated the MDS coordinator was responsible for the accuracy of the MDS, and the DON was responsible for signing the MDS and ensuring accuracy as well. During an interview on 12.10.2025 at 3:12 p.m., the LVN MDS Coordinator stated if a resident did not have a current (within the last seven days) diagnosis of pneumonia then it should not have triggered (checked) on the MDS. She stated this failure would not cause any harm to residents or change the reimbursement status. She stated this failure was due to human error and that it did not change the reimbursement to the facility. She stated she and the DON monitored the MDS for accuracy when the RN signed the MDS. Review of the facility's policy titled, Resident Assessment, not dated, reflected: A comprehensive assessment will be completed within 14 days of admission and annually on each resident. The facility will utilize the Resident Assessment Instrument (RAI).The assessment will include at least the following:a. Medically defined conditions and prior medical historyb. Medical status measurementc. Physical and mental functional status.I. Cognitive status. RAI assessments must be conducted within 14 days after the date of admission: promptly after a significant change in the resident's physical or mental condition.The facility will examine each resident and review the minimum data set expanded core elements specified in RAI no less than once every three (3) months and as appropriate. Results must be recorded to assure continued accuracy of the assessment.The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care. Each assessment will be conducted or coordinated with the appropriate participation of health professionals. Each individual who completes a portion of the assessment must sign and certify the completion of the assessment.Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment. Each resident will be reassessed at regular intervals related to the course of treatment or when the resident's physical, psychosocial, functional or nutritional status significantly changes. Reassessment will occur (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quarterly thereafter or in response to a change in the residents' condition. Documentation reflecting assessment and changes in the plan of care will be reflected in the resident's medical record and/or plan of care. [KA1]It is not necessary to state what is understood to the reader. The reader understands the resident was admitted to the facility.		

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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. Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments and to permit only authorized personnel to have access for 1 of 5 (Medication Cart #1) medication carts reviewed for . The facility failed to ensure Medication Cart #1 was locked when unattended by nurse. This failure could place residents at risk of harm or decline in health due to lack of potency of medications/biologicals or misappropriation of medications. Findings included: During an observation on 12/10/2025 at 1:15 p.m., Medication Cart #1 was left unattended and unlocked, medication cart keys were inserted and hanging from the narcotic box. During an interview on 12/10/2025 at 1:17 p.m. RN E stated Medication Cart #1 was his responsibility, as well as the medication cart keys inserted and hanging from the narcotic drawer. RN E stated the medication carts were supposed to be always locked while not in use. RN E stated there was a resident falling, and he had to help her to her room. He stated, it still should have been locked prior to helping the resident. He stated there were residents that could have easily opened the cart and had access to medications as well as the scissors that were in the opened medication cart. RN E stated there were 15 residents' medication on the medication cart including: Crestor a cholesterol lowering medication; Melatonin a supplement to help induce sleep; Mirtazapine an anti-depressant; Eliquis a blood thinner (medication that interferes with blood clotting); Metoclopramide a medication that increases the speed the stomach empties into the intestines. Lyrica a medication used to treat nerve pain; Calcium / Magnesium / Zinc supplement; Atorvastatin a cholesterol lowering medication; Trazodone an antidepressant that can help with sleeplessness; Baclofen a medication that helps reduce muscle spasms; Carvedilol a medication that is used to help heart and circulation of blood; Famotidine a medication that decreases the amount of acid in the stomach; Keflex an antibiotic for infection; Seroquel an anti-psychotic medication used to treat psychosis; Senna-S a medication used to treat constipation; Buspirone an anti-anxiety medication; Sertraline an anti-depressant; Metoprolol a medication used to treat high blood pressure or elevated heart rate; Potassium chloride a supplement; Ticagrelor a medication that lowers risk for heart attack and helps lower risk of blood clots; Carisoprodol a medication to help relax muscles and reduce nerve pain; Amitriptyline a medication that helps lower depression; Metformin a medication used to help lower blood sugars in Type 2 diabetics; Gabapentin a medication used to help reduce nerve pain; Omeprazole a medication used to lower stomach acid; Donepezil a medication used to treat dementia. Antipsychotics, seizure, bowel, urinary, anxiety, OTC medications, inhalers and allergy meds. In the narcotic box behind one lock was: tramadol, used to treat moderately severe pain; morphine, used to treat moderate to severe pain when alternative pain relief medicines are not effective or not tolerated; lorazepam gel syringes, manage anxiety disorders and for short-term relief of anxiety symptoms associated with depression; Hydrocodone, used to treat pain; Alprazolam , used to treat anxiety and panic disorders; and diazepam gel, used to treat anxiety, muscle pain and seizures. RN E stated the narcotic medications should have been behind two locks. During an interview on 12/10/2025 at 1:35 a.m. the RDO stated the medication carts should have been locked if not in use by the nurse. She stated the keys should have been with the nurse in charge of that cart. During an interview on 12/10/2025 at 1:42 p.m., the RCN stated the keys should have never been left unattended on the medication carts. She stated no medication cart should have been left unlocked because residents could access the medications in the cart. The RCN stated there could have been great harm to residents if the wrong medications were ingested such as choking or an allergic reaction. She stated the failure, she felt was from their previous DON that was terminated. The RCN stated the previously terminated DON had not followed up on training and in particular in-services such as this. Review of the facility's policy titled Medication Storage in the Facility dated 2025 revealed: Policy: Medication sand biologicals are stored safely, securely, and (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	properly. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. Procedure: 9. ALL classes of controlled substances be stored in the lockbox located in the medication cart to adhere to the required double locked/secured storage.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 1 (Resident #64) of 17 residents reviewed for hospice services. The facility failed to maintain required hospice forms and documentation that included certificate of terminal illness to ensure that the needs of the residents were addressed and met 24 hours per day to ensure Resident #64 received adequate end-of-life care. This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings include Record review of Resident #64's electronic face sheet dated 12/08/2025 reflected she was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including failure to thrive (inability to maintain body weight) and protein calorie malnutrition (when a person does not consume enough protein and calories to meet their body's nutritional needs). Record review of Resident #64's quarterly MDS, dated [DATE], reflected a BIMS score of 02 which indicated she had severe cognitive impairment. Further review reflected Resident #64 was not on hospice. Record review of Resident #64's medical record accessed on 12/09/2025 reflected significant change MDS had been initiated but not completed on 12/05/2025. Record review of Resident #64's care plan on 12/08/2025 reflected no focus or interventions for hospice services. Record review of Resident #64's physician orders dated 11/25/2025 reflected may admit to hospice for diagnosis of protein calorie malnutrition. Record review of Resident #64's medical record documents on 12/08/2025 reflected no evidence of hospice election form, physician certification of terminal illness, hospice medication information, OOHDNR form, or hospice physician orders. During an observation and interview on 12/07/2025 at 10:39 a.m., Resident #64 was lying in bed. The bed was in the low position and there was a fall mat to the left of the bed. She smiled when being talked to and stated she had no concerns with her care. During a telephone interview on 12/08/2025 at 4:46 p.m., Resident #64's RP stated Resident #64 had only been on hospice services for several weeks. She stated when Resident #64 had been signed up for hospice services on 11/25/2025, an OOHDNR form had been signed on 11/25/2025 during hospice admission. She stated she was put on hospice services because at this point no one knew what to do with her and she was losing weight. During an interview on 12/09/2025 at 10:22 a.m., LVN L stated Resident #64 was recently admitted on hospice services. He stated hospice documents should have been stored in the electronic medical record under documents if there was no Hospice binder behind the nurses station. He verified that there was no Hospice binder behind the nurses' station for resident number 64. He stated that he would look up a code status in the profile of the resident during an emergency. He pulled up Resident #64's profile and stated she was listed as a full code. LVN L stated he could write a physician's order to change the code status when he had a completed OOHDNR form in front of him and he had verified it was completed. He stated that once he wrote the physician's order in the system, the profile code status would be automatically updated. He stated the resident's profile was viewable in the electronic record and on the medication administration record. He voiced the Hospice binder may have been in resident # 64's room but could not find it in her room at this time. During an interview on 12/09/2025 at 11:25 p.m., hospice RN stated the facility should have hospice documents. She stated the hospice company usually left hospice paperwork in a binder that was kept behind the nurses' station. She stated Resident #64 did have an active OOHDNR on record with the hospice. She stated she would get ahold of her office and get the required documents sent to the facility. She stated the first IDG care plan meeting was for going over the admission of the (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident yesterday on 12/08/2025 and after the physician signed all of the paperwork, the facility would get those care plan notes. She stated the OOHDNR, CTI and hospice election agreement would have been sent to the facility by the end of the day. During an interview on 12/11/2025 at 4:05 p.m., the DON stated she had worked for the facility since 12/08/2025. She stated she was still learning all the documents that were needed from the hospice company. She stated she would have expected the facility to have the OOHDNR if it had been completed by the hospice company. She stated she did not know who was responsible for communicating with the hospice companies. She stated the charge nurses communicated with the hospice nurse when that nurse was in the facility. She did not know where the communication documentation would have been kept. She stated not having required documents could have affected end of life treatments that were to be provided including cardiopulmonary resuscitation. During an interview on 12/11/2025 at 7:35 p.m. the RRN stated she could not code life expectancy of less than 6 months on the MDS unless she had supporting information from the hospice physician and it depended on the hospice company whether she had that information. Review of the facility's policy titled, Hospice Services, no date, reflected 7. The DON or designee will be responsible for immediately notifying the hospice of any significant changes in condition. Notification will be documented in the medical record. 8. The legally binding agreement will have provisions for joint procedures for ordering medications that ensure that the proper payer is billed and for reconciling billing between the nursing facility and the hospice. 9. The DON or designee will be responsible as needed for contracting the hospice prior to filling a new prescription. 10. The DON or designee will be responsible for ensuring that drugs unrelated to the terminal illness are ordered through the Vendor Drug Program. 11. The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record. At a minimum, the documentation will include: The current and past Texas Medicaid Hospice Recipient Election/Cancellation Form (#3071) Texas Medicaid Hospice-Nursing Facility Assessment Form (#3073) Physician Certification of Terminal Illness (#3074) Medicare Election Statement (if dual eligible) Verification that the recipient does not have Medicare Part A Hospice Plan of Care Current interdisciplinary notes to include nurses notes/summaries, physician orders and progress notes, and medications and treatment sheets during the hospice certification period. 12. The nursing facility and hospice provider must ensure that a coordinated plan of care reflects the participation of the hospice, nursing facility, the recipient, and legal representative to the extent possible. 13. The plan of care must include directives for managing pain and other uncomfortable symptoms. The plan must be revised and updated as necessary to reflect the resident's current status.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post in a place readily accessible to residents, and family members and legal representative of residents, the results of the most recent surveys and investigations of the facility including any plans of correction, without identifying information about complainants or residents, for 1 of 1 facility reviewed for resident rights. The facility failed to ensure the investigations that occurred on 3/14/2025, 5/29/2025, and 10/2/2025 with plans of correction were posted for residents, family members, and visitors to review without identifying information about complainants or residents. This failure could place residents and the residents' family members or representatives at risk for violation of the right to review the facility's survey and investigation findings without asking the facility to review the reports. Findings included: During an observation on 12/09/2025 at 8:40 a.m., the last survey results dated 9/06/2024 were in a binder in a bin on the right wall in front of the entrance into the facility. There was a sign informing the public of the binder's location. Review of the survey results binder reflected no results for investigations performed on 3/14/2025, 5/29/2025, and 10/02/2025. During an interview on 12/9/2025 at 8:43 a.m., the ADMN stated she was responsible for updating the survey binder with the most recent survey results. She stated there was no information in the binder after the last standard recertification survey dated 9/06/2024. She stated she thought she put the investigation findings for the investigations performed on 3/14/2025, 5/29/2025, and 10/02/2025 in the binder. The ADMN stated she found the binder out of the bin at one time and put it back, where it was stored after that time. She stated she was unsure if she was to provide the investigation findings in the binder. She stated the facility was investigated on 3/14/2025 with citations written. She also stated the facility was investigated on 5/29/2025 and 10/2/2025 and no citations were written. She stated she would look for a policy on required postings related to the survey binder. During an interview on 12/09/2025 at 9:13 a.m., the ADMN stated she was supposed to have the past investigation survey results with and without citations in the survey binder. She stated she was continuing to look for a policy on survey binder results. During an observation on 12/09/2025 at 9:25 a.m., there was a resident rights posting outside of the ADMN's office which reflected, The resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. During an interview on 12/11/2025 at 4:41 p.m., the ADMN stated she thought only the last standard survey results needed to be in the survey binder. She stated the survey binder was to provide visitors with information about the facility. She stated there was no policy on the survey binder. During an interview on 12/11/2025 at 4:43 p.m., the RDO stated she monitored the survey binder to ensure results from the last surveys were in the binder. She stated she knew how to look for the last standard survey results but did not know survey results from investigations needed to be in the survey binder. She stated the facility did not have a policy on the required posting for the survey binder.		