STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676179	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midland Medical Lodge	3000 Mockingbird LN Midland, TX 79705

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 6 of 28 residents (#11, #37, #83, #87, #96 and #103) who were reviewed for call light response and within reach in that the facility. 1. The facility failed to place Residents #11, #87 and #96's call lights within reach. 2. The facility failed to deliver timely call light response for Residents #37, #83 and #103. This deficient practice could affect residents who receive care at the facility and could result in missed or inadequate care. Findings included: Resident #11 Record review of Resident #11's admission record dated 08/21/2025 indicated she was admitted to the facility on [DATE] with diagnoses of quadriplegia (partial or complete paralysis of both the arms and legs), chronic respiratory failure, tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe), gastrostomy (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression), muscle weakness, and seizures. She was [AGE] years of age. Record review of Resident #11's annual MDS assessment dated [DATE] revealed a Cognitive Skills for Daily Decision Making score of 3, Severely impaired - never/rarely made decisions. Record review of Resident #11's care plan revealed she had an ADL (activities of daily living) performance deficit related to quadriplegia and decreased movement to all extremities. It was revealed that staff were to encourage the resident to use bell to call for assistance and touch pad call light to keep at residents reach to call for assistance. In an observation on 08/21/25 at 09:11 AM, revealed Resident #11 was in bed, watching tv. The call pad was hanging off the left side rail. In an observation and interview on 08/21/2025 at 09:25 AM, revealed Resident #11 was in bed, watching tv. The call pad was hanging off the left side rail. The DON said Resident #11 would not be able to reach the call pad where it was. The DON placed the pad on Resident #11's chest, between her hands. The DON said sometimes the staff forgot to place call bells within reach of the residents after moving them or making the bed. Resident #87 Record review of Resident #87's admission record dated 08/21/2025 indicated he was admitted to the facility on [DATE] with diagnoses of dementia, reduced mobility, history of falling, and muscle weakness. He was [AGE] years of age. Record review of Resident #87's annual MDS assessment dated [DATE] revealed a BIMS score of 02, his cognitive ability was severely impaired. Mobility devices = Wheelchair. He needed substantial/maximal assistance for eating, oral hygiene, toileting, showering, and dressing. Bladder and bowel: Urinary/bowel continence = always incontinent. Record review of Resident #87's care plan dated 05/27/2025 revealed he had difficulty communicating related to a cerebral vascular accident (interruption of blood flow to the brain) with memory deficits. It said that staff needed to ensure and provide a safe environment with the call light in reach, adequate low glare light, bed in lowest position and wheels locked, and to avoid isolation. The care plan reflected that Resident #87 had a history of falling and was at risk for falls. The care plan reflected staff needed to ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed. said the care plan reflected the resident needed prompt response to all requests for assistance and the resident needed a safe environment with a working and reachable call light. In an observation and interview on 08/21/25 at 09:13 AM, revealed Resident #87 was sitting in his wheelchair on the right side of his bed. The resident was asked if he knew where his call light was, he answered no. The call light was at the head of the bed on the left side. In an observation and interview on 08/21/2025 at 09:25 AM, revealed Resident #87 was sitting in his wheelchair on the right side of the bed. The call light was on the bed. The DON asked Resident #87 if he wanted the call light on his chest. He said yes, the DON placed the light on his chest. The DON said sometimes the staff forget to place call bells within reach of the residents after moving them or making the bed. Resident #96 Record review of Resident #96's admission record dated 08/21/2025 indicated she was admitted to the facility on [DATE] with diagnoses of cerebral palsy (a group of conditions that affect movement and posture), reduced mobility, muscle weakness, muscle wasting and muscle atrophy. She was [AGE] years of age. Record review of Resident #96's annual MDS assessment dated [DATE] revealed a BIMS score of 03, her cognitive ability was severely impaired. Mobility devices = Wheelchair. She was dependent on staff for eating, oral hygiene, toileting, showering, and dressing. Bladder and bowel: Urinary/bowel continence = always incontinent. Record review of Resident #96's care plan dated 6/25/2025 revealed she was at risk for falls due to cerebral palsy. The care plan reflected the staff needed to ensure the resident's call light was within reach and encourage the resident to use it for assistance as

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	676179	A. Building B. Wing	08/21/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of seven residents (Resident #23) reviewed for quality of care. The facility failed to provide wound care for Resident #23 using professional wound care standards and failed to follow the physician's treatment order. This failure could place residents at risk of improper wound management, deterioration in existing wounds, leading to infection and pain. Findings include: Record review of Resident #23's Face Sheet dated 7/14/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. He had diagnoses of infection following a procedure, unspecified severe protein-calorie malnutrition, chronic respiratory failure, resistance to multiple antibiotics, systemic inflammatory response syndrome (a life threatening condition that occurs when the body overreacts to a stressor, causing severe inflammation throughout the body), methicillin resistant staphylococcus aureus infection (a type of staph bacteria resistant to many common antibiotics), chronic respiratory failure, methicillin susceptible staphylococcus aureus infection (a type of bacterial infection caused by staphylococcus aureus bacteria that are sensitive to methicillin and similar antibiotics), Escherichia Coli as the cause of diseases classified elsewhere (a type of bacteria commonly found in the intestines of humans), aftercare following joint replacement surgery. Record review of Resident #23's admission MDS dated [DATE] revealed he had a BIMS score of 10 of 15 indicating moderate cognitive impairment. Record review of Resident #23's Care Plan dated 07/15/2025 revealed the resident has a skin tear to his left outer forearm. Record review of Resident #23's Physician orders dated 8/08/2025 revealed skin tear left outer forearm: clean with wound cleanser, pat dry, apply xeroform (a fine mesh gauze dressing impregnated with petrolatum for use on low exudating wounds), cover with dry dressing, change Monday, Wednesday, Friday, and as needed. Observation on 08/20/2025 at 9:58 AM of wound care for Resident #23 revealed: LVN E donned (put on) gloves and opened a treatment cart drawer. LVN E used a small tray covered with wax paper to set up a clean field and place supplies in. LVN E knocked on Resident #23's door explained the procedure, washed her hands, applied PPE (personal protective equipment) required for EBP (enhanced barrier precautions), put on gloves, and removed the dressing from the resident's left forearm. LVN E removed her gloves and placed them as trash in the biohazard bag. LVN E washed her hands, put on gloves, cleansed the wound with normal saline from the inside outwards, and patted dry. LVN E washed her hands, put on new gloves, applied a hydrogel dressing (a type of dressing characterized by its high-water content) to Resident #23's left forearm, removed her gloves, and washed her hands. LVN E did not follow physicians orders for applying a xeroform dressing. In an interview on 08/20/2025 at 10:30 AM LVN E stated hydrogel and xeroform were the same dressings and she was going to call the supplier and tell the supplier if they were sending the wrong dressings. LVN E stated she was not wound-care certified but had completed the wound care competency check-off upon hire. In an interview on 8/20/2025 at 2:30PM LVN E stated she talked to the wound care supplier and the hydrogel dressing was to be used as a dry dressing and she should have applied the xeroform under the hydrogel dressing. In an interview on 08/21/2025 at 10:06 AM the DON stated the wound care procedure would be to follow physician's orders. She agreed that LVN E did not use the correct dressing. The DON said incorrect dressings could delay the healing of wounds. Review of the facility's undated wound care policy received from the DON revealed: 1. Treat wounds with the appropriate products. 2. Effectively heal wounds by using approved products 3. Get treatment order form physician 4. Treat wound until it is healed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	676179	A. Building B. Wing	08/21/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident equipment was maintained in a safe, operating condition for 1 of 7 residents reviewed for wheelchair safety. The facility failed to ensure that Resident #62's wheelchair brakes operated. This failure placed residents at risk for unsafe transfers and/or falls if wheelchair rolled out from under the resident during transfers. The findings included:Review of Resident #62's admission Record, dated 8/20/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included hemiplegia (one sided weakness or paralysis) following stroke affecting the right side, reduced mobility, and history of falling. Review of resident #62's quarterly MSDS assessment, dated 7/11/25, revealed:Resident #62 scored a three of 15 on his mental status exam (indicating severe cognitive impairment),Resident #62 had upper and lower range of motion impairment on one side and used a wheelchair.Resident #62 was totally dependent on staff for bed to chair transfers. Review of Resident #62's Care Plan revealed:Revised 4/28/21: Problem: Resident requires assist with Activities of Daily Living. Goal: Resident is able to perform self-care to optimal level and maintains strength and endurance for 90 days. Interventions included: Provide level of support to complete transferring needs each shift; Reinforce use of aides to mobility as indicated. Revised 5/1/25 Problem: The resident has had an actual fall with no injury 3/10/25 fall. The identified goal was the resident will not sustain serious injury through the review date. Interventions included: 3/10/25 CNA reported during transfer the wheelchair brakes did not lock due to being broken and wheelchair rolled out from underneath resident's bottom, resident was using transfer pole during staff assisted transfer. Intervention - two person transfer initiated 3/11/25. Observation on 08/20/2025 9:02 AM revealed the wheelchair specialist was working on fixing another resident's specialized wheelchair. Observation on 08/20/2025 11:12 AM revealed CNA J and CNA L prepared to do a Sit-to-Stand mechanical lift transfer with Resident #62. CNA J put the sling on Resident #62, locked the wheelchair and hooked the sling onto the machine while CNA L prepared the lift. The wheelchair brake on the left side was noted to not be engaging despite being put in place. CNA J noticed the left brake and braced the wheelchair from behind on the left side while the aides completed the rest of the transfer properly. Interview on 08/20/2025 at 4:00 PM CNA J stated he worked at the facility for 2.5 years and usually worked Resident #62's hall. CNA J stated Resident #62 used to use a transfer pole on another hall, but since moving to the current hall Resident #62 used the Sit-to-Stand lift. CNA J said he checked the wheels on the wheelchair during the transfer and realized the brake did not engage. CNA J said the brake had not worked, but he did not now for how long. CNA J felt with him behind the wheelchair bracing it, that the transfer was safe since there were two people performing the transfer. CNA J stated the other side was secure and he stood on the side that was not. CNA J said he did not report the wheelchair brake not working. Interview on 08/20/2025 at 4:24 PM CNA K stated Resident #62 was ok in his wheelchair. CNA K stated the wheelchair worked for her when she locked the wheelchair; but CNA K said the left side brake did not work since she started working about a month ago. CNA K said she told the physical therapy department because she learned maintenance could not work on the type of wheelchair Resident #62 had. Interview on 08/20/2025 at 4:32 PM CNA L said she was the lead aide and she worked everywhere in the building. CNA L said Resident #62 used the Sit-to-Stand lift. CNA L said she did not feel the observed transfer did not go so well because the lock on the custom wheelchair did not lock. CNA L said she knew the facility could not fix it at the facility because she had another resident's wheelchair fixed that morning. CNA L said Resident #62's wheelchair brake had not been working a while. CNA L said she believed therapy was responsible for monitoring if the specialized wheelchairs worked. CNA L said if the aides noticed the wheelchair brakes not working they would document it in the maintenance book. CNA L said she knew the brake did not work for a while because the last time it was fixed the person accidently put the brake on backwards. CNA L said the transfer she and CNA J completed was done safely because CNA J was behind the chair and holding it stead. CNA L said she was notified it was not working today. CNA L said since she moved hallways so much, she could not say how long Resident #62's wheelchair was not working. Interview on 08/20/2025 at 4:45 PM RN G stated he worked Resident #62's hall for the past two years. RN G stated he was not aware Resident #62's wheelchair was not working. RN G said he did not know if therapy would notice because Resident #62 did not do therapy. RN G stated it could take weeks for a specialized wheelchair to be fixed. RN G said the CNAs did not communicate that Resident #62's brakes were not working. RN G said he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676179	A. Building B. Wing	08/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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	676179	A. Building B. Wing	08/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 assure the accurate acquiring, receiving, and dispensing of routine drugs and biologicals to meet the needs of each resident for 1of 7 residents reviewed for pharmacy services. (Resident #23) The facility failed to ensure Resident #23's ordered Rifampin (antimicrobial drug used to manage and treat diverse mycobacterial infections and gram-positive bacterial infections) medication was available for administration from 8/8/2025-8/20/25. The facility did not notify physician of unavailability until after resident missed 12 doses of Rifampin. These failures could place residents at risk for not receiving medications as prescribed and a decline in health status. Findings included: Record review of Resident #23's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of fracture of unspecified part of neck of left femur (hip fracture), presence of right artificial hip joint, need for assistance with personal care, muscle weakness, osteoarthritis, chronic respiratory failure, elevated white blood cell count. He discharged to the hospital on 7/31/2025 for infection of surgical wound. He readmitted to facility from hospital on [DATE] with diagnoses methicillin susceptible staphylococcus aureus infection (a type of bacterial infection caused by Staphylococcus aureus bacteria that are sensitive to methicillin and similar antibiotics), methicillin resistant staphylococcus aureus infection (a type of staphylococcus bacteria resistant to many common antibiotics), unspecified Escherichia Coli (a type of bacteria commonly found in the intestines of humans). Record review of Resident #23's comprehensive care plan, dated 07/15/2025, revealed he had surgical wound to left hip. The goal was wound will heal without complications through review date. The interventions included: wound treatments per doctor's orders.Record review of Resident #23's admission MDS assessment, dated 07/21/2025, revealed:He had a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment. There were no behaviors or refusal of care. Record review of the order summary report for August 20, 2025, revealed Resident #23 had an order for Rifampin oral capsule 300milligrams to be given two times every day from 8/8/2025 to 9/15/2025 indicated for infection after surgical procedure. Record review of the Medication Administration Record for August 2025 reflected Resident #23 did not receive any doses of his Rifampin because the medication was on order. In an interview on 8/20/25 at 11:05AM LVN C stated the Rifampin medication not being available was out of her hands. She stated she was first notified of the medication not being available yesterday evening (8/19/25) but the pharmacy was already closed. LVN C stated she was unsure why the medications had not come into the facility yet. LVN C called the pharmacy on 8/20/25 and the pharmacy stated they would not be sending the medication due to a possible drug interaction. LVN C said she called to notify the Infection Specialist Doctor but was only able to leave a message. LVN C stated the medication not being available could lead to not being able to treat the residents' diseases appropriately. In an interview on 8/20/25 at 11:45AM the DON stated the medication aides should report all unavailable medications to the nurse and the nurse then would look for the medication. The DON said if it was a prescription medication the nurse would verify it was not delivered, check the order, and call the pharmacy. The DON stated the nurse would report all unavailable medications to the DON and doctor. The DON stated it was the ADON's duty to ensure all medications were delivered. The DON stated resident was taking the medication due to an infection after a hip surgery. The DON stated negative effects could include the resident not receiving what medications they needed leading to prolonged sickness. In an interview on 8/20/2025 at 1:30PM Resident #23 said he was not aware he was not receiving the Rifampin. In an interview on 8/21/2025 at 10:30AM the DON stated the medication was discontinued by Resident #23's primary physician until follow-up appointment with Infectious Disease Specialist on 9/3/2025. The DON said she was going to implement communication forms to notify her if a medication was unavailable. The DON stated she spoke with the pharmacy about notifying the facility if a medication was not going to be dispensed as ordered. The surveyor requested the policy on medication availability, and one was not provided.

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	676179	A. Building B. Wing	08/21/2025

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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 store all drugs and biologicals in locked compartments for 1 of 4 nurse medication carts (Hall 200 cart) reviewed for medication storage and security. The 200-hall nurse medication cart was left unlocked while unsupervised. These failures could place clients at risk for drug diversion or accidental ingestion. The findings included: Record review of Resident #115's admission record dated 08/21/2025 indicated she was admitted to the facility on [DATE] with diagnosis of diabetes. She was [AGE] years of age. Record review of Resident #115's order summary report indicated in part: (Insulin Lispro) Inject as per sliding scale: if 60 - 200 = 0 No insulin; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 499 = 10 units Contact MD subcutaneously before meals for diabetes. Order date 07/25/2025. Record review of Resident #115's care plan dated 04/21/2025 revealed The resident has Diabetes Mellitus - Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During an observation on 08/21/2025 at 11:38 AM revealed RN G performed a blood sugar check for Resident #115 in her room. RN G took the items needed from his medication cart then entered the resident's room. The medication cart was left unlocked as the RN did not press the lock cylinder back into the medication cart. RN G entered the room and the cart was out of his sight as the cart was parked out to the side in the hallway. After checking the resident's blood sugar, the RN returned to the medication cart and obtained an insulin pen and went back into the resident's room and again left the cart unlocked and unattended. During an interview on 08/21/2025 at 11:42 AM RN G said that the medication carts were supposed to be locked when unattended. The RN was made aware that he had left the medication unlocked when he entered the resident's room. RN G said that he could see the cart from the room, but he was made aware that he had his back turned to the cart and had left it unlocked on 2 occasions. RN G said he should have locked the cart. During an interview on 08/21/2025 at 5:08 PM the DON said if a nursing staff stepped away from their medication cart then they were expected to lock it. The DON was made aware of RN G stepping away from the medication cart and leaving it unlocked and unsupervised. The DON said the nurse should have locked it as the cart had several medications in it. Record review of the facility's undated policy and titled Medication cart administration of drugs indicated in part: If the cart is left at any time during medication pass due to an emergency, it must be locked.

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	676179	A. Building B. Wing	08/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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	676179	A. Building B. Wing	08/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #11 and #71) of 5 residents reviewed for infection control in that: The facility failed to ensure LVN B used PPE during PEG tube (percutaneous endoscopic gastrostomy tube-a feeding tube inserted through the abdominal wall into the stomach) care for Resident #11 as the resident was on EBP (enhanced barrier precautions). The facility failed to ensure LVN B sanitized the glucometer with an appropriate sanitizing item after performing a blood sugar test on Resident #71. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: Resident #11 Record review of Resident #11's admission record dated 08/21/2025 indicated she was admitted to the facility on [DATE] with diagnoses of quadriplegia (partial or complete paralysis of both the arms and legs), chronic respiratory failure, tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe), gastrostomy (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression), muscle weakness, and seizures. She was [AGE] years of age. Record review of Resident #11's annual MDS assessment dated [DATE] revealed a Cognitive Skills for Daily Decision Making score of 3, Severely impaired - never/rarely made decisions. Record review of Resident #11's care plan revealed she required a PEG tube for adequate nutritional intake. It was revealed that EBP was implemented due to risk of infection. The care plan revealed she has a tracheostomy related to impaired breathing mechanics. It was revealed that EBP was implemented due to risk of infection. During an observation on 08/20/2025 at 10:48 AM, revealed LVN B entered Resident #11's room, washed his hands, and put gloves on. He performed the PEG tube placement check and residual check. He did not put on any type of PPE such as a gown except gloves during the process. There was an EBP posting outside the door for Resident #11. The EBP posting indicated to use a gown and gloves and the resident was on enhanced barrier precautions. During an interview on 08/20/2025 at 4:46 PM, LVN B stated he did not forget to put on a gown. He said he did not consider PEG tube placement and residual checks high-contact resident care. He said he does gown up when changing PEG tube dressings. During an interview on 08/20/2025 at 5:23 PM, the DON/Infection Preventionist (IP) said she did consider PEG tube placement and residual checks to be high-contact resident care. Record Review of the facility's policy titled Infection Prevention and Control Program, undated, indicated in part: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's (multi drug-resistant organisms) to staff hands and clothing. EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted (Centers of Disease Control) MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if resident is not known to be infected or colonized with a MDRO.Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Resident #71 Record review of Resident #71's admission record dated 08/21/2025 indicated he was admitted to the facility on [DATE] with diagnosis of diabetes. He was [AGE] years of age. Record review of Resident #11's care plan dated 05/27/2025 revealed The resident has Diabetes Mellitus - Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During an observation and interview on 08/21/2025 at 11:24 AM revealed LVN B performed a blood sugar check for Resident #71 using a glucometer. After the LVN had performed the blood sugar check he returned to his cart and cleaned the glucometer with an alcohol prep pad. The LVN was asked if he normally sanitized the glucometer with an alcohol pad and he replied yes. LVN B said as far as he knew that was an appropriate way to sanitize the glucometer. The LVN was in the process of entering another resident's room to perform a blood sugar check with the same glucometer he had just used on Resident #71 when the surveyor intervened and asked the LVN to stop. LVN B looked in his medication cart and found some germicidal bleach wipes and proceeded to sanitize the glucometer before proceeding to perform another blood sugar check. (A glucometer is a device used to test a person's sugar level by applying a drop of blood unto a test strip that is inserted in the glucometer). During an interview on 08/21/2025 at 5:05 PM the DON said the nurses were expected to use a germicidal wipe to sanitize the glucometers in between resident's blood sugar checks. The DON was made aware of a nurse using an alcohol pad to sanitize the