STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676209	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Medical Lodge	701 W Bennett Rd Decatur, TX 76234

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the resident and/or resident's representative(s) in writing of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 2 (Resident #14 and Resident #109) of 6 residents reviewed for discharge planning. The facility failed to notify the residents or the residents' representative or POA of the transfer or discharge with the reasons for the move in writing in a language and manner they understand for Resident #14 and Resident #109.The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #14 and Resident #109These failures could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. A record review of Resident #14's face sheet, dated 04/27/2026, revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE]. Her diagnoses included Cognitive Communication deficit (often caused by brain injury (stroke, tumor, TBI) or neurological disease), Dysphagia (difficulty swallowing), Atherosclerotic heart disease of native coronary artery without angina pectoris (where plaque builds up in the heart's original arteries without causing chest pain), and Acute embolism and thrombosis of the right peroneal vein (blood clot in the deep veins of the calf). Her face sheet also revealed her family member was her responsible party and emergency contact.A record review of Resident #14's MDS, dated [DATE], reflected a BIMS score of 03/15, indicated severe cognitive impairment. Resident #14 required substantial to maximal assistance (which meant staff did more than half the effort) with care.A record review of Resident #14's progress note dated 03/11/2026, revealed Resident #14 was sent to the ER, due to stomach pain, unable to open her eyes, and elevated anion gap (indicates high levels of acid in the blood). There was no evidence that a transfer or discharge notice had been provided to Resident #14 or her responsible party in writing or to the LTC Ombudsman. In an interview on 04/27/2026 at 2:05 p.m., Resident #14 revealed she had never received a written letter when she was sent to the emergency room, but her family member might have received it.An attempt to contact her responsible party on 04/27/2026 at 2:48 p.m., was unsuccessful.2. A record review of Resident #109's face sheet, dated 04/28/2026, revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and her family member was her responsible party. Her diagnoses included Unspecified atrial fibrillation (an irregular, often rapid heart rate where the upper chambers quiver), Dementia (a decline in memory, thinking, and behavioral abilities severe enough to disrupt daily life), Muscle Weakness (reduced ability to exert force with muscles, often caused by nerve damage or disuse), Essential Hypertension (chronic, high blood pressure), and Atherosclerotic heart disease of native coronary artery without angina pectoris (where plaque builds up in the heart's original arteries without causing chest pain).A record review of Resident #109's MDS, dated [DATE], reflected a BIMS score of 03/15, indicated severe cognitive impairment. Resident #109 required substantial to maximal assistance (which meant staff does more than half the effort) with care.A record review of Resident #109's (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress note dated 12/23/2025, revealed Resident #14 was sent to the ER, due to altered level of consciousness and general weakness. There was no evidence that a transfer or discharge notice had been provided to Resident #109 or to her responsible party in writing or to the LTC Ombudsman. In an interview on 04/10/2026 at 1:01 p.m., Resident #109's family member revealed he had never received a written letter when Resident #109 was sent to the emergency room. During an interview on 04/27/2026 at 2:19 p.m., Social Worker revealed that she did not provide a written notice to the resident or the resident's responsible party when a resident was transferred to the emergency room. She explained that the nurses notified the responsible party by telephone at the time of the transfer. She said she sends a list of names to the Ombudsman monthly.During an interview on 04/27/2026 at 2:41 p.m., the DON revealed that she did not provide written notices or letters to residents or their responsible parties when residents were transferred to the emergency room. She explained that she and the nursing staff notified the responsible party by telephone at the time of the transfer. She said she did not see a negative impact on the residents because they did not receive a transfer or discharge notice in writing, because the nurses have conversations with the residents about the reason the went to the hospital when they return to the facility.During an interview on 04/28/2026 at 12:36 p.m., the Ombudsman revealed the only discharges she's received from this facility were from March 2026 and on April 3, 2026, she received one.During an interview on 04/28/2026 at 1:53 p.m., the Administrator revealed that the facility did not provide written notices of transfer or discharge to residents or their responsible parties when a resident was sent to the emergency room. He explained that residents were informed verbally of the transfer, and responsible parties were notified by telephone at the time of the transfer. The Administrator further revealed that a discharge notice was only provided to residents when they returned to their home or transferred to another facility. In a record review of the facility's Transfer or Discharge, Emergency policy, with an unknown date, revealed: .3. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident;e. Notify the representative (sponsor) or other family member;f. Assist in obtaining transportation; and g. Others as appropriate or as necessary.References OBRA Regulatory Reference Numbers S483.15(c) Transfer and dischargeIn a record review of Regulation S483.15(c)(3) states Notice before transfer. Before a facility transfers or discharges a resident, the facility must-(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and(iii) Include in the notice the items described in paragraph (c)(5) of this section.S483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;(ii) The effective date of transfer or discharge;(iii) The location to which the resident is transferred or discharged ;(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility provided the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable for two (Resident #96 and Resident #34) of 5 residents, reviewed for positioning during meals. The facility failed to ensure CNA A correctly positioned Resident #96 for feeding. The facility failed to ensure CNA E correctly positioned Resident #34 for feeding. This failure placed residents at risk for aspiration and choking due to poor positioning while eating. Findings included: Review of Resident #96's Quarterly MDS Assessment, dated 04/02/26, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making were severely impaired. Her diagnoses included stroke, non-Alzheimer's dementia, and Parkinson's disease. The resident was on a mechanically altered diet. Review of Resident #96's Order Summary Report dated 09/01/23, reflected:Regular diet, mechanical soft texture, regular/thin consistency. Review of Resident #96's Comprehensive Care Plans, dated 10/23/24, reflected the resident had an ADL self-care performance deficitFacility interventions included:Eating: Resident was totally dependent on staff for assistance with eating. In an observation on 04/26/26 at 12:50 PM, CNA A fed Resident #96 two bites of her pureed food while the resident was reclined in a geri-chair. The resident did not cough or show symptoms of choking. In an interview on 04/26/26 at 12:55 PM, CNA A said she was feeding the resident in a reclined position because the family wanted the geri-chair to remain reclined. CNA A said the resident was at risk of choking but had never choked before. CNA A said she was trained to position residents for feeding. CNA A asked the Surveyor what she should do. ADON C walked over to Resident #96. ADON C said the resident was supposed to be fed in a reclined position because the family wanted the geri-chair to remain reclined. ADON C said the charge nurse was responsible for ensuring residents were in a correct position to eat. ADON C did say the reclined position to eat could cause aspiration, and choking. ADON C walked away. CNA B walked over and told CNA A to assist him to reposition Resident #96. They were able to sit her in a more upright position. The resident was able to lean forward to eat and drink without issue. In an interview on 04/26/26 at 1:00 PM, LVN D was in the dining room. She said she was an agency nurse and assisted staff to help ensure residents were in the correct position to eat. LVN D said she was not familiar with Resident #96. LVN D said the resident was at risk for aspiration and choking if she was fed in a reclined position. In an interview on 04/26/26 at 1:10 PM, the DON said Resident #96's family was finicky and wanted the resident to stay reclined to eat. The DON said the resident was at risk of choking if fed in a reclined position. The DON said Resident #96 had never choked during eating and staff had been trained how to position residents to correctly feed them. The DON said it was a team effort to ensure residents were correctly positioned to eat. In an interview on 04/26/26 at 1:15 PM, the family representative of Resident #96 said she never told facility staff to recline the resident to eat. She said she expected the facility to know to sit the resident upright to eat. Review of Resident #34's Quarterly MDS Assessment, dated 01/22/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making were severely impaired. Her diagnoses included stroke, heart failure, and non-Alzheimer's disease. The resident was on a mechanically altered diet. Review of Resident #34's Order Summary Report, dated 07/08/25, reflected:No added salt diet, pureed texture, nectar thick consistency. Review of Resident #34's Comprehensive Care Plans, dated 07/03/25, reflected the resident had an ADL self-care performance deficit related to right upper extremity hand contracture.Facility interventions included:Eating: Resident required extensive assistance with (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eating. In an observation and interview on 04/27/26 at 12:50 PM, CNA E was feeding Resident #34. Resident #34 had her neck and head bent over to the left side. CNA E was holding the drinking glass, and the resident was drinking fluids. CNA E said Resident #34 would normally lean over to eat and drink but that did place her at risk for choking. CNA E stood up and repositioned the resident to an upright position. CNA E said she had not been trained to position the resident to eat. ADON Z walked into the dining room and over to the resident. ADON Z said the resident was not supposed to lean over to her left side to eat. In an interview on 04/27/26 at 1:00 pm, the DON said CNA E was trained to position residents correctly and Resident #34 was supposed to sit upright to eat. The DON said the resident did not have any coughing or choking incidents. The DON said administrative staff would make rounds in the dining room and watch for positioning. Record review of the facility policy, Assistance with Meals, revised 02/09/24, reflected: Residents shall receive assistance with meals in a manner that meets the individual needs of the resident.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure food was prepared in a form designed to meet individual needs for one (Resident #63) of 8 residents, reviewed for puree' meals. The facility failed to ensure [NAME] F correctly prepared a puree' meal for Resident #63. This failure placed residents at risk for aspiration and choking due to food not being prepared correctly.Findings included: Review of Resident #63's Quarterly MDS Assessment, dated 03/05/26, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 6 indicating her cognitive skills were severely impaired. Her diagnoses included stroke, seizure disorder, and malnutrition. The resident was on a therapeutic diet. Review of Resident #63's Order Summary Report dated 04/10/26, reflected:Pureed texture, regular consistency diet Review of Resident #63's Comprehensive Care Plans, dated 11/03/25, reflected:Nutritional problem or potential nutritional problem.At risk for malnutrition.Facility interventions included:Provide and serve diet as ordered. An observation on 04/27/26 at 1:30 PM revealed the facility provided a sample tray. The puree' food was tamales, stewed tomatoes, charro beans, rolls, Spanish rice, and a sopapilla. The taste test of the food by the Surveyor revealed there was shredded corn husk in the puree' tamales. The puree' tamales were not edible because the corn husk could not be chewed and had to be spit out by the Surveyor. In an interview on 04/27/26 at 1:35 PM, the Dietary Manager entered the conference room. The Dietary Manager took a bite of the puree' tamale and said, The husk is in there. The Dietary Manager spit out the husk and said, I need to go check on the residents right now. In an interview on 04/27/26 at 3:10 PM, CNA G said she fed Resident #63 the puree' tamales. CNA G said the puree' tamales had some pieces sticking out of it. CNA G said, I had to pull those pieces out and just give her the puree' pieces. CNA G said the resident did not have any coughing, choking, and did not spit the food out. In an interview on 04/27/26 at 3:20 PM, the DON said she did not see any of the lunch trays. The DON said if any of the residents ate the puree' food with the corn husks, it could result in difficulty swallowing. The DON said she assessed all eight residents who were served the puree' lunch meal and none of the residents had any issues after the meal. The DON said the nurses were responsible for checking the trays and dietary staff in the kitchen had to check the trays for consistency. The DON said this incident never happened before and she did not know why it happened on 04/27/26. In an interview on 04/27/26 at 3:30 PM, Dietary Manager said [NAME] F prepared the puree' tamales. She said [NAME] F usually did a great job with her textures. The Dietary Manager said [NAME] F was supposed to taste the food she prepared, but at the end of the day, the Dietary manager was responsible for ensuring food was the correct texture. The Dietary Manager said the puree' food was supposed to be tasted every meal, but she did not taste the puree' tamales for the lunch meal. The Dietary Manager said wrong textures served to residents placed them at high risk and could lead to potential hospitalization. In an interview on 04/27/26 3:35 pm, LVN H said she checked the lunch trays. She said she did not see anything wrong with the puree' trays. In an interview on 04/28/2026 at 1:13 PM, [NAME] F said she had worked at the facility for almost four years. She said she prepared the puree' tamales and had been trained to puree' food. [NAME] F said she would normally taste the food she prepared but did not taste the food at lunch. She said she was in too much of a hurry. [NAME] F said she thought she removed the corn husks from the tamales and did not know how a corn husk ended up in the puree' food. [NAME] F said residents could have a hard time swallowing the food if it was not pureed correctly. Record review of the facility policy, Puree Food Summary, not dated, reflected: Mechanically altered foods are important for those with:Dysphagia - decrease in swallowing ability.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety.The facility failed to ensure that only disposable paper towels were disposed of in the garbage receptacle at handwashing sink #1.The facility failed to ensure food items in the dry storage room were properly stored, sealed, and protected from exposure to air in accordance with professional food service standards.The facility failed to ensure food items in the walk-in freezer were properly stored, sealed, and protected from exposure to air.These failures could place residents at risk for food-borne illness, cross contamination, and infection.During an observation of the #1 handwashing sink's garbage receptacle on 04/26/2026 at 9:54 a.m., the following was revealed:Handwashing sink #1 had a garbage receptacle that contained items other than disposable paper towels, including disposable gloves, a plastic lid, and a straw.During an interview on 04/26/2026 at 9:58 a.m., the Dietary Manager stated that the garbage receptacle at the #1 handwashing sink is used for paper towels and trash should not be thrown in the garbage receptacle.During an observation of the dry storage room on 04/26/2026 at 10:04 a.m., the following was revealed:2-gallon zipper storage bag with more than 10-round buns, opened date 04/25/2026 and use by date 04/28/2026 with no name and open to air.2-gallon zipper storage bag with 4 round buns, opened date 04/16/2026 and use by date 04/24/2026 with no name.1 can Tomato soup 50 oz, (3 lbs. 2 oz.), receive date 03/05/2026 use by date 01/19/2028 dented on top seal.1 can Mixed Vegetables 6 lbs. 8 oz., receive date 04/20/2026, no best by date, dent on lower left side.During an interview on 04/26/2026 at 10:22 a.m., the Dietary Manager stated that dates on the cans and zipper bags are the delivery date, open date, and use by date. If the product is not in its original packaging the product name should also be written on the bag. She said if residents were to eat food that is not properly sealed, they could become seriously ill. She said if there is no best buy date on the cans they go by the food labeling guide to determine the best by date.During an observation of the walk-in freezer on 04/26/2026 at 10:33 a.m., the following was revealed: 2-gallon zipper storage bag, rectangle bread or cheese sticks, opened date 04/25/2026, best by date 05/25/2026, no name on package. 2-gallon zipper storage bag, brown bag inside of zipped bag with opened date 04/13/2026, best by date 05/13/2026, no name on package.During an interview on 04/26/2026 at 10:41 a.m., the [NAME] stated that all staff were responsible for stocking food once delivered and any dented cans should be placed in the Dietary Manager's office. She added that the date received and the date opened were written on the product and if there was no ?best by' or ?use by' date, she used the food labeling guide. She said if residents consumed food that was not properly sealed, they could become seriously ill.During an interview on 04/26/2026 at 10:46 a.m., the Dietary Manager stated that she was primarily responsible for stocking food once it arrived. She noted that any can with a dent on the seam, regardless of size, was always placed in the designated dented can area in her office. She also stated that all freezer items were required to have both an open date and a use by date, and if a product was not in its original packaging, it needed to be labeled with its name. In a record review of the facility's Food Receiving and Storage, dated July 2014, revealed, 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). There is no mention of the appearance of cans. Review of the U.S. FDA Food Code 2022, Chapter 3, 3-202.15 revealed, Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. If the integrity of the packaging has been compromised, contaminants.may find their way into the food.Review of the U.S. FDA Food Code 2022 revealed, Section 6-301.20 Disposable Towels, Waste Receptacle. Waste Receptacles at handwashing sinks are required for the collection of disposable towels so that the paper waste will be contained, will not contact food directly or indirectly, and will not become an attractant for insects or rodents.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment one (Resident #2) of 4 residents, reviewed for PASARR. The facility failed to ensure the MDS Coordinator referred Resident #2 for a PASARR evaluation or PASARR Level 2 screening. This failure placed residents at risk of not receiving PASARR services they could potentially receive.Findings included: Record review of Resident #2's Annual MDS Assessment, dated 02/26/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was 11 indicating his cognitive skills were moderately impaired. His diagnoses included post-traumatic stress disorder, anxiety disorder and depression. Record review of Resident #2's Comprehensive Care Plans, dated 03/27/25, reflected:At risk for a mood problem related to post-traumatic stress disorder.Facility interventions included:Behavioral health consults as needed. Record review of Resident #2's PASARR Level 1 screening, dated 12/26/24, reflected he did not have any mental disorders. Record review of Resident #2's clinical record reflected he did not have a PASARR Level 2 screening or a PASARR Evaluation. In an interview on 04/26/26 at 11:05 am, Resident #2 said he did not receive PASARR services. In an interview on 04/28/26 at 10:31 AM, the MDS Coordinator said the resident was a veteran and did not qualify for PASARR services. The MDS Coordinator said the resident had a negative PASARR Level 1 and it was not correct based on the resident's diagnosis. The MDS Coordinator said she missed the diagnosis and did not submit a new PASARR Level 1 screening. The MDS Coordinator said a negative PASARR Level 1 screening could cause residents to miss PASARR services. The facility policy for PASARR services was requested on 04/28/26 at 1:01 PM from the Administrator and DON. The policy was not received prior to exit on 04/28/26.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to ensure each resident received adequate supervision and assistance devices to prevent accidents for residents for 1 (Resident #13) of 5 residents reviewed for devices. The facility failed to maintain Resident #13's manual wheelchair, which was missing the right-hand armrest and had a cracked and worn left armrest, exposing he resident to possible skin breakdown. This failure could place residents at risk of being uncomfortable and of injury from equipment not properly maintained.Findings included:Record review of Resident #13's Face Sheet, dated 04/27/2026, reflected Resident #13 was a [AGE] year-old male, admitted on [DATE], with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side (paralysis of the left side after a stroke), End Stage Renal Disease (kidney failure), and Unspecified Convulsions.Record review of Resident #13's Comprehensive MDS, dated [DATE], reflected a BIMS Score of 05 indicating severe cognitive impairment. Section GG-Functional Abilities reflected Resident #13 required a wheelchair and was completely dependent for toileting and showering. Section M-Skin Conditions reflected Resident #13 was at risk of developing Pressure Ulcers.Record review of Resident #13's Comprehensive Care Plan, dated 04/08/2026, indicated that under Focus: [Resident #13] had a behavioral problem (picking at skin causing wounds). Goal: [Resident #13] will have fewer episodes through review date. Interventions: Anticipate and meet the resident's needs. Explain all procedures to the resident before starting and allow resident to adjust to changes. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Focus: [Resident #13] is on anticonvulsants therapy. Goal: [Resident #13] will be free of any discomfort or adverse side effects of anticonvulsants therapy through review date' Interventions: Observe and report any seizure activity. Focus: [Resident #13] is on antiplatelet therapy disease process. Goal: [Resident #13 will be free from adverse reactions related to antiplatelet therapy through next review. Interventions: Skin inspections as needed and report changes or increase in bruising.During an observation and interview on 04/26/26 at 12:35 p.m. in the dining room, Resident #13 was seated in a wheelchair at a dining table. Resident #13's wheelchair was noted to be missing an armrest cushion on the resident's right side and the armrest on Resident #13's left side was observed to be cracked, had open areas exposing the cushion-filling underneath and appeared to be missing some of the cushion filling. Resident #13 was noted to have several scabs on both forearms. Resident #13 stated that he was not sure where the scabs on his arms came from. He stated that he would like to have an armrest on the right side of his wheelchair and on the left side of his wheelchair. He stated that he had told his family about the missing armrest. During an interview on 04/27/26 at 1:40 PM, Resident #13's Resident Representative was interviewed in Resident #13's room. She stated she would like to see Resident #13's wheelchair repaired. She stated she believed Resident #13 mentioned the missing armrest to the staff at the facility [she was unable to identify which staff]. She stated that she thought it might be uncomfortable to not have an armrest on the right side of the wheelchair, and it could possibly cause scratches or bruising. During an interview on 04/27/2026 at 1:40 PM, the DOR stated all of the wheelchairs in the facility were owned by the facility and rehabilitation was not responsible for the wheelchairs, but her staff would notify the facility if a wheelchair needed repairs.During an interview on 04/27/2026 at 2:13 PM, CNA E stated she had not seen any wheelchairs that needed to have armrests repaired or replaced. She stated if she had seen wheelchairs that needed repair, she would report it to the nurse. She stated there was not a physical logbook but knew there was an electronic way to notify the Maintenance Manager of equipment that needed repair. She further stated that not having wheelchair armrests could cause skin breakdown.During an interview on 04/28/2026 at 11:11 AM, the DON said t skin breakdown could occur on the arms of a resident if the armrest was missing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676209	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Medical Lodge	701 W Bennett Rd Decatur, TX 76234

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or cracked. She stated the process for maintaining maintenance on wheelchairs would be started by ADON to go through all resident equipment to make sure equipment stayed in good repair. She stated maintenance issues were reported through an electronic interface that all CNAs and nurses had access to.During an interview on 04/28/2026 at 12:29 PM, the Maintenance Manager said the staff used an electronic interface to communicate equipment in the facility to be repaired. He stated he was not aware of any repairs that were needed for Resident #13's wheelchair. Record review of a facility policy titled, Equipment Maintenance, dated September 2005 and updated June 2019 revealed 3. all resident equipment supplied by the facility will be maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #86) of 5 residents, reviewed for infection control. The facility failed to ensure CNA I performed hand hygiene during incontinence care for Resident #86. This failure placed residents at risk for infection due to not performing hand hygiene.Findings included: Review of Resident #86's Quarterly MDS Assessment, dated 04/01/26, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 7 indicating her cognitive skills were severely impaired. Her diagnoses included heart failure and non-Alzheimer's dementia. Review of Resident #86's Comprehensive Care Plans, dated 02/26/26, reflected:ADL self-care performance deficit related to muscle weakness.Facility interventions included:Toilet use: Resident required extensive assistance from one staff with toiletuse. In an observation on 04/27/26 at 10:00 AM, CNA I was preparing to perform incontinence care for Resident #86. CNA I cleaned the resident and removed the soiled brief. CNA I changed gloves and did not perform hand hygiene. CNA I placed a clean brief on the resident. In an interview on 04/27/26 at 10:05 AM, CNA I said she was supposed to perform hand hygiene when she changed gloves. She said she did not do the hand hygiene this time but was trained too. CNA I said the resident was at risk for the spread of germs if hand hygiene was not performed. In an interview on 04/28/26 at 10:47 AM, the DON said staff were supposed to perform hand hygiene when they changed gloves and had been trained to do it. The DON said monitoring was in place and management observed staff for hand hygiene and educated staff frequently. The DON said residents were at risk for the spread of infection if hand hygiene was not performed. Record review of the facility policy, Hand Washing/Hand Hygiene, revised 12/22/23, reflected: The facility considers hand hygiene the primary means to prevent the spread of infections.7. Use an alcohol-based hand rub.or alternatively, soap. and water for the following situations.m. After removing gloves.