

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: 676217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Royse City Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 901 W Interstate 30 Royse City, TX 75189	
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 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 observations, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that: The facility failed to ensure food items in the facility walk-in refrigerator were dated and labeled on 2/10/2026. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination. Finding included: Observation on 2/10/2026 at 9:13 AM of the walk-in refrigerator revealed one block of cheese wrapped in plastic and one pack of lunch meat not dated or labeled. In an interview on 2/11/2026 at 10:30 AM with the Consultant Dietitian revealed her expectation was that all food items in the kitchen should be appropriately labeled and dated. She stated that if the deli meat and cheese block was taken out of the original packaging, it should be labeled and dated with received date. She stated that the risk to residents of not appropriately dating and labeling food items was potential food borne illness. During an interview on 02/11/2026 at 1:09 PM with the Dietary Manager revealed that cooks were typically responsible for labeling and dating food items with received date or open date when they were stored in the refrigerator. She stated she expected all kitchen staff to date and label food items. She stated that risk of not labeling food items was food contamination and could make the residents sick. She stated that she provided frequent in-services to all kitchen staff on appropriate food storage. In an interview on 02/11/2026 at 1:17 PM with [NAME] B revealed she had been working as a cook in the facility for the last 6 years. She stated that everyone working in the kitchen were responsible for dating and labeling food items in the kitchen. She stated that they typically write used by date on all open items and received date on food items that were not opened. She stated that not labeling and dating food items could cause cross contamination and potentially cause illness in residents. Record Review of the facility policy titled Food Storage revised June 1, 2019, reflected, .2. Refrigerator. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Review of the Food and Drug Administration Food Code, dated 2022, reflected, 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility to all the residents the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 2 (Resident #2 and Resident#59) of 8 residents reviewed advanced directives. 1- The facility failed to obtain a physician order for a DNR in a timely manner after Resident #2 signed a DNR on [DATE]. 2- The facility failed to obtain a physician order for a DNR in a timely manner after Resident#59 signed a DNR on [DATE]. The care plan did not reflect the correct code status. These failures could place residents at risk of not having a physician order followed and could affect the rights of residents that elected a DNR and could result in the facility not honoring the resident's wishes. 1- Record review of Resident #2's Face Sheet dated [DATE] reflected resident was a [AGE] year-old male with an original admission date of [DATE] and re-admission date on [DATE]. Relevant diagnoses included unspecified Dementia (cognitive decline affecting daily life), Cognitive Communication Deficit, Type 2 Diabetes, Atherosclerotic heart disease (a heart condition caused by plaque buildup arterial walls) and Neurocognitive Disorder (a condition involving significant decline in mental functions). Record review of Resident #2's MDS assessment dated [DATE] reflected Resident #2 was unable to complete cognitive testing. Review of Resident #2's Out of Hospital Do Not Resuscitate Order reflected a completed form with a signature dated [DATE]. Review of Resident #2's physician orders dated [DATE] reflected an order for DNR dated [DATE]. During an interview with the MDS Nurse on [DATE] at 10:46am revealed the process for DNRs was the Social Worker completed the DNRs with the residents or their representatives, then the DNRs were provided to the ADONs and they obtained an order from the residents' physicians and entered it in the medical record. Once the order was entered into the system, the DNR warning for the residents would be visible in their record. She stated there could be a risk to the resident if an order by the physician was not entered timely after the resident signed their DNR because they (staff) could perform code against residents' wishes. The MDS Nurse stated when a resident had an emergency, staff would look at the physician orders to determine if they could perform CPR. During an interview with the DON on [DATE] at 10:58am revealed Resident #2 had signed the DNR on [DATE] but the physician order was not signed until [DATE]. She stated her ADONs oversaw orders after a DNR was signed. The DON stated it was an oversight that Resident #2 did not have an order immediately following the signed DNR. She stated she was made aware of Resident #2 not having had an order during an audit and it was corrected on [DATE]. The risk to the resident of not having had a DNR order in the medical record timely was, the resident could have gotten CPR against their wishes. During an interview with ADON E on [DATE] at 1:49 PM revealed it was the responsibility of the social worker to make sure that residents' wishes regarding a DNR were granted. ADON E stated DNRs were discussed with residents during care planning. The DRNs were then handed to the ADONs so they could obtain the physician orders. The DNR paperwork should have been given by the social worker to the ADONs the same day. ADON E stated when she received the DNR paperwork she would put the order in the system on the same day it was signed. ADON E stated she did not know why there was a delay in obtaining the DNR from the social worker for Resident #2. She did not recall receiving Resident #2's DNR but obtained the order for his DNR during a random audit in [DATE]. The risk to the Resident of not having had the order for the DNR entered timely was the resident could have stopped breathing and the staff could have done CPR, which would have been against the families wishes. ADON E stated the residents face sheet changed in their medical record once the order for the DNR was entered into the system. 2- Record review of Resident #59's Quarterly MDS assessment dated [DATE] reflected Resident #59 was a [AGE] year-old female admitted to the facility on [DATE], and readmitted [DATE] with diagnoses included hypertension (elevated blood pressure), cerebrovascular accident (a medical (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency occurring when blood flow to the brain is interrupted or reduced, causing brain cells to die), Hemiplegia or Hemiparesis (both neurological conditions causing one-sided body weakness, typically due to stroke, brain injury, or tumor), non-Alzheimer's dementia (distinct brain disorders (e.g., Vascular, Lewy Body, Frontotemporal) that often present with early personality changes, hallucinations, or motor issues rather than memory loss), and seizer disorder (a chronic neurological condition characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain). Resident #59's had a BIMS score of 08/15, which indicated moderate cognitive impairment. Record review of Resident#59's care plan with revision date [DATE] revealed Focus: Resident#59 has elected a FULL CODE status. Goal: Resident/RP wishes will be respected x90 days. Intervention: Honor wishes Inform care givers of Full code Notify MD and family as soon as possible start of CPR and call 911. Record review of Resident #59's advance directive revealed Resident#59 signed Do not resuscitate form on [DATE], and the form was scanned to the PCC the same day ([DATE]). Record review of Resident#59's primary provider orders revealed summary order DNR (Do Not Resuscitate) dated [DATE]. Interview on [DATE] at 1:25 PM MDS nurse, she stated she did the care plan review quarterly. She stated the SW worker was responsible for getting the advance directive form signed by the Resident/ Resident representative and passed the form to the ADON to transcribe the order in the PCC. She stated the care plan not been updated with the correct advance directive will not affect the Resident because the nurses check the face sheet in case of emergency and the face sheet reflected the correct advance directive once the order was transcribed to PCC. She stated Resident#59's advance directive order not been transcribed to the PCC from [DATE] to [DATE] could lead to Resident#59 been resuscitated against her wishes. Interview on [DATE] at 1:49 PM ADON E stated if Resident#59 wishes were not followed properly and after the signature of the DNR form if the order was not in the system, the Resident could be resuscitated against her wish. She stated it was her responsibility to transcribe the DNR form order to the PCC once it was signed by the Resident or her representative. She stated the SW was responsible for getting the DNR form signed by the Resident or his/her representative and hand it to her to transcribe it to PCC. ADON E further stated she did not know how the order was not placed in PCC for one month and half. She further stated the Resident's face sheet changed once the order was in the PCC. Attempted to call Social Worker regarding Resident #2's signed DNR on [DATE] at 2pm and received no response. Requested Social Worker call Surveyor back but did not receive a call back. Interview on [DATE] at 2:04 PM the Medical Record staff stated the SW worker would give her or put in the basket (Basket for form/papers to be scanned) the DNR form signed, and she will scan it to PCC. The Medical Record staff stated her responsibility was just to scan the forms/papers staff member put in the basket for her to scan. She further stated it was not her responsibility to notify anyone about the scanned papers, because all the staff members that had access to PCC could see the scanned documents. Record review of the facility's policy Advance Directives revised [DATE] reflected .20. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 of 9 residents (Resident #61) reviewed for accuracy of assessments. The facility failed to accurately complete Resident #61's Quarterly MDS Assessment on 12/12/25 related to prescribed opioid medication use. This failure could place the resident at risk of not appropriately monitoring her medications Findings included: Record review of Resident #61's face sheet dated 2/12/26 reflected an [AGE] year-old female with an original admission date of 12/10/11 and readmission date of 12/22/22. Pertinent diagnoses included chronic kidney disease (long term progressive loss of kidney function, where kidneys are damaged and unable to properly filter waste), Acute and Chronic Respiratory Failure (the inability of the lungs to exchange oxygen and carbon dioxide) and Carcinoma of anus (cancer of the anus). Record review of Resident #61's Quarterly MDS assessment, dated 12/12/25 reflected resident had no cognitive impairment and had a BIMS of 15. Section N reflected resident continued antidepressant and antiplatelet medication, but Opioid medication was not checked. Record review of Resident #61's Order Summary Report as of 2/12/26, reflected a physician order dated 8/17/23 for Norco Oral Tablet 7.5-325 mg every 4 hours as needed. Record review of Resident #61's Medication Administration Record for December of 2025 reflected in the 7 days prior to the MDS completion, Norco Oral Tablet 7.5-325mg was given to Resident #61 on 12/5, 12/9 and 12/11. Interview and observation with the MDS Nurse Coordinator on 2/12/26 at 10:45am revealed she had last updated Resident #61's MDS assessment on 12/12/25 and it was her quarterly assessment. The MDS Nurse Coordinator reviewed Resident #61's assessment and noted Opioids were not checked off. She then reviewed the medical record for Resident #61 and stated the resident received opioid medication 7 days prior to when she completed the MDS assessment and therefore opioid should have been checked off on the MDS assessment. She stated she must have overlooked that the resident had received opioid medications when she completed the MDS assessment. The MDS Nurse Coordinator stated she got information to complete the quarterly MDS assessment from the MARS, CNA documentation, nurses' documentation, physician orders and progress notes. Some of the sections required a 7 day look back period and the medication section was one of those areas. The MDS Nurse Coordinator stated if something was not properly coded on the MDS assessment it could affect the care planning for the residents and managing/monitoring of their medications. The RAI manual was used to help her determine what she coded. She completed MDS training annually or as needed when CMS did updates. In an interview with the DON on 2/12/26 at 3:00pm revealed the MDS Nurse Coordinator was responsible for accurately completing the MDS Assessments of all residents. The facility did not have a policy for MDS Assessments because they used the RAI requirements set out by CMS. Record review of CMS's RAI Version 3.0 Manual effective October 2024 reflected .N0415H1. Opioid: Check if an opioid medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).		

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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 interviews and record reviews, the facility failed to ensure residents received adequate supervision and assistive devices, which enabled residents to transfer independently, for one (Resident #7) of three residents reviewed for assistive devices. The facility failed to obtain physician's order prior to installing Resident #7's Trapeze bar used for mobility and transfers (trapeze bar is an overhead assistive device designed for residents, with limited mobility to safely lift, reposition, or transfer themselves in and out of bed) This failure could affect residents by placing them at risk for not having their physician orders followed and decline in resident's mobility. Findings include: Record review of Resident #7's Quarterly MDS assessment dated [DATE] revealed Resident # 7 was a [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included: Peripheral vascular disease (narrowed blood vessels usually in the legs), Stroke (interruption of blood flow to the brain), Cerebral Palsy (permanent, non-progressive neurological disorders appearing in infancy that affect movement, muscle tone, and posture due to abnormal brain development or injury), Diabetes (high blood sugar), Hyperlipidemia (high blood lipids), generalized muscle weakness. Her BIMS score was 15 which indicated Resident #7 was cognitively intact. Resident #7 needed supervision or touching assistance for transferring from chair /bed to chair. Record Review of Resident #7's care plan revised on 12/12/25 reflected, Focus: [Resident #7] has an ADL self-care performance deficit [for Bilateral Above Knee Amputation], Developmental Disability, Reduced mobility. Intervention: Trapeze bar to assist with positioning. Record review of Resident #7's physician orders with the DON on 2/12/2026 revealed Resident #7 did not have a physician order for trapeze bar for mobility. In an observation and interview on 02/10/2026 at 12:38 PM with Resident #7 revealed she was in her wheelchair that was placed next to her bed. Resident #7 had bilateral above knee amputation. There was a free-standing trapeze bar above the bed. Resident #7 stated that she used trapeze bar for mobility from bed to wheelchair and back. She stated that the trapeze bar was put in about 5-6 months ago on her request. She stated she had a Trapeze bar at home and wanted one in the facility for easier transfers. In an interview on 02/11/2026 at 11:42 AM with ADON A stated that therapy department mostly provides recommendation for mobility devices. The charge nurses were then responsible for obtaining orders, discussing with the physician and transcribing them to physician orders. She stated that she did not remember if Resident #7 had physician orders for the trapeze bar. She stated that the risk of not having a physician order was residents would not get the care they need. In an interview on 02/11/26 at 11:55 AM with LVN C stated that she was not aware that there was no order for Trapeze bar. She stated that therapy sends recommendations and nurses would put in the physician order on behalf of the physician. She stated that having a physician order was important, so the resident receives the care. She stated that she did not know when the resident got the trapeze bar but stated she had seen the resident using the bar while transferring. In an interview on 02/11/2026 at 2:19 PM, the Director of Rehab (DOR) stated that Resident #7 received physical therapy services in the facility. The DOR reported that Resident #7 got out of bed independently, transferred herself to a wheelchair, and brought herself to the therapy room. The DOR stated that the trapeze bar was not recommended by therapy but acknowledged that it assisted with resident mobility due to the resident's bilateral above knee amputation. She stated that therapy department had observed Resident #7 transferring herself using the trapeze bar safely. She further stated that therapy provides recommendations for mobility devices and then handed them to the nursing department to be transcribed into physician orders. The DOR emphasized that physician orders were required for all mobility devices. In an interview on 2/11/26 at 2:30 PM with the DON stated that the trapeze bar was considered adaptive equipment and was therefore included in the resident's care plan. She reported that the physician was aware of and in agreement with the use of the trapeze bar and had approved it verbally. She (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged that the trapeze bar should have had a corresponding physician order in the medical record. The DON explained the risk associated with not having a written physician order, emphasizing that staff must follow physician orders for all mobility and adaptive devices to ensure resident safety and accurate documentation. The DON confirmed that maintenance installed the trapeze bar per Resident #7's request. In a phone interview on 02/11/2026 at 2:48 PM with the MDS Nurse stated that usually MDS and care plans were developed based on active physician orders. She stated that she observed Resident #7 transferring herself while holding the trapeze bar during a transfer in December 2025 and added it to her care plan. She reported that she did not check for a physician order for the trapeze bar at that time. She stated that having a physician order was important for accurate documentation. In an interview on 02/12/2026 at 9:59 AM with the Maintenance Director stated that for installing any mobility device, the process typically involved the ADON obtaining a physician order before equipment was put into place. The Maintenance Director stated that the trapeze bar for Resident #7 had been in place for approximately 5-6 months and he did not recall whether he checked with Nursing regarding Physician order for the same. In a follow-up interview on 02/12/2026 at 12:33 PM with the DON she stated that facility did not have specific policy for obtaining physician orders for mobility devices, however her expectation was staff followed nursing standards of practice which required obtaining a physician order for all resident care needs.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 (Resident #4) of 6 residents observed for infection control. The facility failed to ensure LVN D and CNA F wore appropriate PPE when transferring Resident #4 on EBP isolation from shower chair to bed on 02/10/26. This failure could place residents at risk for infection and cross contamination of pathogens and illness. Record review of Resident #4's Quarterly MDS assessment dated [DATE] reflected Resident #4 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), cerebrovascular accident (a medical emergency occurring when blood flow to the brain is interrupted or reduced, causing brain cells to die), Hemiplegia or Hemiparesis (both neurological conditions causing one-sided body weakness, typically due to stroke, brain injury, or tumor), non-Alzheimer's dementia (distinct brain disorders that often present with early personality changes, hallucinations, or motor issues rather than memory loss), and cognitive communication deficit. Resident #4 had a BIMS score of 09/15, which indicated moderate cognitive impairment. The MDS assessment indicated Resident #4 was coded 09 for Tub/shower transfer indicating: Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Record review of Resident #4's Care Plan dated 12/10/25, reflected the following: Focus: [Resident #4] has an ADL self-care performance and require staff assistance for all ADL's . Goal: The resident will maintain current level of function through the review date. Interventions: . Hoyer lift for transfers . Staff to assist with all ADL's as required .Review of Resident#4 Doctor order summary dated 02/10/26 and active revealed Nursing intervention: implement and maintain enhanced barrier precautions when performing high contact care activities. Diagnosis wound Observation on 02/10/26 at 10:31 AM, revealed there was signage on the right side of Resident #4's door that read: Enhanced barrier precautions everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and gown for the following high-contact Resident care activities. Inside Resident #4 room, there was PPE supplies (gloves, gowns.) stored on a supplies storage plastic drawers sitting on the top of the Resident's nightstand. CNA F was observed exiting Resident #4's room with gloved hands. CNA F removed her gloves, put them in the housekeeper trash humper, sanitized her hands with hands sanitized dispenser in the Hallway, and went looking for someone to help her transfer Resident#4 from shower chair to bed. CNA F and LVN D entered Resident #4's room. Both CNA F and LVN D washed their hands, put on clean gloves and did not put on gowns. Resident #4 was seen sitting in the shower chair covered with a blanket with the Mechanical lift sling under her. A Mechanical lift was observed next to Resident #4's bed. LVN D and CNA F attached the lift sling to the Mechanical lift and transferred Resident #4 from chair to bed. Once the transfer was completed, both staff turned Resident #4 side to side and removed the sling. LVN D removed her gloves, washed her hands, and exited the room. CNA F removed her gloves, took the Mechanical lift outside the room, and sanitized hands. In an interview and observation on 02/10/26 at 10:47 AM, LVN D stated she did not put the gown on, because she did not notice the signage at the entrance of the room, was not familiar with the resident, and it was her first day on the job. LVN D looked at the signage by the door, and reentered the room, and located the supplies at Resident#4 room, and stated yes the EBP was for Resident#4. LVN D stated that residents' transfer was a form of high contact with the Resident on EBP that required wearing a gown and gloves. She said the risk of not wearing appropriate PPE was increased risk of infection and possible cross contamination to the residents. In an interview on 02/10/26 at 10:52 AM, CNA F revealed she was a hospice Aide, that had been coming to the facility to render hospice service to Resident #4. She stated she did not know that Resident #4 was in EBP, and she did not notice the signage by the room entrance. She stated when she stepped outside the room (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with gloved hands, she was looking for help with Resident #4's Mechanical transfer. She said the risk of not wearing appropriate PPE was increased chance of infection and possible cross contamination to the residents. Interview with the DON on 02/12/26 at 10:26 AM, she stated for the EBP they had signage outside the resident's room, and for any high contact activity with the resident on EBP including transfer, peri care .staff should be gowning and gloving. She stated she and the staffing coordinator were responsible for training staff on infection control. The DON further stated training for EBP was done on hire, on monthly staff meeting, and as needed. The DON stated training for hospice agency staff was done by their agency, and sometimes she incorporated them with her staff training. The DON stated they used EBP to prevent infection to high-risk residents. Review of the facility policy titled Implementation of Standard and Transmission-Based Precautions dated 03/2024 revealed .3. Enhanced Barrier Precautions (EBP) - Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities.I. Enhanced-Based Precautions are indicated during: . Bathing/showering in a shared/common shower room. Transferring .		