STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676335	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadmoor Medical Lodge	5242 Medical Drive Rockwall, TX 75032

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 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. (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 0644 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 interview and record review the facility failed to incorporate the recommendations from the PASARR Level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 1 of 2 residents (Resident #2) reviewed for PASARR. The facility failed to initiate an NFSS within 20 business days following the date the services were agreed upon in the IDT meeting. This failure could cause residents with mental health disorders and psychiatric conditions to have a delay in services or not receive specialized services or equipment that may be needed.Findings included:Record review of Resident #2's face sheet, dated 11/19/25, reflected Resident #2 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included major depressive disorder and anxiety. Record review of Resident 2's significant change in status, dated 04/07/25, reflected Resident #2 rarely/never made herself understood and rarely/never understood others. The assessment reflected Resident #2 cognitive skills for daily decision making was severely impaired. Record review of the PCSP meeting dated 06/10/24 indicated that a customized manual wheelchair was recommended for Resident #2. Record review of Resident #2's EMR dated 11/18/25 indicated Resident #2 passed away on 04/09/25 at the facility on hospice. During a telephone interview on 11/18/25 at 11:17 a.m., the complainant stated the facility failed to ensure Resident #2 received a customized wheelchair 20 days after the IDT meeting on 06/10/24. During an interview on 11/18/25 at 12:10 p.m., the MDS Coordinator stated it was never a request for a wheelchair. The MDS Coordinator stated the only time Resident #2 got out of bed was for her to sit in the recliner. The MDS Coordinator stated after the IDT meeting, she entered the information into the portal and then the Habitation Coordinator reviewed the information and signed off as completed. The MDS Coordinator stated the next step should have been to get with the DOR and discuss getting the DME company out to fit the resident for an appropriate chair. The MDS Coordinator stated she had 20 business days to submit the NFSS form to the portal. The MDS Coordinator stated that the resident, nor the family requested a wheelchair, she entered it incorrectly that a wheelchair was recommended. The MDS Coordinator stated Resident #2 was using the facility chair, and it met her needs. The MDS Coordinator stated she noticed the error after surveyor intervention. The MDS Coordinator stated it was important to complete the NFSS in time for continuity of care. During an interview on 11/18/25 at 12:31 p.m., the DOR stated the OT was already in the process of getting her a personalized wheelchair through a DME company. The DOR stated the family wanted her to get up more often and have her mobile. The DOR stated a standard wheelchair would not fit her. The DOR stated the resident received the wheelchair through a DME company. The DOR stated the wheelchair was delivered on 12/24/24. When asked what the reason for the delay in the resident getting the chair, the DOR stated, the facility was trying to file it through Resident #2 insurance source instead of PASRR. The DOR stated she remembered during the meeting, the habilitation coordinator asking the family if they wanted to go through PASRR or a DME company and the family requested to speak to the DME company. During a telephone interview on 11/18/25 at 12:54 p.m., the Habilitation Coordinator stated during the initial PSCP meeting on 06/10/24 a wheelchair was recommended and the family agreed to go through PASRR. The Habilition Coordinator stated she sent an email to the DON, ADON, Social Worker, DOR, and the MDS Coordinator on 10/03/24 informing them that they did not make a request for the customized wheelchair on 06/10/24. The Habilitation Coordinator stated she reached out again via email on 10/08/25 for an update. The Habilition Coordinator stated after following up several times she was notified by the DOR that the facility went through a part B source (DME company) not part A (PASRR). The Habilitation Coordinator stated the facility wheelchair was standard and the one through PASRR fitted specifically to the resident. The Habilition Coordinator stated the facility had 20 business days to initiate the wheelchair process from the IDT meeting on 06/10/24. The Habilition Coordinator stated the risk of not completing the process within the time frame put Resident #2 not having the full QOL she potentially could have. During an interview on 11/19/25 at 5:45 p.m., the DON stated she was not aware of the exact time when the NFSS should be completed after the IDT meetings. The DON stated that it was the MDS Coordinator responsibility to complete the NFSS within the appropriate time frame. The DON stated the Regional Clinical Reimbursement Specialist was responsible for monitoring and overseeing the PASRR process. The DON stated it was important to ensure the residents' needs were met in a timely manner. During a telephone interview on 11/19/25 at 6:05 p.m., the Regional Clinical Reimbursement Specialist stated that the NFSS should be

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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 0692 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, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for 3 of 15 residents (Residents #3, #4 and #5) reviewed for nutrition. 1. The facility did not ensure Resident #3 was given double protein portion as ordered by the physician. 2. The facility did not ensure Resident #4 was given ice cream and a shake as ordered by the physician. 3. The facility did not ensure Resident #5 was given a shake as ordered by the physician. These failures could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity.Findings Included: 1. Record review of Resident #3's face sheet, dated 11/19/25, reflected Resident #3 was an [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included hemiplegia (paralysis that effects on side of the body) affecting left non dominant side. Record review of the nutrition/dietary note dated 04/08/25 reflected the dietician recommended adding enhanced and double protein portions with meals. Record review of Resident #3's quarterly MDS assessment, dated 10/02/25, reflected Resident #3 usually made himself understood, and usually understood others. Resident #3's BIMS score was 6, which reflected his cognition was severely impaired. Resident #3 required set-up or clean up assistance with eating. Resident #3 has not had 5% weight loss or more in the last month or loss of 10% or more in last 6 months. Record review of Resident #3's undated comprehensive care plan reflected Resident #3 had potential nutritional problems related to adult failure to thrive, dysphagia (difficulty swallowing), and GERD (acid reflux). The care plan interventions included: provide, serve diet as ordered. Record review of Resident #3's order summary report, dated 11/19/25, reflected regular diet, pureed texture, regular consistently, enhanced and double portions with meals with a start date 11/12/24. During an observation and record review on 11/17/26 at 11:47 a.m., Resident #3 received a single serving of the entree which was golden fried chicken. The meal ticket reflected double portions. During an interview on 11/17/25 at 12:40 p.m., [NAME] D stated he should have gotten two servings of golden fried chicken instead of one. [NAME] D stated, it was a mistake when asked why Resident #3 did not receive double portions. [NAME] D stated it was his responsibility to ensure the trays were correct before serving a resident. [NAME] D stated this failure could potentially put Resident #3 at risk for further weight loss. 2. Record review of Resident #4's face sheet, dated 11/19/25, reflected Resident #4 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included muscle wasting and atrophy (decrease in size of a body part, cell, organ, or other tissue. Record review of the nutrition/dietary note dated 04/29/25 reflected the dietician recommended ice cream and house shake with lunch. Record review of Resident #4's quarterly MDS assessment, dated 11/13/25, reflected Resident #4 made herself understood, and understood others. Resident #4's BIMS score was 12, which reflected her cognition was moderately impaired. Resident #4 required set-up or clean up assistance with eating. Resident #3 has not had 5% weight loss or more in the last month or loss of 10% or more in last 6 months. Record review of Resident #4's comprehensive care plan, revised on 09/23/25, reflected Resident #4 had a history of unplanned/unexpected weight loss. The care plan interventions included: give the resident supplements as ordered. Record review of Resident #4's order summary report, dated 11/19/25, reflected mechanical soft texture, regular consistency. add shake and ice cream at lunch with a start date 09/04/25. During an observation and record review on 11/17/26 at 11:45 a.m., Resident #4 did not receive ice cream nor a shake with her lunch meal. The meal ticket reflected add shakes and ice cream at lunch. 3. Record review of Resident #5's face sheet, dated 11/19/25, reflected Resident #5 was an [AGE] year-old female, originally admitted to the facility on [DATE] with a diagnosis which included active primary progressive multiple sclerosis (chronic autoimmune disease that affects the central nervous system). Record review of the nutrition/dietary note dated 06/23/25 reflected the dietician recommended house shakes BID between meals. Record review of Resident #5's quarterly MDS assessment, dated 11/06/25, reflected Resident #5 usually made herself understood, and usually understood others. Resident #5's BIMS score was 9, which reflected her cognition was severely impaired. Resident #5 required set-up or clean-up assistance with eating. Resident #5 has not had 5% weight loss or more in the last month or loss of 10% or more in last 6 months. Record review of Resident #5's comprehensive care plan, revised on 05/20/25, reflected Resident #5 had unplanned/unexpected weight loss related to poor fluid intake. The care plan interventions included: give the resident supplements as ordered. Record review of Resident #5's order summary report, dated 11/19/25, reflected regular texture, regular/thin consistency with a start date 04/03/24. The order summary report did

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 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 interview and record review, the facility failed to collaborate with hospice representatives through effective communication for 1 of 2 residents (Resident #1) reviewed for hospice services. The facility failed to communicate with hospice on 08/13/25 when Resident #1 fell, and on 10/17/25 when Resident #1 received bruises. This deficient practice could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: 1. Record review of Resident #1's face sheet, dated 11/21/25, indicated he was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), hypertension (high blood pressure), and stroke. Record review of Resident 1's significant change in status, MDS assessment, dated 08/20/25, indicated Resident #1 was sometimes understood and was sometimes understood by others. Resident #1's BIMS score was a #00, which indicated she was severely cognitively impaired. The MDS indicated Resident #1 required total or extensive assistance with her ADLs. The MDS indicated she was receiving hospice service. Record review of Resident #1's physician orders dated 08/07/25 indicated an order for {name} hospice. Record review of Resident #1's incident report dated 08/13/25 did not indicate that hospice was notified of the fall. The incident did not reveal any injuries. Record review of a complaint intake dated 10/14/25 indicated the hospice company was not being notified of all changes on Resident #1. Record review of Resident #1's incident report dated 10/17/25 did not indicate that hospice was notified of bruises to the left forearm. Record review of Resident #1's comprehensive care plan, dated 11/04/25, revealed Resident #1 had a terminal prognosis related to the diagnosis of dementia with risk for weight loss, developing pressure injuries, constipation, and decline in ADLs. Resident #1 was admitted to {name} hospice. The intervention was for staff to adjust the provision of ADLS to compensate for the residents' changing abilities. Encourage participation to the extent the resident wishes to participate and consult with the physician and Social Services to have Hospice care for the resident in the facility. During a phone interview on 11/17/25 at 2:05 p.m., the Hospice DON said they admitted Resident #1 on 08/07/25. She said the facility should notify them of any changes with Resident #1. She said the RP had mentioned, as well as hospice nurse B, that they were not being notified when the residents had a change, such as a fall or skin changes. The DON looked at the call log and could not see where the facility called hospice on 08/13/25 or 10/17/25. She looked at the nurses' notes for dates of 08/13/25 and 10/17/25 and could not see any documentation on those dates. She said it was important for the facility to notify hospice of any changes so that hospice could assess and correlate care with the facility. During an attempted phone interview on 11/18/25 at 4:53 p.m., LVN C, who completed Resident #1's incident report on 08/13/25, was unsuccessful. During a phone interview on 11/18/25 at 5:00 p.m., LVN A said she did a skin assessment on Resident #1 but could not remember the date on which she identified the bruises. She said she notified the DON but could not recall if she notified hospice. She said she was supposed to notify hospice of any changes for continuity of care. During an interview on 11/19/25 at 6:25 p.m., the DON said she expected the charge nurses to notify hospice of any changes. She said she did not know that hospice was not notified of Resident #1's changes. She said she and the nurse managers were the overseers for ensuring hospice was notified of changes. She said they monitored any changes in the morning meetings, looked at the 24-hour report for any changes and reviewed documentation. She said failure to notify hospice of any changes meant they were not aware and unable to provide care for the residents' needs. During an interview on 11/19/25 at 6:35 p.m., the Administrator said it was the nurse's responsibility to ensure hospice was notified of any changes in the residents. He said the nurse management team was the overseer of the process. He said hospice should be made aware of any changes in the residents to ensure their needs were met. He said failure to notify hospice was a lack of coordination of care. Record review of the facility's policy Hospice Program revised July 2017, indicated the facility was responsible for the following. C. notify hospice about the following changes, (1) a significant change in resident physical, mental, social, or emotional status. D. Communicating with the hospice provider (and documenting such communication) to ensure that the residents needs are addressed and met 24-hours per day.