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	12/05/2024

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

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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 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** 45879 Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 1 of 18 residents (Resident # 14) reviewed for MDS assessment accuracy. The facility failed to code Resident #14's hospice accurately. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #14's face sheet, dated 12/04/24 indicated Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia(forgetfulness), seizures, anxiety (uneasiness or fear), and high blood pressure. Record review of Resident #14's physician orders dated 07/27/24 indicated an order for {name} hospice. Record review of Resident #14's quarterly MDS assessment, dated 11/08/24, indicated Resident #14 was not on hospice service. Record review of Resident #14's care plan dated 10/29/24 indicated Resident #14 had a terminal prognosis and was on hospice service. The intervention was to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. During an interview on 12/04/24 at 1:42 p.m., the MDS Coordinator N said she was responsible for the completion of the MDS assessments. She looked at section O on Resident # 14 MDS assessment and said she did not code hospice. She said Resident #14 was on hospice services. She said it was important to code the MDS assessment correctly because it reflected their care and reimbursement. During an interview on 12/05/24 at 11:49 a.m. the DON said the MDS Coordinator was responsible for completing the MDS assessments. The DON stated she did not know why the MDS indicated Resident # 14 was not on hospice. The DON stated it was important for the MDS assessments to be accurately coded to make sure they provided the residents with the care they needed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 12:26 p.m. the Administrator said the MDS Coordinator was responsible for completing the MDS assessments. He said the DON was the overseer. The Administrator said he expected the MDS assessment, for any resident, to be completed thoroughly and correctly based on the resident assessment. During an interview on 12/05/24 at 12:46 p.m., the Regional Nurse Consultant indicated they do not have a policy for MDS coding. She said they follow the CMS RAI manual. Record review for the RAI manual on https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual: indicated on Section 00110 to code if a resident was on hospice.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review the facility failed to review and revise the person-centered care plan to reflect the current condition for 1 of 3 (Resident #49) residents reviewed for care plan revisions. The facility failed to revise Resident #49's care plan to remove her wound care when she no longer had a wound. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings Included: Record review of Resident #49's face sheet dated 12/04/24, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), Multiple Sclerosis (a chronic disease that damages the central nervous system), depression(a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily) and high blood pressure. Record review of Resident #49's quarterly MDS assessment dated [DATE], indicated Resident #49 understood and was understood by others. The MDS assessment indicated Resident #49 had a BIMS score of 10 indicating she was moderately cognitively impaired. The MDS indicated she required assistance with ADLs and set up for meals. The MDS did not indicate any wounds. Record review of Resident #49's comprehensive care plan revised on 04/03/24, indicated Resident #49 had a Stage 3 pressure ulcer on the right hip related to decreased mobility. The care plan interventions were for staff to provide wound care as ordered. Record review of Resident #49's order summary report dated 12/04/24, indicated Resident #49 had no wound orders. Record review of Resident #49 wound care note dated 04/24/24 indicated her wound had healed. During an interview on 12/05/24 at 11:14 a.m., MDS Coordinator N said she was responsible for the care plans for the long-term residents. She said the care plan was done so the staff would know how to care for the resident. She said she was made aware of the residents' changes in the morning meeting and at times the floor staff would communicate to her about changes. She said anytime the residents had a change in their care, she should revise the care plan. She said Resident #49's wounds had healed, and the care plan should have been revised. She said care plans were done to reflect the resident's care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 11:49 a.m., the DON said she expected the care plans to be accurate. She said the MDS Coordinator was responsible for ensuring the care plans were kept current with the resident's care. She said during the morning meetings they discussed any changes with the resident's care, she said they also had weekly and quarterly meetings where the care plan should have been updated. She said Resident #49 did not have any current wounds. She said it was important to have the most updated care plan so that staff would know what care they needed to provide. During an interview on 12/04/24 at 12:46 p.m., the Administrator said the MDS Coordinator was responsible for the care plans. He said the DON was the overseer of the care plans. He said if care plans were not done residents might receive something they do not need or not receive something they do need. Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated, Policy statements a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy interpretation and implementation #2 The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment #13 Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. #14 The Interdisciplinary Team must review and update the care plan: a. when there has been a significant change in the resident's condition, b. when the desired outcome is not met, c. when the resident has been readmitted to the facility from a hospital stay and, d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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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** 45879 Based on observations, interviews, and record reviews, the facility failed to ensure that the resident environment remained as free of accident hazards as possible for 1 of 18 Residents (Resident #37) reviewed for accidents and hazards. The facility failed to ensure Resident #37 had on her wander guard bracelet on 12/2/24 and 12/3/24. This failure could place residents at risk of elopement, injury, or harm. Findings included: 1.Record review of Resident #37's face sheet, dated 12/04/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory), Schizophrenia (a chronic mental disorder that affects a person's ability to think, perceive reality, and interact with others), and depression (sadness). Record review of Resident #37's quarterly MDS assessment, dated 11/21/24, indicated Resident #37 understood and was understood by others. Resident #37's BIMS score was a 10 indicating her cognition was moderately impaired. The MDS indicated Resident #37 required limited assistance with her ADLs including transfers and bed mobility. The MDS indicated she had an elopement/wander alarm. Record review of Resident #37's comprehensive care plan dated 09/30/24 indicated, she was at risk for elopement/wandering related to impaired safety awareness. The interventions were for staff to monitor the wander guard to the left lower leg and distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Also, remind the resident not to leave the facility without assistance. Record review of Resident 37's Physician order dated 09/16/24 indicated, she had a wander guard to the Left lower leg related to exit-seeking behaviors. Check placement every shift. Record review of Resident #37's Elopement Risk Evaluation dated 09/16/24 indicated she was at risk of elopement. During an observation on 12/02/24 at 11:35 a.m., Resident #37 was in bed with no wander guard bracelet on her left lower leg. During an interview on 12/04/24 at 5:00 p.m., Resident #37 said she did have on her wander guard, but it had been removed a long time ago (unknown date). During an observation and interview on 12/04/24 at 5:18 p.m., Resident #37 was lying in her bed and no wander guard was on her leg. CNA R verified by looking at Resident #37's leg and said she did not have a wander guard bracelet on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 11:49 a.m., the DON said Resident #37 was supposed to have her wander guard on and the nurses should check for placement each shift. She said Resident #37 had removed her wander guard before but was not sure why Resident #37's wander guard was not in place. She said all staff was responsible for ensuring the residents who had orders for wander guards, had the wander guards on. She said if Resident #37 did not have on her wander guard she was at risk for elopement. During an interview on 12/05/24 at 12:46 p.m., the Administrator said if Resident #37 had an order for a wander guard, then she should have had on her wander guard. He said wander guards were used for residents at risk of wandering. He said all staff were responsible for ensuring the wander guard was in place. Record review of facility policy titled, Wandering and Elopement, dated November 15, 2023, indicated, Policy statement: The facility will identify residents who are at risk of unsafe wandering and implement appropriate protective measures to help guard against a resident wandering from the facility. The facility strives to prevent harm while maintaining the least restrictive environment for residents. Policy interpretation and implementation: identifying residents at risk 1. on admission, readmission, quarterly doing observation period of the MDSs, annual significant changes, and as needed. The nurse will screen each resident for elopement risk using the elopement risk evaluation or equivalent form. After reviewing this information, the nursing staff will determine if the resident is at risk of wandering or elopement.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 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 4 of 4 resident reviewed for pharmacy services. (Resident's #5, #11, #49, and #50) The facility failed to ensure Resident #11's ordered alprazolam (antianxiety) medication was available for administration on 11/26/2024, 11/27/2024, 11/28/2024, and 11/29/2024, which resulted in 11 missed doses of her antianxiety medication. The facility failed to ensure Resident #50's ordered Letrozole (hormone treatment for breast cancer) medication was available for administration 12/03/2024. The facility failed to ensure Resident #49's tramadol (scheduled ll pain medication) was accurately reconciled on 12/03/2024. The facility failed to ensure Resident #5 was not administered Hydrocodone 10/325 milligrams out of the ordered administration times on 12/04/2024. These failures could place residents at risk to have increased symptoms of anxiety, change in hormonal levels affecting breast cancer, medication errors and loss of medications through drug diversion. The findings included: 1. Record review of the face sheet, dated 12/05/2024, reflected Resident #11 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of unspecified dementia, without behaviors (a group of symptoms affecting memory, thinking and social abilities that interferes with daily life) and generalized anxiety disorder (a mental and behavioral disorder characterized by excessive, uncontrollable, and often irrational worry about events or activities). Record review of the admission MDS assessment, dated 10/22/2024, reflected Resident #11 had clear speech and was understood by others. The MDS reflected Resident #11 was able to understand others. The MDS reflected Resident #11 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #11 had no behaviors or refusal of care. The MDS reflected Resident #11 had an active diagnosis of anxiety disorder. The MDS reflected Resident #11 received an antianxiety medication with a noted indication for use. Record review of the comprehensive care plan, revised 10/23/2024, reflected Resident #11 used antianxiety medication related to anxiety disorder. The interventions included: administer antianxiety medication as ordered by the physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the order summary report, dated 12/02/2024, reflected Resident #11 had an order, which started on 10/15/2024, for alprazolam (antianxiety medication) 1 mg by mouth three times a day for anxiety. Record review of the MAR, dated November 2024, reflected Resident #11 refused the 3 PM dose of alprazolam on 11/26/2024. The MAR reflected Resident #11 did not receive the alprazolam on 11/27/2024 at 9 AM, 3 PM, or 9 PM; on 11/28/2024 at 9 AM; on 11/28/2024 at 9 AM; and on 11/29/2024 at 9 AM. There were 7 missed doses of alprazolam documented on the MAR. There were no documented behaviors on the MAR. Record review of the controlled drug record sheet, undated, reflected Resident #11 received the last dose of her alprazolam on 11/26/2024 at 9 AM. Record review of the controlled drug record sheet, dated 11/29/24, reflected Resident #11's alprazolam was given at 11/30/2024 at 8 AM. Resident #11 missed 11 doses of her alprazolam (antianxiety medication). Record review of the administration note, signed and dated 11/27/2024 at 9:09 AM by MA G, reflected Resident #11's alprazolam was not administered related to out of stock. The note indicated the nurse was notified. Record review of the administration note, signed and dated 11/28/2024 at 8:59 AM by MA G, reflected Resident #11's alprazolam was not administered related to out of stock. The note indicated the nurse was notified. Record review of the administration note, signed and dated 11/29/2024 at 9:22 AM by MA G, reflected Resident #11's alprazolam was not administered related to out of stock. The note indicated the nurse was notified. During an observation and interview on 12/02/2024 beginning at 11:32 AM, Resident #11 was sitting on her bed. Resident #11 was pleasant and calm during the interview with her hair neatly combed and clothing without stains or odors. Resident #11 stated she had no problems whatsoever with the care she received at the facility. Resident #11 stated she had an issue during the last week (11/25/24 to 11/30/24) with not receiving her antianxiety medication. Resident #11 stated she felt like she had an anxiety attack because her toes went numb. Resident #11 stated she was going to talk to the doctor about it and was waiting on him to come to the facility. During an interview on 12/02/2024 beginning at 5:47 PM, RN A stated he did not normally work on Resident #11's hallway. RN A stated he worked on Resident #11's hallway on 11/29/2024 and was passing medications. RN A stated he realized Resident #11 was out of her alprazolam, so he notified the pharmacy. RN A said the pharmacy reported they were unable to see the order on their side, so RN A stated he re-entered the order in the computer system to fix it. RN A stated Resident #11 did not receive her alprazolam on 11/29/2024 because it was unavailable at the facility. RN A stated he was unsure how long Resident #11 went without her medication. RN A stated he did not notice if Resident #11 had an increased anxiety or signs of a panic attack. RN A stated resident's who did not receive their antianxiety medication could have had increased anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/03/2024 beginning at 8:01 AM, RN H stated last week on approximately Thursday (11/28/2024) MA G reported Resident #11 had approximately 2 alprazolam left. RN H stated the psychiatric doctor was at the facility and she believed the doctor was going to send in the refills to the pharmacy. RN H stated to her knowledge Resident #11 did not go without her antianxiety medication. RN H stated she did not notice if Resident #11 had any increased anxiety or signs of a panic attack. RN H stated the process for re-ordering narcotic medication was as follows: when the card got down to about 7 or 8 pills, the MA should have notified the charge nurse. The charge nurse then notified the pharmacy to see if there were any refills available. RN H said if the medication had refills left the charge nurse was able to re-order the medication. RN H stated if no refills were available, then the charge nurse would have notified the agent for the doctor so they could have called in the order to the pharmacy. RN H stated the ADONs were agents for the doctors at the facility. RN H stated the facility had a lot of problems with the pharmacy including sending medication timely. RN H said they also had trouble with getting the agents to call in the refill orders. RN H said that if a resident did run out of their antianxiety medication, she would have notified the doctor to get a STAT order or to see if anything could have been put in place. RN H said if a resident did not receive antianxiety medication, it could have caused a panic attack. RN H said signs of a panic attack included increased heart rate, sweating, agitation, and confusion. During an interview on 12/03/2024 beginning at 8:05 AM, MA G said Resident #11 ran out of her antianxiety medication last week. MA G stated she was unsure what day it was and was unsure how long she went without the medication. MA G stated she notified RN H about 3 days before Resident #11 ran out of medication. MA G stated RN H notified LVN K and LVN K called the medication into the pharmacy. MA G said the last she heard about the medication was that it needed a new prescription, and the pharmacy was waiting on the doctor to send it in. MA G stated alprazolam was not in the e-kit. MA G stated she kept asking and reminding the nurses who worked that she was out, but she was unsure if anything was done. MA G said the process for re-ordering controlled medication was to notify the nurse, then the nurse would have notified the pharmacy to see if any refills were available. MA G said if refills were available the pharmacy would have sent the medication. MA G said if refills were unavailable the nurse would have notified the doctor. MA G said medication aides could not have re-ordered controlled medication. MA G said resident who did not receive their antianxiety medication could have cause anxiety, insomnia, and increased moodiness. During an interview on 12/03/2024 beginning at 8:12 AM, LVN K stated she did not believe it was reported that Resident #11 was out of alprazolam. LVN K stated if a resident ran out of medication, the medication aid should have let the charge nurse know. LVN K said the charge nurse should have notified the pharmacy and checked for refills. LVN K said if refills were available then the pharmacy would have sent the medication. LVN K said if refills were unavailable then the charge nurse was supposed to notify her because she was an agent of the doctor. LVN K said she then would call the prescription into the pharmacy. LVN K said she did not work on 11/28/2024 and did not believe the pharmacy was open on 11/27/2024. LVN K said she worked on 11/29/2024 but did not remember being notified Resident #11 was out of medication. LVN K said the nurses should have been able to get the alprazolam out of the e-kit if Resident #11 was out. LVN K said she would have had to call and authorize the prescription as an agent of the doctor. LVN K said then the charge nurses would have been able to call the pharmacy to obtain a code to remove controlled medication out of the e-kit. LVN K stated residents who did not receive antianxiety medication could have caused withdrawal symptoms or a panic attack. LVN K said signs of a panic attack were breathing heavy, and increased anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an attempted phone interview to gather additional evidence on 12/03/24 at 8:32 AM, LVN L did not answer the phone. A brief message was left with a call back number. No return call received upon exit of the facility. During an interview on 12/05/2024 beginning at 10:39 AM, the Pharmacy Technician said a nurse from the facility called in Resident #11's alprazolam on 11/29/2024. The Pharmacy Technician stated there was no call in to the pharmacy regarding Resident #11's alprazolam before that date. The Pharmacy Technician said it was called in after the first delivery cut off time, so the medication was delivered on the midnight run. The Pharmacy Technician said the medication was delivered on 11/30/2024 at 3:55 AM. The Pharmacy Technician said they were open all the time and was never closed, even during the holidays. The Pharmacy Technician said the facility would have been responsible for calling in the medication because they had no automatic system for refills. During an interview on 12/05/2024 beginning at 11:19 AM, PA M stated the psychiatric doctor typically was responsible for reordering psychotropic medication in residents who had a psychiatric diagnosis, such as anxiety. PA M stated if the facility was unable to get a response from the psychiatric doctor, then the facility could have notified him, and he would have sent in a 14 day order to the pharmacy. PA M stated he expected the facility staff to ensure controlled antianxiety medication was available to administer to the residents. PA M stated he was not notified Resident #11 was out of alprazolam during the last week (11/25/24 - 11/30/24). PA M stated Resident #11 had a true diagnosis of anxiety and histrionic behaviors. PA M stated Resident #11 was already anxious and going without her medication could have caused her to become more anxious. PA M stated it was important to ensure antianxiety medications were administered to keep the residents stable. During an interview on 12/05/2024 beginning at 12:32 PM, the DON said the charge nurse was responsible for monitoring to ensure medications were re-ordered and available at the facility. The DON stated the medication aide should have notified the charge nurse if controlled medications were running low. The DON said the charge nurse would have called the pharmacy to determine if refills were available. The DON said if refills were unavailable then the charge nurse should have notified the agent of the doctor at the facility. The DON stated the nursing management was responsible for monitoring the charge nurses to ensure medication was available. The DON stated she was notified on 11/30/2024 that Resident #11 was out of her medication when the alprazolam arrived at the facility. The DON stated the charge nurses should have gotten the medication out of the e-kit until the medication arrived. The DON said it was important to ensure Resident #11 received her antianxiety medication to keep her at a therapeutic level. The DON said if Resident #11 did not receive her medication it could have caused anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/09/24 beginning at 1:11 PM, the Administrator said he expected the nursing staff to administer medication as ordered and prescribed by the doctor. The Administrator stated a nurse was notified Resident #11 was out of medication and that nurse did not get the medication out of the e-kit. The Administrator stated he was unable to explain that and Resident #11's alprazolam should have been administered out of the e-kit. The Administrator stated if Resident #11 was on the medication long-term then they have a system in place for ensuring residents did not go without medication. The Administrator stated the medication aide should have notified the charge nurse when there were 8 or 9 pills left, so the charge nurse could have gotten a new order or refill. The Administrator stated nursing management was responsible for monitoring to ensure medication was available at the facility and the nursing staff was following the system for re-ordering medication. The Administrator stated it was important to ensure Resident #11 received her antianxiety medication so it did not increase her anxiety or behaviors. 33249 2. Record review of a face sheet dated 12/04/2024 indicated Resident #50 was a [AGE] year-old female who admitted on [DATE] with the diagnoses of dementia (memory loss), and malignant neoplasm of the female breast (breast cancer). Record review of the comprehensive care plan dated 6/28/2024 failed to indicate Resident #50 was receiving hormonal treatment for her diagnosis of breast cancer. Record review of the Quarterly MDS dated [DATE] indicated Resident #50's BIMS score was 3 indicating severe cognitive impairment, she was usually able to understand and was usually understood. Section I-Active Diagnoses failed to indicate the diagnosis of malignant neoplasm of the female breast as an active diagnosis. Record review of the physician's orders dated 12/04/2024 indicated Resident #50 was ordered Letrozole 2.5 milligram tablet give one tablet daily for breast cancer on 6/18/2024. Record review of the electronic administration record dated December 2024 indicated on 12/03/2024 Resident #50 had a missed dose of Letrozole 2.5 milligrams. During an observation and interview on 12/03/2024 at 8:33 a.m., RN A attempted to prepare Resident #50's ordered Letrozole 2.5 milligrams for administration but there were none available for administration. RN A placed an order for the medication using his computer. RN A said he would notify the physician of the missed dose of medication. RN A said he was unsure why the medication was unavailable. RN A said the nursing staff were responsible for ensuring medications were available for administration. 3. Record review of a face sheet dated 12/03/2024 indicated Resident #49 was a [AGE] year-old female who admitted on [DATE] with the diagnosis of a healing fracture and dementia (memory loss disease). (continued on next page)

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	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an Admission MDS dated [DATE] indicated Resident #49 was understood and understood others. The MDS indicated Resident #49's BIMS score was a 6 indicating severe cognitive impairment. Section I-Active Diagnoses of the MDS indicated Resident #49 had a diagnosis of fractures or other multiple traumas. The MDS also indicated in Section I8000 Additional active diagnoses indicated pain to the left hip. Section J-Health Conditions in the section J0100 indicated Resident #49 received as needed pain medications. Record review of the comprehensive care plan dated 10/08/2024 indicated Resident #49 received pain medication for a right hip fracture. The goal of the care plan was Resident #49 would be free of any discomfort or adverse side effects from pain medications. The care plan interventions included to administer analgesic medications as ordered by the physician. Record review of the consolidated physician's orders dated 12/03/2024 indicated Resident #49 was ordered Tramadol 50 milligrams one tablet three times daily. Record review of the electronic medication administration record dated December 2024 indicated Resident #49 was administered Tramadol 50 milligrams on 12/03/2024 at 9:00 a.m. and 3:00 p.m. Record review of the undated narcotic administration record on 12/03/2024 at 4:30 p.m., Resident #49's Tramadol 50 milligrams was not signed out for the doses administered at 9:00 a.m. and 3:00 p.m. Record review of a Medication Administration Audit Report dated 12/03/2024 indicated Resident #49 was administered Tramadol 50 milligrams at 9:58 a.m. by RN A, and at 3:56 p.m. by MA B. The Medication Administration Audit Report failed to indicate a Tramadol 50 milligrams was administered at 4:30 p.m. on 12/03/2024 when MA B had the Tramadol 50 milligrams prepared and attempting administration when the surveyor intervened. The Medication Administration Audit Report indicated MA B administered the 9:00 p.m. dose of Tramadol 50 milligrams at 8:16 p.m. During an observation and interview on 12/03/2024 at 4:30 p.m., MA B was walking away from the 300-hall medication cart with a medication cup with one tablet in the cup. MA B said was he was administering Resident #49's Tramadol at this time. MA B provided the narcotic administration sheet for the surveyor to review. The narcotic administration record indicated there had not been any entries of the administration of the Tramadol for 12/03/2024. MA B was then asked to reconcile the narcotic Tramadol with the surveyor. Resident #49's narcotic administration record indicated there was 57 medications on hand. Resident #49's medication card of Tramadol 50 milligrams RX 5505760.00 filled on 11/21/2024 had 54 tablets. Resident #49's narcotic administration record indicated there should be 57 tablets available for administration. MA B said he had not reconciled the narcotics with RN A prior to taking over the medication cart. MA B was unable to explain the risks involved in not accurately reconciling the narcotics. During an interview on 12/03/2024 at 6:00 p.m., RN A said he had administered Resident #49's Tramadol for the 9:00 a.m., and 3:00 p.m. doses but failed to sign out the narcotic sheet. RN A said he was distracted and failed to sign out the administered medication on the narcotic sign out sheet. RN A said the narcotic sign out sheet should be signed when administering the medication. RN A said the risks were medication errors with readministering medications, and drug diversions (missing medications). RN A said the narcotic counts were to be reconciled at the start of a shift and at the end of shift, and/or when changing of nursing staff. (continued on next page)

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	676335	A. Building B. Wing	12/05/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Medication Administration Observation Report dated 7/19/2024 indicated MA B was observed by the pharmacist in the techniques including correct medication verified by visual check of the medication, label, and MAR (omission, unordered medication, wrong dose, route, dosage form, drug, and time). Record review of a Competency Assessment Administering Oral Medications dated 9/12/2024 indicated RN A was checked off on medication administration by the ADON. The check off included 9b. For Narcotics check the narcotic record for the previous drug count and compare with supply on hand. Report any discrepancies to the nurse supervisor. During an interview on 12/05/2024 at 11:30 a.m., the DON said she expected the medications to be signed out as administered. The DON said the importance of signing out as administered was to prevent re-administration and accurate record keeping. The DON said she expected the nursing staff to reconcile the narcotics each shift prior to accepting the cart and at the end of the shift prior to the next nurse assuming the cart. The DON said spot checks and check offs were used to ensure compliance. During an interview on 12/05/2024 at 11:48 a.m., LVN E said he expected the MAs to sign out the medications as they were administered to ensure medications were not re-administered. LVN E said nursing was responsible for re-ordering medications timely. During an interview on 12/05/2024 at 12:46 p.m., the Administrator said medication counting was a critical part of shift change. The Administrator said medications should be documented as giving as they were administered to ensure nursing was aware the medication was administered. The Administrator said signing out of narcotics was a way to account for the use of the narcotics. The Administrator said he expected the nurse to monitor the MAs, the ADON and DON were responsible for oversight ultimately. 4)Record review of a face sheet dated 12/05/2024 indicated Resident #5 was a [AGE] year-old male who admitted on [DATE] and 3/09/2024 with the diagnoses of cognitive impairment, and low back pain. Record review of the comprehensive care plan dated 4/05/2024 indicated Resident #5 had chronic and acute pain related to diabetic disease and chronic low back pain. The goal of Resident #5's care plan was he would not have an interruption of his normal activities due to pain. The interventions included monitor and document causes of each pain episode, monitor/record/report to the nurse resident complaints of pain or request of pain treatment, notify the physician if interventions were unsuccessful or current complain was a significant change from the resident's past experience of pain. Record review of a Quarterly MDS dated [DATE] indicated Resident #5 was understood and understood others. The MDS indicated Resident #5's BIMS score was 9 indicating moderate cognitive impairment. The MDS in Section J-Health Conditions indicated Resident #5 received routinely scheduled pain medications and had not received as needed pain medications. Record review of the consolidated physician's orders dated 12/05/2024 indicated Resident #5 was ordered Norco Oral Tablet 10/325 milligram (hydrocodone-acetaminophen) give 1 tablet by mouth 4 times daily for pain on 4/05/2024. (continued on next page)

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	676335	A. Building B. Wing	12/05/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Medication Administration Record dated December 2024 indicated on 12/04/2024 Resident #5 was scheduled to receive Norco 10/325 milligrams one tablet at 1:00 a.m., 7:00 a.m., 1:00 p.m., and 7:00 p.m. Record review of the undated Individual Narcotic Count Sheet indicated Resident #5's Rx N7443372 Norco (hydrocodone) 10/325 milligrams was signed out on 12/04/2024 at 2:00 a.m., 8:00 a.m., 2:00 p.m., and 8:00 p.m. dose indicated was pulled for dosing by MA B but wasted by the DON. Record review of the Medication Administration Audit Report dated 12/02/2024 - 12/04/2024 indicated Resident #5 last administration of Norco 10/325 milligrams at 12:34 p.m. for the scheduled 1:00 p.m. by MA C. During an observation and interview on 12/04/2024 at 3:44 p.m., MA B was standing at the medication cart. MA B was asked to allow the surveyor to review the medication cart for compliance with opened and dated medications, and cleanliness. MA B opened the top drawer of the medication cart and there were 3 medication cups with prepared medications for administration. MA B grabbed the cups and attempted to place them in his jacket pocket. Upon request MA B removed the medications from his pocket and attempted to add applesauce to the medication cup MA B indicated was for Resident #5. MA B indicated Resident #5 was crying in pain and he was administering the 7:00 p.m. scheduled Norco 10/325 milligram at this time. MA B attempted several times to walk inside Resident #5's room to administer the medication but was stopped each time by the surveyor to clarify the administration. MA B said RN D had advised him to administer this medication. RN D who was standing a few feet away was summoned to the medication cart. RN D said he had in fact had not been consulted concerning Resident #5 crying in pain or the need to administer Norco 10/325 milligram at this time. RN D summoned the DON as requested . The DON and Corporate Clinical Nurse arrived at the medication cart. The DON questioned MA B concerning his preparation and attempt of administration of Resident #5's 7:00 p.m. medications at 3:44 p.m. MA B attempted to inform the DON of how Resident #5 was crying in pain and needed the medication early. The DON was noted to inform MA B this was out of his scope of practice and that he was not able to administer any medications without the physician's order. The DON advised MA B to waste the Norco 10/325 milligram medication at this time with her approval. The DON was informed the surveyor intervened in the administration due to the fact Resident #5's narcotic sheet indicated he had received his Norco 10/325 milligram at 2:00 p.m. just 1 hour and 44 minutes earlier. During an interview on 12/04/2024 at 4:32 p.m., the DON indicated Resident #5 was assessed and he denied being in pain and was sitting up in his wheelchair in his room. The DON said Resident #5 probably would not have suffered any adverse effects from the early administration of the Norco 10/325 milligrams, but another resident could suffer adverse effects. The DON said she had validated with MA B no other residents had received medications early off their scheduled times. Record review of a Medication Administration Observation Report dated 7/19/2024 indicated MA B was observed by the pharmacist in the techniques including correct medication verified by visual check of the medication, label, and MAR (omission, unordered medication, wrong dose, route, dosage form, drug, and time). (continued on next page)

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	676335	A. Building B. Wing	12/05/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/2024 at 11:39 a.m., the DON said she expected the MAs and nurses to follow the rights of medication administration including right time. The DON said administering pain medications too closely together could adversely affect some residents. The DON said she monitors the medication audit report to monitor for missed doses. The DON said the pharmacist also monitors the nursing staff with medication compliance. The DON said the nurses were responsible for reordering medications timely to ensure the medications were available for administration. The DON said missed medications could affect the residents adverse by not having optimal levels and effectiveness. During an interview on 12/05/2024 at 11:55 a.m., RN E said MAs were unable to assess residents for pain and decide what the course of action should be. RN E said the nurse should assess for pain, evaluate when the last administration of pain medications was provided, evaluate if an as needed dose of medication was required, and notify the physician for further guidance. RN E said nurses and MAs were responsible for reordering timely to ensure no medications were missed due to unavailability. RN E said the physician should be notified and all attempts made to ensure the medication was available for administration. During an interview on 12/05/2024 at 1:00 p.m., the Administrator said the nursing staff should know when the medication was low and order prior to exhausting what was on hand. The Administrator said the nurses have access to the emergency kit and the pharmacy could make a stat (three hour turn around) delivery. The Administrator said MA B made a decision he had never witnessed before. The Administrator said MA B failed to follow the facility's process for medication administration. The Administrator said nursing management was responsible for ensuring monitoring of medication management and administration of staff competencies. Record review of an Adverse Consequences and Medication Error policy dated April 2014 indicated, the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions and side effects 6. Examples of medication errors included: b. Unauthorized drug is administered without a physician's order g. Wrong time Record review of a Documentation of Medication Administration policy dated April 2007 indicated, the facility shall maintain a medication administration record to document all medications administered. 1. A nurse or Certified Medication Aide shall document all medication administer to each resident on the resident's medication administration record (MAR). Record review of a Controlled Substance policy dated December 2012 indicated, the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nursing going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. 10. The director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties and shall give the Administrator a written report of such findings. Record review of Medication Orders and Receipt Record policy, dated April 2007, reflected Medication should be ordered in advance, based on the dispensing pharmacy's required lead time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Pharmacy Services - Role of the Provider Pharmacy, dated April 2010, reflected the provider pharmacy shall agree to provide services that comply with applicable facility policies and procedures; accepted professional standards of practice, and laws and regulations, including (but not limited to), the following: .establish a reliable way to notify the facility in a timely fashion of issues and concerns related to medications and prescriptions .provide and maintain the facilities emergency medication supply . deliver medications to the facility . Record review of a Documentation of Medication Administration policy dated April 2007 indicated, the facility shall maintain a medication administration record to document all medications administered. 1. A nurse or Certified Medication Aide shall document all medication administer to each resident on the resident's medication administration record (MAR). Record review of a Controlled Substance policy dated December 2012 indicated, the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nursing going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. 10. The director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties and shall give the Administrator a written report of such findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on interview and record review, the facility failed to act upon the recommendations of the pharmacist report of irregularities for 1 of 5 residents (Resident #25) reviewed for (DRR) Drug Regimen Review. The facility failed to implement the pharmacy recommendations for Resident #25's medications that contained acetaminophen. This failure could place residents at risk for adverse side effects and not receiving medications at the most effective dosage. The findings included: Record review of the order summary report, dated 12/04/2024, reflected Resident #25 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of Parkinson's disease (age-related degenerative brain condition, meaning it causes parts of your brain to deteriorate) and chronic pain. Record review of the quarterly MDS assessment, dated 11/21/2024, reflected Resident #25 had no speech and was rarely/never understood by others. The MDS reflected Resident #25 was rarely/never able to understand others. The MDS reflected Resident #25 had poor long-term and short-term memory problems. The MDS reflected Resident #25 was unable to recall the current season, location of her own room, staff names and faces, or that she was in a nursing home. The MDS reflected Resident #25 had severely impaired decision making skills. The MDS reflected Resident #25 had an active diagnosis of chronic pain. The MDS reflected Resident #25 had no indicators of pain or possible during the last five days of the look-back period. Record review of the comprehensive care plan, revised 11/08/2024, reflected Resident #25 received pain medication therapy. The interventions included administer medication as ordered by the physician. Record review of the Director of Nursing Report from the pharmacy consultant, dated 08/28/2024, reflected Resident #25 had a pharmacy recommendation that stated Please note this resident has orders for routine and/or prn medications that contain acetaminophen. The FDA believes that limiting the amount of acetaminophen per tablet, capsule, or other dosage unit in prescription products will reduce the risk of severe liver injury from acetaminophen overdosing, an adverse event that can lead to liver failure, liver transplant, and death. Due to the high concern of hepatic injury, the makes or OTC Extra Strength Tylenol (acetaminophen) have voluntarily decided to change the directions on their label to include a revised maximum daily dosage of 3,000 mg (3 gm). Suggest adding to all orders that contain acetaminophen to not exceed 3,000 mg (3 gm) per day. (continued on next page)

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	676335	A. Building B. Wing	12/05/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Director of Nursing Report from the pharmacy consultant, dated 09/26/2024, reflected Resident #25 had a pharmacy recommendation that stated Please note this resident has orders for routine and/or prn medications that contain acetaminophen. The FDA believes that limiting the amount of acetaminophen per tablet, capsule, or other dosage unit in prescription products will reduce the risk of severe liver injury from acetaminophen overdosing, an adverse event that can lead to liver failure, liver transplant, and death. Due to the high concern of hepatic injury, the makes or OTC Extra Strength Tylenol (acetaminophen) have voluntarily decided to change the directions on their label to include a revised maximum daily dosage of 3,000 mg (3 gm). Suggest adding to all orders that contain acetaminophen to not exceed 3,000 mg (3 gm) per day. Record review of the order audit report, dated 12/04/2024, reflected Resident #25 had an order for acetaminophen - give 500 mg by mouth every 6 hours as needed for pain or fever. The order did not indicate to not exceed 3,000 mg (3 gm) per day. Record review of the order audit report, dated 12/04/2024, reflected Resident #25 had an order for Norco (Hydrocodone-Acetaminophen) 5-325 mg - Give 1 tablet by mouth every 6 hours as needed for pain. The order did not incident to not exceed 3,000 mg (3 gm) per day. During an interview on 12/05/2024 beginning at 10:54 AM, the Pharmacy Consultant stated when she made recommendation, she expected the facility to follow up and address the recommendations. The Pharmacy Consultant stated she expected do not exceed 3,000 mg (3gm) per day on at least one of the orders that contained acetaminophen. The Pharmacy consultant stated it was important to ensure do not exceed 3,000 mg (3 gm) per day was on the orders because it was the manufactures guidelines. The Pharmacy Consultant stated administering acetaminophen in the elderly placed them at risk for liver toxicity if they were to exceed 3,000 mg. The Pharmacy Consultant said it was important to have the information on the orders so the nurses were aware and could have calculated the amount of acetaminophen Resident #25 was getting. During an interview on 12/05/2024 beginning at 12:32 PM, the DON said when the pharmacy recommendations were received, she printed them out. The DON said her and the ADON went through the recommendations and updated the orders. The DON stated she missed Resident #25's recommendation for the acetaminophen. The DON said it was important to ensure pharmacy recommendations were implemented to ensure residents were getting the best care they could. During an interview on 12/05/2024 beginning at 1:11 PM, the Administrator stated he expected the pharmacy recommendations to be addressed and implemented. The Administrator stated nursing leadership was responsible for ensuring pharmacy recommendations were implemented. The Administrator stated failing to implement pharmacy recommendations could have placed residents at risk for side effects from medication or discomfort. Record review of the Pharmacy Services - Role of the Consultant Pharmacist policy, revised April 2007, reflected the consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility including: .helping identify and evaluate medication-related issues .appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities . The policy did not address implementing pharmacy recommendations.

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	676335	A. Building B. Wing	12/05/2024

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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. 33249 Based on observation, interview, and record review, the facility failed store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 2 medication carts (Hall 300 nurse medication cart and 300 hall medication cart) of 6 medication carts reviewed for medication storage. The facility failed to ensure MA B secured a controlled narcotic medication when he left a Tramadol inside a medication cup sitting on the 300-hall medication cart when he walked to the nurse's station. The facility failed to ensure RN F secured the 300-hall nurse cart when she entered the room, standing behind the privacy curtain to obtain a blood pressure, then again when she went behind the privacy curtain to obtain the over-the-bed table to prepare the supplies, then lastly when she closed the door and stepped behind the privacy curtain to administer the gastrostomy tube medications. Theseis failures could place residents at risk of ingesting medications not prescribed, and access to sharps (needles and lancets). Findings included: During an observation and interview on 12/03/2024 at 4:30 p.m., MA B had a medication cup in his hand, and a cup of water. MA B was asked about the administration of the medication in the cup. MA B said he needed to retrieve his computer from the nurse's station at the end of the hall 300. MA B placed the medication cup with a Tramadol 50 milligrams on top of the 300-hall medication cart while he went to obtain his computer from the nurse's station. MA B was out of the surveyor's line of site when he left the medication. MA B refused to answer why securing the medication was important. During an observation and interview on 12/03/2024 at 7:00 p.m., RN F took 300-hall cart to the resident's room . RN F opened the cart, obtained a blood pressure cuff, then walked into the room to assess the residents blood pressure. RN F then returned to the unlocked cart, then re-entered the room to obtain the over-the-bed table. After RN F prepared the medications for administration, she entered the room, shut the door, and went around the privacy curtain to administer the medications. RN F said she should have locked her medication cart each time. RN F said any resident can open the cart and obtain medications that were not prescribed to them. During an interview on 12/05/2024 at 11:42 a.m., the DON said she expected the medications and medication carts to be secured when not within site or easy reach. The DON said a resident could get into the cart, obtain medications, and pilfer through the cart. The DON said nurse management monitored with spot checks looking for unlocked carts and unsecured medications. The DON said nurses, medication aides, and nurse management were responsible for ensuring the medication carts remain locked and medications remain secured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 1:09 p.m., the Administrator said he expected the medications and medication carts to be always secured. The Administrator said management rounds were made several times during the day to check for compliance. The Administrator said drug diversions and residents could suffer adverse effects from obtaining medications from an unsecured medication cart. Record review of a Storage of Medications policy dated April 2019 indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls .3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner 8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes). 9. Unlocked medication carts are not left unattended.

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	12/05/2024

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

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure residents received therapeutic diets that were prescribed by the attending physician for 1 of 3 residents (Resident #49) reviewed for therapeutic diets. The facility did not ensure Resident #49 was given her ice cream as ordered by the physician. This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity. Findings Included: Record review of Resident #49's face sheet dated 12/04/24, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), Multiple Sclerosis (a chronic disease that damages the central nervous system), depression(a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily) and high blood pressure. Record review of Resident #49's quarterly MDS assessment dated [DATE], indicated Resident #49 understood and was understood by others. The MDS assessment indicated Resident #49 had a BIMS score of 10 indicating she was moderately cognitively impaired. The MDS indicated she required assistance with ADLs and set up for meals. The MDS assessment indicated Resident #49 had a therapeutic diet. Record review of Resident #49's comprehensive care plan revised on 09/20/24, indicated Resident #49 was at risk for nutrition problems related to the diagnosis of dementia. The care plan interventions were for staff to provide and serve diet as ordered. Record review of Resident #49's order summary report dated 04/03/24, indicated Resident #49 had the following order: Enhanced diet: Regular texture and thin consistency. Divided plate with meals, add butter, salt, and ice cream with lunch, and enhance mashed potatoes with dinner. During an observation and interview on 12/02/24 at 12:43 p.m., Resident #49's lunch meal ticket dated 12/02/24, indicated under meal note add shake and ice cream. Resident #49 did not have her shake or ice cream until the surveyor intervened by asking CNA R where her shake and ice cream were. CNA R said the nurses usually check the trays, but the CNAs should also recheck as they pass the trays to ensure the residents had everything on their trays. CNA R went to get the shake and ice cream. (continued on next page)

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	676335	A. Building B. Wing	12/05/2024

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/04/24 at 1:04 p.m., Resident #49 was in the dining room eating lunch. She did not have her ice cream on her tray. LVN E looked at her meal ticket and said she did not have her ice cream. He said the ice cream should have been passed out with her tray. He said he would get the ice cream. He said he did not realize when he was checking the tray cards that he missed her ice cream. During an interview on 12/05/24 at 11:49 a.m., the DON said the trays were supposed to be checked by the nurses in the dining room and then the aides when they passed the trays. She said it was important for the staff to read the tickets and ensure the residents were receiving the correct diets. She said Resident #49 should be receiving her ice cream when they serve the trays. She said failure to give the ice cream could cause Resident #49 weight loss. During an interview on 12/05/24 at 12:46 p.m., the Administrator said when staff was serving the trays, they were responsible for ensuring the resident had the correct diet and all supplements that were ordered. He said it was important for residents to receive the correct diet/supplement to prevent weight loss. Record review of the facility's policy titled Therapeutic Diet, dated October 2017, indicated Therapeutic diets are prescribed by the attending physician to support the resident treatment and plan of care and in accordance with his or her goals and purposes. Policy interpretation and implementation: #1 Diets will be determined in accordance with the resident's informed choices, preferences, treatment goals, and wishes diagnosis alone will not determine whether the resident is prescribed a therapeutic diet #7 The dietitian, nursing staff, and attending physician will regularly review the needs for, and resident acceptance of, prescribe a therapeutic diet.

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	676335	A. Building B. Wing	12/05/2024

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observations, interviews, and record reviews the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 1 resident reviewed (Resident #34) for special eating equipment and assistance when consuming meals. The facility failed to provide Resident #34's physician ordered plate guard. Thisese failures could place residents at risk for harm by weight loss, diminished independence, and self-esteem. Findings included: Record review of a face sheet dated 12/04/2024 indicated Resident #34 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnosis of dementia (memory loss), stroke, hemiplegia (paralysis or weakness of one side) and a contracture (shortening or hardening of muscle or tendon leading to rigidity) of the left hand. Record review of a Quarterly MDS dated [DATE] indicated Resident #34 was understood and understood others. The MDS failed to reflect Resident #34's BIMS score. The MDS indicated Resident #34 had a memory problem and was severely impaired on daily decision-making cognitive skills. The MDS indicated Resident #34 required partial/moderate assistance with eating. Record review of the Comprehensive Care Plan dated 2/28/2024 indicated Resident #34 had a potential for nutritional problems related to dementia and poor appetite. The goal of the care plan indicated Resident #34 would maintain adequate nutritional status as evidenced by no symptoms of malnutrition. The Comprehensive Care Plan dated 4/16/2024 indicated Resident #34 had a self-care deficit related to her stroke and limited mobility. The goal of the care plan was Resident #34 would maintain her current level of function. The care plan intervention for eating was to provide the required assistance. The care plan failed to mention the use of a plate guard. Record review of the Consolidated Physician's Orders dated 12/04/2024 indicated on 9/25/2023 Resident #34 was ordered an enhanced diet mechanical soft texture, thin liquids, and use of a plate guard and regular utensils with all meals. During an observation on 12/02/2024 at 4:50 p.m., Resident #34 was eating her evening meal in her room and in her bed. Resident #34 had enchiladas, beans, and broccoli with cauliflower. Resident #34's tray card failed to reveal a plate guard was required, and the plate guard was not present on Resident #34's plate. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/04/2024 at 11:55 a.m., Resident #34 was eating lunch in the dining room. Resident #34's lunch plate failed to have a plate guard. LVN E said he was unaware if Resident #34 required a plate guard. LVN E said Resident #34's tray card had not reflected the need of a plate guard. The DM said he was unaware of Resident #34 requiring a plate guard for her plates. LVN E said when an order was received for a device for meals, an order was provided to the DM. The DM said when he received the order communication, he would place the notice on the tray card in order Resident #34 received the needed plate guard during meal services. During an interview on 12/05/2024 at 11:35 a.m., the DON said she expected Resident #34 to have the plate guard in place with meals. The DON said the plate guard allows Resident #34 to feed herself independently. The DON said the process was the nurse would give the DM a copy of the order to implement the device. The DON said she shared the dietary audit report at least monthly with the DM to audit his diet cards. The DON said nursing was responsible for ensuring Resident #34 and all other residents had the needed devices during meals. During an interview on 12/05/2024 at 12:55 p.m., the Administrator said not having a plate guard could become a dignity and malnutrition issue for Resident #34. The Administrator said the meal was the one main part of the day a resident looked forward to and getting it right was important. The Administrator said the process was when the order was received, the nurse manager also ensured the DM received the orders as part of the review of orders. The Administrator said and the diets were reviewed weekly in the standards of care meetings. Record review of a Quality of Life-Accommodation of Needs policy dated August 2009 indicated our facility's environment and staff behaviors are directed toward assisting he resident in maintaining and/or achieving independent functioning, dignity, and well-being. 1. The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. 2. The resident's individual needs and preferences including the need for adaptive devices and modifications to the physician environment, shall be evaluated upon admission and reviewed on an ongoing basis.

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	676335	A. Building B. Wing	12/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45879 Based on observation, interview, and record review, the facility failed to ensure food was prepared and served in a manner that prevented foodborne illness for 1 of 1 kitchen reviewed for food preparation and serving. The facility did not ensure hair restraints were worn appropriately by the Dietary Manager. This failure could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During an observation on 12/02/24 at 11:10 a.m., revealed the Dietary Manager came into the kitchen and did not apply his hair or beard restraint. The Dietary Manager was in the freezer and storage area without his hair and beard restraint on. The Dietary manager's facial and beard hair was approximately 1/4 to 1/2 inch long. During an interview on 12/02/24 at 11:49 a.m., the Dietary Manager said he had ran to the store and heard that the state was in the facility and he was trying to get back and see what he needed to do. The Dietary Manager said he went into the freezer and the storage room without his hair or beard restraint on. He said he knew it was important to wear his hair and face restraint to prevent hair from getting into the food. During an interview on 12/05/24 at 11:49 a.m., the DON said she expected everyone to wear a hair restraint while in the kitchen area. She said that everyone should wear hair restraints to prevent hair or bacteria from entering the food and for infection control issues. During an interview on 12/05/24 at 12:46 p.m., the Administrator said he expected the kitchen to be clean and staff to prevent cross-contamination. He said the Dietary Manager was the overseer of the kitchen and should have had on his hair and beard restraints while in the kitchen. The Administrator said he expected hair restraints and face restraints (if required) to be worn to prevent hair loss in the food. Record review of the facility policy titled, Food Preparation and Services, dated July 2014, indicated, Policy: Food service employee shall prepare and serve food in a manner that complies with safe food handling practice. Foodservice/Distribution: #7 Dietary staff shall wear hair restraints (hair net, hat, beard restraints, etc) so that hair does not contact food.

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	676335	A. Building B. Wing	12/05/2024

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City of Ennis Dba Broadmoor Medical Lodge	5242 Medical Drive Rockwall, TX 75032

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 18 residents (Resident #14, and Resident #129) reviewed for hospice services. The facility failed to maintain Resident #14's, and Resident #129's hospice binder containing information related to hospice services provided for the resident such as the most recent plan of care, hospice election form, physician recertification, and hospice medication profile. These deficient practices 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 #14's face sheet, dated 12/04/24 indicated Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), seizures, anxiety (uneasiness or fear), and high blood pressure. Record review of Resident #14's physician orders dated 07/27/24 indicated an order for {name} hospice. Record review of Resident #14's quarterly MDS assessment, dated 11/08/24, indicated Resident #14 rarely understood and was rarely understood by others. Resident #14 had short and long-term memory loss indicating he was cognitively impaired. The MDS indicated Resident #14 required total or extensive assistance with his ADL's. The MDS indicated Resident #14 was not on hospice services. Record review of Resident #14's comprehensive care plan dated 10/29/24 indicated Resident #14 had a terminal prognosis and was on hospice services. The intervention was to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #14's hospice binder revealed it did not have the Physician certification of the terminal illness, care plan, medication list, or Hospice election form. The last IDT meeting was dated 8/08/24. The last recertification was dated 07/23/24-10/23/24. The resident had new orders for enhanced barriers and therapy added to his orders. (continued on next page)

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	676335	A. Building B. Wing	12/05/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 9:15 a.m., LVN H said she did not look at the hospice folder because she often communicated with hospice for all the changes related to Resident #14's care. She said she was not sure how often the hospice company had a meeting to discuss Resident #14's care or how often his folder should be updated. She said the hospice company was responsible for the upkeep of their folders or binders. She said hospice should have all the information for the resident such as meds and plan of care in the resident's folders or binders. During a phone interview on 12/04/24 at 2:36 p.m., the Hospice Administrator said the binders at the facility should contain a face sheet, the do not resuscitate copy, the IDG meetings, 3074 certifications of hospice, and any supporting notes or documentation needed for Resident #14. She said they met every two weeks for the IDG meetings and said the documentation should be updated at least monthly. She said someone from the office would usually bring all the information needed from the office to the nursing facility. She said it was important to have the binders at the facility to help the facility know why the resident was admitted and to ensure we were providing the care he needed. She said she would have someone drop off the necessary paperwork today (12/04/24). During an interview on 12/05/24 at 11:49 a.m., the DON said she expected the hospice documents to be at the facility with the most recent plan of care and current medication orders. The DON said the failure to ensure those documents were at the facility was due to a lack of communication with the facility and the hospice companies. The DON said it was the responsibility of the hospice company to ensure their documents were to the facility timely and then it was the nurse manager's responsibility to ensure that was being completed. The DON said there had not been any monitoring in place to ensure the hospice documents were being brought to the facility. She said the hospice binders help with medication changes and correlate care. During an interview on 12/05/24 at 12:46 p.m., the Administrator said it was the facility's responsibility to ensure all hospice documents were up to date. He said the nurse managers were the overseers of the process. He said the books should be updated because they reflect the care the resident should be receiving. 33249 2. Record review of a face sheet dated 12/04/2024 indicated Resident #129 was an [AGE] year-old male who admitted on [DATE] with the diagnosis of Alzheimer's Disease (memory loss disease). Record review of the Consolidated Physician's Orders dated 12/04/2024 indicated Resident #129 was orderedhad an order on 11/27/2024 to admit to hospice care. Record review of Resident #129's electronic medical record indicated the Admission MDS was in process. Record review of the Baseline Care Plan dated 11/27/2024 indicated in Section 4d.1 Specify home services: on hospice services. Record review of Resident #129's hospice binder and electronic medical record revealed there was not a hospice plan of care, a hospice election form, or a physician's certification of terminal illness. (continued on next page)

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	676335	A. Building B. Wing	12/05/2024

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/03/2024 at 2:57 p.m., the Director of the hospice provider indicated the entire hospice team was responsible for ensuring Resident #129's hospice record had the hospice plan of care, the hospice election form, and the physician's certification of terminal illness. The Director of the hospice provider indicated these forms were pertinent to ensure coordination of care. During an interview on 12/05/2024 at 11:33 a.m., the DON said the hospice provider should supply all the admission paperwork when the resident admitsadmitted to the facility. The DON said the facility had their own orders, and their own plan of care and she believed there would be minimal effect on the quality-of-care Resident #129 received. The DON said the nurse managers were responsible for ensuring the hospice provider updated the clinical records of each hospice resident. The DON said the nurse managers usually checked the hospice records at least with 24-48 hours of admission. During an interview on 12/05/2024 at 11:50 a.m., LVN E said he expected the hospice providers to keep Resident #129's hospice record current. LVN E said it was especially important to ensure coordination of care with medications and comfort. During an interview on 12/05/2024 at 12:50 p.m., the Administrator said he expected the hospice to provide all the required documents at the time of admission to ensure an accurate hand off of care ensuring the coordination of care. The Administrator said the nurse completing the admission was responsible for ensuring the documentation was available. The Administrator said the process was reviewed in the daily meetings to review the admissions, and then again in the weekly standards of care meetings. Record review of the Hospice Program policy dated July 2017 indicated Hospice services are available to residents at the end of life .2. In order for a resident to qualify for the hospice benefit under Medicate, he or she must be: a. Entitled to Medicare Part A; and b. Certified as being terminally ill 12 d. Obtaining the following information from the hospice: 1. The most recent hospice plan of care specific to each resident; 2. Hospice election form; 3. Physician certification and recertification of terminal illness specific to each resident . Record review of the facility's policy titled, Hospice Program, Hospice services are available to residents at the end of life. Policy Interpretation and Implementation: Our facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a Hospice program may do so. #5 Hospice providers who contract with this facility must have a written agreement with the facility outlining in detail the responsibilities of the facilities and the Hospice agreement and are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility.#12 Our facility has designated hospice and facility staff to collaborate care such as D. #1 Obtaining the following information from the Hospice the most recent hospital plan of care specific to each resident, #2 Hospice election form, #3 Physician certification and recertification of the terminal illness specific to each resident, #4 Names and contact information from Hospice personnel involved in Hospice care of each resident, #5 instructions on how to access the Hospice 24 hour on-call system, #6 Hospice education information Pacific to each resident, #7 hospital physician and attending physician if any order specific to each resident.

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	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 45879 Based on observation, interview, and record review, 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 reviewed for 2 of 18 residents (Resident #45, and Resident #49) reviewed for infection control. 1. The facility failed to ensure the Treatment Nurse performed hand hygiene while performing wound care for Resident #45 who had wounds, on 12/03/24. 2. The facility failed to ensure CNA S changed gloves or performed hand hygiene while providing incontinent care for Resident #49 who was incontinent, on 12/03/24. These failures could place residents, and staff at risk of the spread of infections. Findings included: 1.Record review of Resident #45's face sheet, dated 12/05/24 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included pressure wounds (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body), dementia (decline in mental abilities that affects a person's daily life) and diabetes. Record review of Resident #45's quarterly MDS assessment, dated 11/25/24, indicated Resident #45 understood and was understood by others. Resident #45 BIMS score was a 04 indicating she was severely cognitively impaired. The MDS indicated she required assistance with her ADL's such as toileting and hygiene. The MDS indicated Resident #45 was always incontinent of bowel and bladder. The MDS indicated Resident #45 had wounds. Record review of Resident #45's Physician order dated 11/18/24 indicated: Cleanse Stage 3 pressure wound to sacrum (a triangular bone located at the base of the spine, which plays a crucial role in providing stability and support to the pelvis) with normal saline, pat dry and apply Iodosorb (medication) cover with a border dressing daily and monitor for any signs of infection. Record review of Resident #45's comprehensive care plan dated 08/29/24 indicated, she had a Stage 3 (open wound) pressure ulcer related to her diagnosis of diabetes, history of ulcers, and immobility. The interventions were for staff to administer treatments as ordered and monitor for effectiveness. Monitor nutritional status. Serve diet as ordered, monitor intake, and record. During an observation on 12/03/24 at 2:09 p.m., revealed the Treatment Nurse provided wound care to Resident #45. She explained what she was going to do and put on her gown and gloves. She cleaned the wound area, then removed her gloves and applied new gloves without hand hygiene. She patted the area dry, put on the Iodoform, and applied the dressing. Afterward, she removed her gown, wiped the table, removed her gloves, and washed her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/24 at 2:18 p.m., the Treatment Nurse said she forgot to wash her hands between dirty and clean, she said she knew she was supposed to hand hygiene and could not believe she forgot to hand hygiene. She said without proper hand hygiene it could cause infection. 2. Record review of Resident #49's face sheet dated 12/04/24, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), Multiple Sclerosis (a chronic disease that damages the central nervous system), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily) and high blood pressure. Record review of Resident #49's quarterly MDS assessment dated [DATE], indicated Resident #49 understood and was understood by others. The MDS assessment indicated Resident #49 had a BIMS score of 10 indicating she was moderately cognitively impaired. The MDS indicated she required assistance with ADL's such as toileting and set up for meals. The MDS assessment indicated Resident #49 was always incontinent of bowel and bladder. Record review of Resident #49's comprehensive care plan revised on 09/20/24, indicated Resident #49 had an ADL self-care performance deficit related to activity intolerance, impaired balance, and diagnosis of Dementia. The care plan interventions were for staff to assist with ADL care. During an observation on 12/03/24 at 7:53 p.m., revealed CNA S was providing incontinent care for Resident #49 who had an incontinent episode. She explained what she was going to do provided hand hygiene and applied gloves. CNA S washed Resident #49's peri area side to side and front to back and then turned her over touching her side with the same dirty gloves on, then cleaned her buttock wiping side to side and front to back and back to front. CNA S then changed her gloves but did not hand hygiene, applied new gloves, pulled up the covers, and lowered the bed. During an interview on 12/03/24 at 8:06 p.m., CNA S said she should have used hand hygiene when changing her gloves and when going from dirty to clean. She said she was not supposed to wipe back to front or side to side when performing incontinent care. She said she forgot but knew it was important to wipe front to back to prevent cross-contamination. She said she had been trained on hand hygiene and incontinent care but not at the current facility. She said she was hired in August 2024. During an interview on 12/05/24 at 11:49 a.m., the DON said she expected staff to perform peri-care, wound care, and hand hygiene correctly to prevent infection. The DON said she and the ADON usually did peri-care and wound care checkoffs with staff on hire, annually and as needed. The DON said failure to perform incontinent care, wound care, and hand hygiene properly could lead to infection issues. During an interview on 12/05/24 at 12:46 p.m., the Administrator said all staff were responsible for infection control issues. He said failure to do proper incontinent care, wound care, and hand hygiene could lead to infection. Record review of the facility policy for Handwashing/Hand Hygiene, dated December 22, 2023, indicated, This facility considers hand hygiene the primary means to prevent the spread of infection. (continued on next page)

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	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City of Ennis Dba 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy for Perineal Care, dated October 2010, indicated, The purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Steps: 9b. Wash the perineal area, wiping from front to back. (1) Separate the labia and wash the area downward from front to back 4e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttock. Do not reuse the same washcloth or water to clean the labia. Record review of the facility policy for Wound Care, dated November 2017, indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote wound healing. Steps in procedure: #4 Put on exam gloves, loosen the tape and remove the dressing, #5 Pull gloves over the dressing and discard in appropriate receptacle and wash and dry hands