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	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident had a right to confidentiality of his or her personal and medical records for eight of eighteen residents (Residents #39, #73, #84, #98, #109, #125, #126, and #127) reviewed for privacy and confidentiality. The facility failed to ensure LVN E secured Residents #39, #73, #84, #98, #109, #125, #126, and #127's medical information before leaving her cart on 03/03/2026. This failure could place the residents at risk of their medical information being accessed by unauthorized individuals. Findings included: Record review of Resident #39's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #73's Face Sheet, dated 03/05/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #84's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #98's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with localized swelling (enlargement of a part of a body due to accumulation of fluid). Record review of Resident #109's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #125's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #126's Face Sheet, dated 03/05/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #127's Face Sheet, dated 03/05/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension. During an observation on 03/03/2026 at 9:41 AM revealed an untitled piece of paper was left on top of a nurse's cart parked in the hallway. On the piece of paper were the names of Residents #39, #73, #84, #98, #109, #125, #126, and #127. Written beside each of the names of the residents were the resident's blood pressures, pulse rates, temperatures, and oxygen saturations. The nurse's cart was unattended and was facing the hallway with several staff and residents passing by the cart. During an observation and interview on 03/03/2026 at 9:42 AM revealed LVN E flipped the piece of paper as soon as she came back to her cart. She said she was looking for a resident; that was why she left her cart. She said the piece of paper had the residents' vital signs and was confidential. She said she should have secured the paper before leaving the cart. She said vital signs were medical information and when exposed to unauthorized individuals could be a HIPAA (law protecting health information aimed at ensuring confidentiality) violation. During an interview on 03/05/2026 at 6:45 AM, ADON A said the staff should have turned over the paper with the residents' vital signs before leaving the cart. She said vital signs were confidential medical information and could be a HIPAA violation if other individuals, that had nothing to do with the residents' care, would be able to see them. She said the expectation was, before leaving the cart, the staff should have secured it somewhere so unauthorized individuals would not see them. She said the staff could have flipped it, put it under the laptop, or locked it in one of the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drawers. She said she would coordinate with the DON to do an in-service about confidentiality of medical records. During an interview on 03/05/2026 at 7:11 AM, the Administrator said the expectation was for the staff to have turned the paper upside down before leaving the cart because what was written on the paper was supposed to be confidential. He said confidential information could not be disclosed to unauthorized individuals. He said he would coordinate with the DON regarding confidentiality of medical records. During an interview on 03/05/2026 at 7:39 AM, the DON said if what was written on the piece of paper were the vital signs of the residents, then the paper should not be left exposed because unauthorized individuals might see it. She said medical information about a resident should be protected and not be visible to everybody to see. She said the health information of a resident could not be shared without the permission of the resident or the resident's responsible party. She said if the confidential information was exposed, non-nursing staff, other residents, and visitors would be able to see it. She said the expectation was for the staff to practice confidentiality of medical records. She said the staff should have flipped the paper, locked it inside the cart, or brought it with her. The DON stated she would start an in-service about confidentiality of medical records and would closely monitor the staff on their adherence to the policy. Record review of the facility's policy, Protected Health Information (PHI), Management and Protection of 2001 MED-PASS, Inc. revised April 2014 reflected Policy Statement: Protected Health Information (PHI) shall not be used or disclosed except as permitted by current federal and state laws . Policy Interpretation and Implementation . 1. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for three of eighteen residents (Residents #85, #89, And #128) and one LVN (LVN E) of three LVNs reviewed for medication storage. 1. The facility failed to ensure that Resident #85 did not have an eye drop inside the room on 03/03/2026. 2. The facility failed to ensure that Resident #89 did not have eye drops inside the room on 03/03/2026. 3. The facility failed to ensure that a skin barrier was not left on top of Resident #128's overbed table on 03/03/2026. 4. The facility failed to ensure LVN E did not leave a plastic vial of medication for breathing treatment on top of the nurse's cart unattended on 03/03/2026. These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions.Findings included: 1. Record review of Resident #85's Face Sheet, dated 03/05/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with age-related macular degeneration (irreversible vision loss) and legal blindness (vision impairment that affects central or peripheral visions, or both). Record review of Resident #85's Comprehensive MDS Assessment, dated 02/27/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated the resident had age-related macular degeneration and legal blindness. Record review of Resident #85's Comprehensive Care Plan, dated 01/26/2026, reflected that the resident had legal blindness and macular degeneration, and the intervention for both was to administer eye medication as ordered. Record review of Resident #85's Physician's Order, dated 01/09/2025, reflected Polyvinyl Alcohol Ophthalmic Solution 1.4 % (Polyvinyl Alcohol) Instill 1 dose in both eyes every 24 hours as needed for teary eyes. Record review on 03/03/2026 of Resident #85's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation on 03/03/2026 at 9:25 AM revealed Resident #85 was not inside her room. It was observed that there was a container of eyedrops on top of the resident's overbed table. During an observation and interview on 03/03/2026 at 9:38 AM, RN B said she did not notice Resident #85 has an eye drop inside her room. She said the MA was already administering her eyedrops, so she was not sure why there was an eyedrop inside the resident's room. She took the eye drop and said she would talk to the resident to see who brought the eye drop. She said medications should not be inside the room of the resident because the resident might use it more than recommended. She said confused residents might consume them as well that could result in upset stomach and nausea. 2. Record review of Resident #89's Face Sheet, dated 03/03/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with a lack of coordination and anxiety. Record review of Resident #89's Comprehensive MDS Assessment, dated 02/16/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had a lack of coordination and anxiety. Record review of Resident #89's Comprehensive Care Plan, dated 02/12/2026, reflected that the resident had ADL self-care performance deficit and used anti-anxiety medications. The interventions were to assist with ADLs and observe memory loss, confusion, and blurred vision. Record review on 03/03/2026 of Resident #89's Physician Order reflected that the resident did not have an order for eyedrops. Record review on 03/03/2026 of Resident #89's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation on 03/03/2026 at 9:13 AM revealed Resident #89 was not inside her room. It was observed that three eye drops were on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	top of the resident's overbed table. 3. Record review of Resident #128's Face Sheet, dated 03/03/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obesity, muscle wasting (loss of muscle leading to its shrinking and weakening), and contact dermatitis (inflammation of the skin). Record review of Resident #128's Comprehensive MDS Assessment, dated 02/20/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment reflected the resident was always incontinent for bowels and bladder. Record review of Resident #128's Comprehensive Care Plan, dated 02/04/2026, reflected the resident had an ADL self-care performance deficit and one of the interventions was to assist with personal hygiene. Record review of Resident #128's Physician Orders, dated 01/30/2026, reflected May apply house barrier cream Q shift as preventative every shift for prevention. Record review on 03/03/2026 of Resident #128's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 03/03/2026 at 9:09 AM revealed Resident #128 was in her bed, awake. It was observed that there were two tubes of barrier creams on top of the resident's side table. The resident said the staff would use the creams after the staff changed her brief. During an observation and interview on 03/03/2026 at 9:45 AM, LVN D said the barrier creams should not be on top of Resident #128's side table because the resident might mistakenly use it as a toothpaste or use it as a moisturizer. She said there would be confused residents in the facility that might consume the barrier cream. She took the tube of barrier cream and said the tubes should be locked in a cart, and the staff would just ask them if they were going to use the skin barrier. She said she did not notice Resident #89 had eye drops inside her room. She went inside Resident #89's room and saw the eye drops on top of Resident #89's overbed table. She said eye drops should not be inside the resident's room because if the resident was using it, it was not being monitored. She said she would also check if the resident had an order for eye drops so she could request an order if Resident #89 needed the eye drop. She took the eye drops and said she would talk to the resident when she came back to the facility. 4. During an observation on 03/03/2026 at 9:41 AM revealed a vial of medication for breathing treatment was observed on top of a cart unattended. During an observation and interview on 03/03/2026 at 9:42 AM, LVN E said no medications should be left on top of the cart unattended because residents might be able to reach for it and consume it. She said she was looking for a resident; that was why she left her cart but should have placed the medication inside the drawer before leaving her cart. she took the medication for breathing treatment and put it inside her cart. During an interview on 03/05/2026 at 6:45 AM, ADON A said no medications should be inside the residents' room because the residents might be using them with any assessment and orders. She said it could result in adverse reactions. She said the staff could have been administering the eyedrops, and then the resident would self-administer also. She said if those were pills, it could result in overdose. She said barrier creams should not be within the reach of the residents because the creams had chemicals in them that could cause irritation and stomach upset. She said the staff should have secured the medication for the breathing treatment before leaving the cart because residents passing the cart could get it and consume it. She said she would coordinate with the DON to do an in-service about medication storage. She said she would educate the family members to give the staff any medication that they would be bringing. During an interview on 03/05/2026 at 7:11 AM, the Administrator said the expectation was for the staff to make sure there was no medications inside the resident's rooms or on top of the carts unattended because the residents might consume the medications or use them inappropriately. He said he was not a clinician and would let the DON take a lead on the issue. During an interview on 03/05/2026 at 7:39 AM, the DON said medications should not be stored inside the resident's room because the residents might use them inappropriately that could result in adverse reactions. She said skin barriers were applied topically and could be harmful when ingested. She said the same rationale applied to the eye drops found inside the rooms of the residents and the medication left on top of the nurse's cart. She (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the expectation was for the staff to be vigilant that when they entered the residents' room to check for any medications, for staff using the skin barriers to not leave the tubes within reach of the residents, and not to leave any medications on top of the carts unattended. She said she had already started an in-service about medication storage. Record review of the facility's policy, Storage of Medications 200 I MED-PASS. Inc. revised April 2019 MED-PASS revised reflected Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 1. Drugs and biologicals used in the facility are stored in locked compartments . The nursing staff is responsible for maintaining medication storage.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: Number of residents cited: Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food storage, labeling, and dating. The facility failed to ensure all food items in the facility kitchen were dated and discarded prior to their use-by date . These failures could place residents at risk for food contamination and food-borne illness. Finding included: During observation on 03/03/2026 between 9:15 AM and 9:50 AM in the facility's kitchen revealed: 1 Gallon size bag of Frosted Flakes no use by date 1 box of long grain enriched Parboiled rice not properly sealed and exposed to air contaminants. 1 Bag of oats cereal dated with no visible expiration date was observed. 1 Bag of raisin bran dated with no visible expiration date observed. 1 bag of cane sugar date with no visible expiration date observed. 1 bag of opened biscuit mix not properly sealed and exposed to air contaminants. 1 5 lb. bag of graham cracker crumbs opened not properly sealed and exposed to air contaminants. During an interview on 03/05/2026 at 12:05 PM DC, stated he was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. DC confirmed the surveyor observations and stated the listed items would be corrected. DC stated once items are opened they should be properly sealed and dated and that these were oversights. DC stated he was responsible for ensuring policy was followed. All kitchen staff are responsible for labeling and making sure that the items are labeled properly. He said the risk to residents if policy was not followed was a health risk to the residents. The DC stated the bags should be labeled, and the risk of the concerns not being addressed could result in food-borne illnesses. DC stated he will conduct a full in-service of food rotation and storage pertaining to what the proper procedures are dealing with food rotation and storage. DC stated if food items were not dated when opened then they will not be able to know how long they will last. The risk of serving foods that are past use by date or serving food that was not labeled or dated can cause food borne illness. During an interview on 03/05/2026 at 12:45 PM, ADM stated he oversaw all departments, and ensured residents were taken care of. ADM stated he was made aware of the concerns observed in the kitchen and has spoken with the DC. He stated that the issues could cause food contamination and this matter would be resolved. If items are expired they do not want to serve them to residents. The ADM stated the risk of all these concerns observed in the kitchen could result in residents getting sick. The ADM said the policy or procedure for storing food was, everything needed to be dated, and if opened it needed to have an open date and an expiration date. He said the risk to residents if policy were not followed was that they could get sick from food borne illnesses. The ADM stated he would expect the DC to ensure that the kitchen followed all guidelines, including ensuring the food items were labeled properly in the kitchen. The ADM stated he expected staff to ensure they were following policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. The ADM stated the risk of these concerns not being addressed could result in food contamination and residents becoming ill. ADM stated if foods were not discarded properly, sanitized properly, or heated properly, there was the potential for foodborne illness. Record review of the facility's Food Receiving and Storage Policy, dated July 2014, indicated 6 Dry food that are stored in bins will be removed from original packaging, labeled, and dated (use by date). Such food will be rotated using a first in - first out system. 13. Food items and snacks kept on the nursing units must be maintained as indicated below: e. Other opened containers must be dated and sealed or covered during storage. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Packaged Food shall be labeled (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as specified in law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for three of eighteen residents (Resident #10, #18 and #93) and for six of eight direct care staff (RN B, RN C, CNA G, CNA H, CNA J, and COTA I) reviewed for infection control. 1. The facility failed to ensure RN B did not put the two cups of barrier cream she already placed on Resident #10's overbed table, inside the first drawer of her cart on 03/04/2026. 2. The facility failed to ensure CNA H did not put gloves inside her pockets and use them during Resident #18's incontinent care on 03/04/2026. 3. The facility failed to ensure CNA G wore a gown when shaving Resident #93 on 03/03/2026. 4. The facility failed to ensure CNA G and COTA I wore gowns when changing Resident #93's clothes on 03/03/2026. 5. The facility failed to ensure RN C did hand hygiene while passing plates on 03/03/2026.6. The facility failed to ensure CNA J conducted hand hygiene in between assisting feeding two residents on 03/03/2026. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #10's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #10's Comprehensive MDS Assessment, dated 01/22/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was incontinent for bowels. Record review of Resident #10's Comprehensive Care Plan, dated 01/31/2026, reflected that the resident had bowel incontinent and one of the interventions was to clean the perineal (area between the thighs) area. During an observation on 03/04/2026 at 6:46 AM revealed RN B put some barrier creams in two cups. After placing creams in the cups, she went inside Resident #10's room and placed the two cups on top of the resident's overbed table. The resident told RN B that she wanted the cream later. RN B took the cups of cream from the overbed table, went back to her cart, opened the first drawer, and placed the two cups inside the drawer. During an interview on 03/04/2026 at 6:54 AM, RN B said since the cups of creams had contact with Resident #10's overbed table, she should have not returned them inside the cart's drawer because the cups could have been contaminated and the contamination could be transferred to the carts and indirectly to other residents. 2. Record review of Resident #18's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #18's Comprehensive MDS Assessment, dated 12/18/2025, reflected that the resident had severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident was incontinent for bowels and bladder. Record review of Resident #18's Comprehensive Care Plan, dated 01/14/2026, reflected that the resident was incontinent and one of the interventions was to clean the perineal area with each incontinent care. During an observation on 03/04/2026 at 12:30 PM revealed CNA H was about to do incontinent care for Resident #18. CNA H grabbed some gloves from a box on the wall and put them inside her pockets. She then proceeded with incontinent care. When she changed her gloves, it was observed that she pulled a pair of gloves from her left pocket and used them to continue cleaning the resident. During an interview on 03/04/2026 at 12:47 PM, CNA H said she should not put gloves in her pockets because she was not sure if her pocket was clean. She said she guessed her pocket was not clean because she would put her keys and cell phone in her pocket. She said she would not put gloves inside her pocket again and would just get them from the box to make sure she was using clean gloves during incontinent care. 3. Record review of Resident #93's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #93's Comprehensive MDS Assessment, dated 01/31/2026, reflected that the resident was cognitively intact with a BIMS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #93's Comprehensive Care Plan, dated 02/08/2026, reflected the resident required EBP for having a g-tube and one of the interventions was to provide patient with standard precaution when providing hygiene. Record review of Resident #93's Physician Order, dated 01/31/2025, reflected Enteral (pertaining to the stomach) Feed Order every shift related to GASTROSTOMY STATUS (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support) Enteral: Enteral Nutrition Novasource Renal at 50 ml per hour for 24 hours via pump. Record review of Resident #93's Physician Order, dated 06/01/2024, reflected Dialysis: Send approved snack with resident on dialysis days every day shift every Mon, Wed, Fri get snack from dietary to send with resident. During an observation on 03/03/2026 at 11:16 AM revealed CNA G shaving Resident #93's face. CNA G was not wearing a gown while providing hygiene and was leaning directly to the resident's bed. It was observed that there was a sign outside the resident's room that the resident was on enhanced barrier precautions, and PPE was required when providing hygiene. 4. Record review of Resident #93's Comprehensive Care Plan, dated 02/08/2026, reflected the resident required EBP for having a g-tube and one of the interventions was to provide patient with standard precaution when dressing. During an observation on 03/03/2026 at 11:29 AM revealed CNA G and COTA I were changing Resident #93's clothing. CNA G and COTA I were not wearing gowns while dressing the resident. It was observed that there was a sign outside the resident's room that the resident was on enhanced barrier precautions and PPE were required during dressing. It was observed that ADON A went inside the room and told CNA G and COTA that they need to wear gowns. During an interview on 03/03/2026 at 11:31 AM, CNA G said Resident #93 was on EBP because the resident had a g-tube and was undergoing dialysis. She said there was a sign outside the resident's room to remind the staff to wear a gown in addition to gloves to prevent cross contamination. She said when a resident was on EBP, it meant that a gown was required when doing any ADL such as hygiene and dressing. She said she did not know why she forgot to wear a gown. She said since ADON A reminded her she needed to wear a gown; she would wash her hands and would get a gown. During an interview on 03/03/2026 at 11:33 AM, COTA I said she was just helping CNA G but should have worn a gown because the resident had a g-tube and was undergoing dialysis. She said gowns were required to prevent introducing any microorganisms to residents with tubing like the g-tube and the dialysis shunt (surgically created connection between the blood vessels). During an interview on 03/03/2026 at 12:45 PM, ADON A said she saw CNA G and COTA I were not wearing gowns when dressing Resident #93. She said there was a sign outside the resident's door reminding the staff to wear a gown when providing hygiene and when changing the resident's clothing. She said if the resident was on EBP then the staff should wear a gown to prevent transfer of microorganism from one resident to another. 5. During an observation on 03/03/2026 at 12:01 PM revealed RN C was passing plates in the dining area. It was observed that he was not doing hand hygiene between plates. He did it five times. During an interview on 03/03/2026 at 12:15 PM, RN C said he was not aware he was not doing hand hygiene when he was passing plates. He said the best practice was to sanitize the hands after placing a plate for a resident whether he touched the resident or not. He said not sanitizing hands between plates could result in cross contamination. 6. During an observation on 03/03/2026 at 12:05 PM revealed CNA J was assisting feeding two residents in the dining area. It was observed that she was not doing hand hygiene between assisting the residents. She was observed to assist for over 5 minutes. During an interview on 03/03/2026 at 12:10 PM the DON stated that staff were seen assisting two residents simultaneously to eat lunch and she was aware that was a risk to the residents. The DON stated there could have been the spread of infection from one resident to another resident from lack of hand hygiene. The DON stated she would give the staff members who assist residents with meals (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand sanitizer to use when assisting more than one resident at a time. During an interview with CNA J on 03/03/2026 at 1:25 PM, the CNA stated that hand sanitizer should have been used between assisting each resident in order to avoid cross contamination between the residents. CNA J stated that she was focused on making sure to not confuse the resident's utensils. CNA J stated that it was best to ask another staff member for help and to not attempt to assist two residents at the same time with meals. During an interview on 03/05/2026 at 6:45 AM, ADON A said gloves should not be placed inside the pockets because the pockets were dirty, rendering the gloves dirty when used during incontinent care. She said the cups that had contact with the resident's overbed table should have been thrown away and not placed inside the drawer because of possible cross contamination. She also said hand hygiene should be performed when passing plates for the same rationale. She said the issues discussed contributed to probable infection. She said the expectation was for the staff to be mindful of what they were doing to protect the residents. She said the DON had already started an in-service about infection control, hand washing, and EBP. During an interview on 03/05/2026 at 7:11 AM, the Administrator said that the expectation was for the staff to wear gowns in addition to the gloves if the residents were on EBP, not to put gloves in their pockets, to not put anything on the cart from the resident's room, and to perform hand hygiene when passing plates during meal times. He said the concerns discussed would all contribute to the development and spread of infection. He said he was not a clinician and would let the DON take the lead on the issue of infection control. During an interview on 03/05/2026 at 7:39 AM, the DON said if a resident was on EBP, then the staff doing care or treatment should wear a gown every time they had contact with the resident. She said residents with g-tube and dialysis shunt catheter were on EBP and required PPE to prevent the spread of infection from one resident to another. She said there might be no policy that would say not to put the gloves in the pockets, but the best practice was not to put gloves inside the pockets to make sure the gloves being used were clean. She said it was also an infection control issue if the staff did not sanitize their hands between plates. She said she already started an in-service about infection control and hand hygiene. In an interview on 03/05/2026 at 9:46 AM, ADON B said she was the Infection Preventionist of the facility. She said she was made aware of the issue of infection control. She said anything that was taken inside the resident's room should be discarded and not placed inside the cart. She said gowns should be worn if the residents were on EBP. She said there were signs outside the residents' rooms to remind the staff when they were supposed to wear gowns in addition to the gloves. She said gloves were not supposed to be inside the pockets of the staff because their pockets could be dirty. She said hand hygiene was required when passing plates as well. She said the DON already started an in-service, and she would be closely monitoring the staff's adherence to the policies of infection control, hand hygiene, and EBP. She said the facility might not have a policy regarding not putting gloves in their pockets and not putting anything from the resident's room in the cart, but the best practice was not to do them because the outcome could be cross contamination. Record review of the facility's policy Enhanced Barrier Precautions (Orientation Tool) undated, reflected Enhanced Barrier Precautions (EBP}: Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO (Multi-Drug Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics) to staff hands and clothing . Examples of Enhanced Based Precaution residents . Indwelling medical devices . feeding tubes . Enhanced-Based Precautions are indicated during . Dressing . providing hygiene. Record review of the facility's policy Handwashing/Hand Hygiene 2001 MED-PASS, Inc. revised December 22, 2023, reflected Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub . o. Before and after eating or handling food . p. Before and after assisting a resident with meals.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for one of two residents (Residents #93) reviewed for feeding tube management. The facility failed to ensure Resident #93 had orders to flush the g-tube before and after medication administration, to check the placement, and to check the residual on 03/04/2026. These failures could place residents with g-tubes at risk for tube displacement, clogging, aspiration, and discomfort.Findings included: Record review of Resident #93's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #93's Comprehensive MDS Assessment, dated 01/31/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #93's Comprehensive Care Plan, dated 02/08/2026, reflected the resident received required tube feeding and one of the interventions was to check residual (food, liquid, and secretions remaining in the stomach) and placement before initiation of formula, medication administration, and flushing the g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach). Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order to check for tube placement. Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order to check for gastric residuals. Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order to flush before and after medication administration. During an observation and interview on 03/03/2026 at 11:16 AM revealed Resident #93 was in his bed awake. It was observed that the resident had g-tube on his upper left abdomen. The resident said he had an issue with swallowing; that was why he had a g-tube. During an observation on 03/04/2026 at 11:45 AM revealed RN C was about to administer Resident #93's medication via g-tube. He sanitized his hands, put the medication in a small plastic cup, crushed it, returned the crushed medication to the small plastic cup, and dissolved it with 10 cc of water. He then went inside the resident's room and placed the crushed medication and some water on the resident's overbed table. He washed his hands and put on a gown and a pair of gloves. He took a 60 ml piston syringe from a plastic bag hanging in an IV pole and placed it also on the overbed table. He raised the bed, elevated the head of the bed, turned off the machine, and disconnected the g-tube from the formula. After disconnecting the g-tube, he pulled the plunger out of the syringe halfway and checked for the placement and the gastric residual. After checking for the placement and the gastric residual, he pulled the plunger of the syringe and attached it to the g-tube. After attaching the barrel of the syringe to the g-tube, he flushed the g-tube with 30 cc of water, poured the dissolved medications, and flushed it again with 30 cc of water. After he was done administering the medications, he detached the syringe and cleaned the table and the syringe. During an interview on 03/04/2026 at 12:19 PM, RN C said he flushed before and after medication administration to make sure the g-tube was patent (unobstructed), checked the placement and the residual to see if the tube was not dislodged and that the resident's stomach had no problem with absorption. When asked if the resident had an order for flushing the g-tube, checking for placement, and checking for the residual, RN C checked his computer for the order and said there were no orders for flushing the g-tube, checking for placement, and checking for the residual. He said he knew what to do, but there should be an order for flushing the g-tube, checking for placement, and checking for (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residual. He said this should have been caught by whoever was administering the resident's medications, so orders were put in place. He said he was partly at fault because he did not check if the resident had appropriate orders. He said there should be an order for everything done for the resident to ensure continuity of care. He said he would just finish what he was doing and then transcribe the orders. During an interview on 03/05/2026 at 6:45 AM, ADON A said there should be orders for everything done for the residents. She said even though the nurses knew what to do, there should be an order in the resident's profile pertaining to the flushing, checking for placement, and checking for residuals. She said it was an oversight for those administering the resident's medications, and it was also an oversight on her part because she was supposed to check the orders as well. She said the expectation was for the staff to check for g-tube placement and to check if appropriate orders were in place. She said she would be doing a one-on-one with the nurses regarding putting orders in the system. She said she would coordinate with the DON regarding an in-service about enteral feeding and physician orders. During an interview on 03/05/2026 at 7:11 AM, the Administrator said he was not a clinician and would let the DON take the lead on the issue. He said the expectation was if orders for g-tube were needed, then there should be orders in the residents' profile. During an interview on 03/05/2026 at 7:39 AM, the DON said the expectation was orders to be inputted in the residents' eMAR or eTAR and would be followed correctly. She said the placement of the g-tube and the gastric residual should be checked to prevent aspiration. She said the g-tube should be flushed before and after to make sure the g-tube was working. She said even though the staff did the right procedure and knew that the g-tube needed flushing before and after administering medications via g-tube, there should still be orders for flushing, checking for placement and gastric residual. She said, new nurses might not be familiar with how to administer medications via g-tube and end up not flushing, not checking for placement, and not checking for residuals, and then they would wonder why the g-tube was clogged. She said she would start an in-service regarding g-tube and physician orders. Record review of the facility's policy Administering Medications through an Enteral Tube 2001 MED-PASS, Inc., revised July 5, 2019, reflected Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . Preparation . 1. Verify that there is a physician's medication order for this procedure . Steps in the Procedure . 11. Confirm placement of feeding tube . 13. Check gastric residual volume (GRV) to assess tolerance of enteral feeding . 14. When correct tube placement and acceptable GRV have been verified, flush tubing . 20. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of tap water or prescribed amount.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of twelve residents (Resident #6 and Resident #128) reviewed for respiratory care. 1. The facility failed to ensure Resident #6's Yankauer suction tip connected to the suction machine was properly stored on 03/03/2026. 2. The facility failed to ensure Resident #128's nasal cannula connected to the oxygen concentrator was properly stored on 03/03/2026. These failures could place the residents at risk of respiratory infection and not having their respiratory needs met.Findings included: 1. Record review of Resident #6's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with cerebral infarction (blockage in the blood vessels of the brain). Record review of Resident #6's Comprehensive MDS Assessment, dated 02/19/2026, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a cerebral infarction and was admitted to hospice. Record review of Resident #6's Comprehensive Care Plan, dated 02/15/2026, reflected that the resident had a terminal prognosis related to cerebral infarction, was admitted to hospice, and had impaired gas exchange (disruption in the exchange of gases in the lungs). The interventions were to initiate oxygen therapy at 2 - 5 L/min per nasal cannula as needed and to suction as needed. Record review of Resident #6's Physician Order, dated 04/25/2025, reflected Suction as needed. During an observation and interview on 03/03/2026 at 9:29 AM revealed Resident #6 was in his bed, awake. It was observed that there was a suction machine on top of the resident's drawer. A Yankauer suction tip (oral suctioning tool used to remove fluid and secretions from the airway) was connected to the tubing of the suction machine. The suction tip was behind the suction machine and was laying on top of the table. The suction tip was not bagged. When asked about his suction machine, the resident did not reply. During an observation and interview on 03/03/2026 at 9:38 AM, RN B said Resident #6 was a hospice resident, and the hospice was the one who provided the suction machine. She said the suction tip should be bagged when not in use to prevent cross contamination. She said the issue was not if the resident was using it or not, but if it was kept clean in case the resident needed it. She disconnected the suction tip, threw it, and said she would get another suction tip and would put it inside a bag. 2. Record review of Resident #128's Face Sheet, dated 03/03/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Record review of Resident #128's Comprehensive MDS Assessment, dated 02/20/2026, reflected that the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 09. The Comprehensive MDS Assessment reflected the resident had sleep apnea and was using oxygen. Record review of Resident #128's Comprehensive Care Plan, dated 02/04/2026, reflected the resident had altered respiratory status/difficulty breathing r/t sleep apnea and one of the interventions was oxygen setting: O2 via n/c @2 lpm at night. Record review of Resident #128's Physician Orders, dated 01/30/2026, reflected Oxygen delivery at nighttime 2 liters via nasal cannula at bedtime for oxygen. During an observation and interview on 03/03/2026 at 9:09 AM revealed Resident #128 was in her bed awake. It was observed that an oxygen concentrator was at bedside with a nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) connected to it. The nasal cannula was hanging on top of the oxygen concentrator and was not bagged with the prongs of the nasal cannula almost touching the floor. The resident said she would only use her oxygen at night. She said she was the one who took it off and gave it to the nurse. During an observation and interview on 03/03/2026 at 9:45 AM, LVN D said whoever the staff that the resident (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handed over the nasal cannula should have placed it inside a plastic bag to prevent cross contamination. LVN D disconnected the nasal cannula and threw it in the trash can. She said she would get a new one and would put it in a plastic bag, so the resident would use a clean one for her next use. During an interview on 03/05/2026 at 6:45 AM, ADON A said the nasal cannula and the Yankauer should be bagged whenever the residents were not using them to prevent cross contamination and eventually infection. She said the nasal cannula was inserted into the nose and the Yankauer to the mouth, and if they were dirty, it was just like introducing germs to the inside of the body. She said the expectation was for the staff to ensure the equipment used for respiratory care was properly stored. She said she would coordinate with the DON to do an in-service about bagging the nasal cannula and the Yankauer when not in use. During an interview on 03/05/2026 at 7:11 AM, the Administrator said everything the residents were using should be kept clean to prevent infection. He said he was not a clinician and would let the DON take the lead on the issue. During an interview on 03/05/2026 at 7:39 AM, the DON said the nasal cannula and the yankauer were supposed to be in a bag when the residents were not using them to prevent cross contamination and respiratory infections. She said, they might not have policy for the suction tip but the policy for bagging the nasal cannula could be applied as well to the suction tip. She said the expectation was for the staff to be mindful and make sure the nasal cannula and the yankauer were kept clean and bagged when the residents were not using them. She said she would conduct an in-service about respiratory care. Record review of the facility's policy, Oxygen Use (Respiratory Therapy) - Prevention of Infection 2001 MED-PASS, Inc. revised November 2011, reflected Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Steps in the procedure . Infection Control Considerations Related to Oxygen Administration . 8. Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of two residents (Resident #9 and Resident #93) reviewed for dialysis. 1. The facility failed to ensure Resident #9 had orders for ongoing assessment of the resident's condition before and after dialysis treatments received at a certified dialysis facility. 2. The facility failed to ensure Resident #93 had orders for ongoing assessment of the resident's condition before and after dialysis treatments received at a certified dialysis facility. These failures could place residents undergoing dialysis at risk for proper assessment not done that could result in hypotension (abnormally low blood pressure), bleeding, and clotting of dialysis site.Findings included: 1. Record review of Resident #9's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with end stage renal disease (a condition where the kidneys can no longer function adequately). Record review of Resident #9's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 02/06/2026, reflected the resident was cognitively intact with a BIMS (screening tool used to assess cognitive status) score of 15. The Comprehensive MDS Assessment indicated the resident was undergoing dialysis (medical treatment that filters waste and excess fluids from the blood when the kidney can no longer function). Record review of Resident #9's Comprehensive Care Plan, dated 01/25/2026, reflected the resident went to dialysis Monday, Wednesday, and Friday due to renal failure (kidneys were not functioning) and one of the interventions was check and change dressing daily at access site. Record review on 03/05/2026 of Resident #9's Physician Order reflected that the resident did not have an order to monitor the dialysis site. Record review on 03/05/2026 of Resident #9's Physician Order reflected that the resident did not have an order for her dialysis appointment. Record review on 03/05/2026 of Resident #9's Physician Order reflected that the resident did not have an order to obtain vital signs post dialysis. Record review on 03/05/2026 of Resident #9's Physician Order reflected that the resident did not have an order to remove pressure dressing to dialysis site post dialysis. Record review on 03/05/2026 of Resident #9's Physician Order reflected that the resident did not have an order to check bruits (sound produced by the blood flow) and thrills (vibration that could be felt over the dialysis site). Record review on 03/05/2026 of Resident #9's Physician Order reflected that the resident did not have an order to refrain from getting the blood pressure or finger stick from the arm with a shunt (surgically created connection between the artery and the veins). During an observation and interview on 03/03/2026 at 11:21 AM revealed Resident #9 was in her wheelchair and was eating lunch. She said she would go to a dialysis session every other day. 2. Record review of Resident #93's Face Sheet, dated 03/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with end stage renal disease. Record review of Resident #93's Comprehensive MDS Assessment, dated 01/31/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident was undergoing dialysis. Record review of Resident #93's Comprehensive Care Plan, dated 02/08/2026, reflected the resident received hemodialysis (medical treatment that filters waste and excess fluids from the blood when the kidney can no longer function) and one of the interventions was to send approved snack with resident on dialysis days. Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order to monitor dialysis site. Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order for his dialysis appointment. Record review on 03/05/2026 of Resident #93's Physician Order reflected the resident did not have an order to obtain vital signs post dialysis. Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order to (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remove pressure dressing to dialysis site post dialysis. Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order to check bruits and thrills. Record review on 03/05/2026 of Resident #93's Physician Order reflected that the resident did not have an order to refrain from getting the blood pressure or finger stick from the arm with a shunt (connection between the artery and the veins). During an observation and interview on 03/03/2026 at 11:16 AM revealed Resident #93 was in his bed, awake. It was observed that the resident had a shunt to his right upper arm. The resident said his kidneys were not functioning anymore; that was why he was receiving dialysis for almost two years. During an observation and interview on 03/04/2026 at 7:52 AM, ADON A said if a resident was undergoing dialysis using an outside dialysis clinic, the facility was responsible in assessing the resident when the resident came back to the facility. She said the dialysis site should be assessed for any bleeding, for signs and symptoms of infection, and for bruits and thrills. When asked if the residents had orders for the mentioned assessments, ADON A turned on her computer and went to Resident #93's profile and saw that the resident did not have any orders pertaining to dialysis except for sending approved snack during dialysis appointment. She then opened Resident #9's profile and said Resident #9 also did not have any orders for dialysis. She said the nurses knew what to do, but there should be orders in everything done for the residents. She said the orders were transcribed to make sure the care or treatment was being done. She said the orders should be in the residents' eTAR to remind the staff what to do and assess for residents undergoing dialysis. She said the residents could be in danger of hemorrhage and infection if the dialysis site was not assessed. She said what might have happened was when the residents went to the hospital; the orders were discontinued but when the residents were re-admitted back to the facility, all the orders for dialysis should have been put back in the residents' profile. ADON A started to put the orders for dialysis for Resident #93 and Resident #9. She said she would coordinate with the DON to do an in-service about dialysis care. During an interview on 03/04/2026 at 11:13 AM, RN B said she noticed that there were no orders for Resident #9's dialysis, but she forgot to inform the ADON or forgot to put the orders. She said there should be orders for dialysis because new nurses might not be able to assess the dialysis site because they did not see any orders for dialysis care. During an interview on 03/04/2026 at 12:19 PM, RN C said he was the one sending Resident #93 out for dialysis. He said he did not notice the orders because the resident would come back to the facility on the next 2 PM to 10 PM shift. He said, but that was not an excuse. He said orders for assessing the dialysis site and the precautions should be in the residents' profile to make sure that the resident was being taken care of. During an interview on 03/05/2026 at 7:11 AM, the Administrator said he was not a clinician and would let the DON take the lead on the issue. He said the expectation was if orders for dialysis were needed, then there should be orders in the residents' profile. During an interview on 03/05/2026 at 7:39 AM, the DON said the expectation was orders to be inputted in the residents' eMAR or eTAR and would be followed correctly. She said the issue was not about if the nurses knew what they were supposed to do, but about not putting the orders for dialysis that could eventually affect the care being given to the residents undergoing dialysis. She said the nurse admitting the residents were responsible in putting up the orders, and the ADONs were responsible in checking the residents' profile the following day. She said orders should be transcribed to ensure assessment and care for the dialysis of residents were being done. She said she would start an in-service regarding dialysis of care and physician orders. Record review of the facility's policy End-Stage Renal Disease, Care of a Resident with 2001 MED-PASS, Inc. revised September 2010 reflected Policy Statement: Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care . Policy Interpretation and Implementation . 1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents . 2. Education and training . a. The nature and clinical management of ESRD (including infection prevention and nutritional needs) . b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis . c. Signs and symptoms of worsening (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	03/05/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition and/or complications of ESRD . d. How to recognize and intervene in medical emergencies such as hemorrhages and septic infections . f. Tinting and administration of medications, particularly those before and after dialysis . g. The care of grafts (tube used to connect the blood vessels) and fistulas (an access made between the blood vessels). Record review of the facility's policy Medication and Treatment Orders 2001 MED-PASS. Inc. revised July 2016 reflected Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation and Implementation . 1. Medications-shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state . 3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart . 9. Orders for medications must include . a. Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy .c. Dosage and frequency of administration . d. Route of administration .e. Clinical condition or symptoms for which the medication is prescribed . f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for one of eighteen residents (Resident #126) reviewed for pharmaceutical services. The facility failed to ensure MA F did not leave Resident #126's medications inside the resident's room for the resident to administer unattended on 03/03/2026. This failure could place residents at risk of not receiving medications as ordered, taking medications without a self-administration assessment, potential overdose, and adverse effect.Findings included: Record review of Resident #126's Face Sheet, dated 03/03/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar) and hypertension (high blood pressure). Record review of Resident #126's Comprehensive MDS Assessment, dated 03/06/2026, reflected the resident had severe impairment in cognition with a BIMS of 07. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and hypertension. Record review of Resident #126's Comprehensive Care Plan, dated 03/02/2026, reflected that the resident had diabetes mellitus and hypertension and the intervention for both was to administer medications as ordered. Record review of Resident #126's Physician's Order, dated 03/03/2026, reflected Losartan Potassium Oral Tablet 50 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN Hold for sbp less than 110, HR less than 60. Record review of Resident #126's Physician's Order, dated 03/02/2026, reflected Metformin HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day for DM. Record review on 03/03/2026 of Resident #126's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 03/03/2026 at 9:17 AM revealed Resident #126 was in his bed, awake. It was observed that there were two dry pills on the resident's overbed table. According to the resident, the staff gave him the pills and told him to take the pills when he was done eating his candy. He said he knew one of the medications was for his blood pressure, but he forgot what the other pill was for. He said he was new in the facility and still did not know if the staff that gave him the medications was a nurse or the medication aid. During an observation and interview on 03/03/2026 at 9:21 AM, MA F said when administering medications, staff should make sure the medications were taken before leaving the residents' rooms. She said she thought the resident took the pills. She said she should have stayed with the resident until the resident had taken all the medications. She said the pills should not be left with the residents because the residents might not take them, throw them, or choke while taking them, and no one would know. She said other residents or visitors might be able to get hold of the medication and consume them and allergic to the said medications. She went inside Resident #126's room and asked the resident if he already took the medications. During an interview on 03/03/2026 at 9:38 AM, RN B said MA F told her about the medications that were left inside Resident #126's room. She said not to leave any medications inside the room for the resident to take later because the resident might forget to take them and then consume them with the next batch of same medications that could result in overdose. During an interview on 03/05/2026 at 6:45 AM, ADON A said staff should not leave any medications with the residents for the residents to take unsupervised. She said the staff administering the medications should stay with the resident until the resident was done with the medications. She said the resident might not take them, or someone else might, like another resident or a visitor. She said the resident might aspirate or choke while taking the medications, and nobody would know. She said the residents could not take medications by themselves except if they were assessed that they could self-administer. She said she would coordinate with the DON to do an in-service about not leaving the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications with the residents. During an interview on 03/05/2026 at 7:11 AM, the Administrator said the expectation was the staff would not leave medications with the residents unattended because of the risk of the resident not taking them or the pills not being taken on time. He said he was not a clinician and would let the DON take the lead on the issue. During an interview on 03/05/2026 at 7:39 AM, the DON said staff should never leave the medications at the bedside for the resident to take later. She said the staff must ensure the resident took his medications before leaving the room. She said the resident could hoard or hide the pills to avoid taking them, could overdose on hoarded pills, and could choke without anybody to help the resident. She said the expectation was that no residents were administering their medications without proper assessment. The DON said she would have an in-service about not leaving pills inside the rooms. Record review of the facility's policy Administering Medications 2001 MED-PASS, Inc. revised April 2019 reflected Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so . 23. Residents may self-administer their own medications only if . had determined that the decision - making capacity to do so safely.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for one of four direct care staff (RN C) reviewed for other environmental conditions. The facility failed to ensure that RN C did not leave a container of germicidal wipes on top of the nurse's cart unattended on 03/04/2026. This failure could result in having an environment that was not safe for the residents, staff, and public. Findings included: During an observation on 03/04/2026 at 11:41 AM revealed a container of germicidal wipes (substance that destroys germs and microorganisms) was on top of an unattended cart parked in the hallway. It was observed that several residents were passing by the hallway. During an observation on 03/04/2026 at 11:45 AM revealed RN C went inside a resident's room to administer medications. He closed the door while administering medications. He left his cart outside the resident's room with the container of germicidal wipes still on top of his cart. The container of germicidal wipes was left unattended until he finished giving medications. During an observation and interview on 03/04/2026 at 12:19 PM, RN C said he should have placed the germicidal wipes inside the cart before leaving the cart to go to the nurse's station and before he closed the door to give medications because residents might be able to get hold of the wipes and use them to clean their faces and eyes that could result in irritations. He took the container of germicidal wipes and put it inside the last drawer of the cart he was using. During an interview on 03/05/2026 at 6:45 AM, ADON A said the germicidal wipes should be stored inside the cart for safety reasons. She said residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, and skin. She said it might cause irritation and toxicity. She said anything that indicated Keep out of reach of children. should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. She said she would coordinate with the DON to do an in-service about not leaving the germicidal wipes on top of the carts. During an interview on 03/05/2026 at 7:11 AM, the Administrator said the germicidal wipes should be placed somewhere not accessible to the residents. He said if the wipes had chemicals in them, that could be harmful when consumed or had contact with the eyes. He said he would coordinate with the DON to start an in-service about properly storing germicidal wipes. During an interview on 03/05/2026 at 7:39 AM, the DON said the germicidal wipes should be locked inside the carts and not left on top of the cart when not in use. She said it should be secured inside the carts so that the residents would not be able to access the wipes that had chemicals on them. She said confused residents might get hold of the wipes and wipe their face and body that could result in irritations. She said the expectation was for the staff to be mindful and never leave the germicidal wipes on top of the carts unattended. She said she would start an in-service about storing the germicidal wipes properly. Record review of the facility's policy Storage of Medications 200 I MED-PASS. Inc. revised April 2019 reflected Policy Statement: The facility stores all drugs and biologicals in a safe . manner . Policy Interpretation and Implementation . 7. Antiseptics, disinfectants, and germicides used in any aspect of resident care have legible, distinctive labels that identify the contents and the directions for use and are stored separately from regular medications. Record review of Safety Data Sheet (SDS) dated 01/21/2026 reflected Safety Data Sheet Medline Micro-Kill Two Germicidal Wipes . Section 2. Hazards Identification . Classification . acute toxicity - oral . eye irritant . flammable liquids . Hazard Statements: Causes serious eye irritation . Flammable liquid and vapor . May cause drowsiness or dizziness . Storage: Keep out of the reach of children.