STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676348	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Medical Resort	5001 Office Park Drive Odessa, TX 79762

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 10 of 10 (Resident #5, Resident #6, Resident #12, Resident #44, and Resident #58, Resident #61, Resident #65, Resident #100, Resident #113, Resident #133) residents reviewed for comprehensive person-centered care plans. 1. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measurable objectives in the focus areas of risk for infections, at risk for injury/immobility due to the need for quarter for half side rails, discharge plans are long term care, required assist with ADLs, limited range of motion, little or no activity involvement, ADL self-care performance deficit r/t right femoral neck arthroplasty (surgical procedure to replace or repair a joint with an artificial prosthesis), diagnosis of Hyperlipidemia (condition characterized by high levels of lipid in the blood), Hypertension, short-term memory problems, use of antidepressants, and pain management for Resident #5. 2. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the focus areas of at risk for psychosocial well-being r/t medically imposed restrictions r/t to COVID-19 restrictions, at risk for injury/immobility due to the need for quarter or half side rails, discharge plans are long term care, risk for infections, required assistance with ADLs r/t blindness, lack of coordination, and mobility, and dialysis, limited range of motion, behavior problems, Hypertension, and diagnosis of Hyperlipidemia (condition characterized by high levels of lipid in the blood) for Resident #6. 3. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the focus areas of discharge plans are long term care, at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, at risk for psychosocial well-being concern r/t medically imposed restrictions r/t to COVID-19 precautions, at risk for COVID-19, requires assistance with ADLs, ADL self-care r/t right femur fracture, behavior problems, short-term memory loss, hypertension, Edema, difficulty hearing, dehydration, Hypothyroidism, anticoagulant therapy, antidepressant therapy, antianxiety therapy, and use of opioid medication for Resident #12. 4. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, at risk for COVID-19, discharge plans are long term care, requires assistance with ADLs, the resident will participate in activities of choice, limited range of motion, Multiple sclerosis, Hypertension, short-term memory loss, difficulty making self-understood and understanding others, Edema, Dehydration, GERD, Anti-anxiety therapy, antidepressants, and pain management for Resident #44. 5. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of medically imposed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restrictions r/t COVID-19 restrictions, at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, risk for infections, discharge plans are long term care, requires assistance with ADLs, ADL self-care performance deficit, Hypertension, impaired cognitive function/dementia, dehydration, Diabetes Mellitus, Hypothyroidism, GERD, antidepressant therapy, and use of antianxiety medication for Resident #58. 6. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, at risk for COVID-19, discharge plans are long term care, ADL self-care deficit r/t Myopathy 2nd to UTI, behavior problems, short-term memory loss, Edema, difficulty making self be understood, at risk for dehydration, Hypothyroidism, will be compliant with diet through the review date, GERD, anti-anxiety therapy, antidepressant therapy, opioid medication, and pain management for Resident #61. 7. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, medically imposed restrictions r/t to COVID-19 restrictions, risk for infections, discharge plans are long term care, requires assistance with ADLs, limited range of motion, ADL self-care performance deficit r/t Asymptomatic Bradycardia (resting heart rate below 60 beats per minute), Hypertension, Edema, impaired cognitive function/impaired thought processes, communication problem r/t English/Spanish speaking, dehydration, Hypothyroidism , Hyperglycemia, Alteration in gastro intestinal status GERD, antidepressants, antianxiety medication, opioid medication, and pain management for Resident #65. 8. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, risk for infections, medically imposed restrictions r/t to COVID-19 restrictions, discharge plans are long term care, requires assistance with ADLs, behavior problem, short-term memory, long-term memory impairment, Hypertension, dehydration, GERD, antidepressants, diuretic therapy, and pain management for Resident #100. 9. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of discharge plans are long term care, at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, medically imposed restrictions r/t COVID-19 restrictions, risk for infections, ADL self-care performance deficit r/t right femur fracture, behavior problem-incidents, short-term memory problems, Edema, dehydration, Hypothyroidism, antianxiety medication, opioid medication use, and pain management for Resident #113. 10. The facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of allergies, at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning, requires supplements, discharge plans are long term care, requires assistance with ADLs, limited range of motion, ADL self-care performance deficit, behavior problems, Hypertension, altered cardiovascular status, Edema, anticoagulant therapy, Dehydration, short-term memory problems, Diabetes Mellitus, GERD, gastral intestinal alterations, diuretic therapy, antianxiety medication and pain/pain management for Resident #133. These failures could place residents at risk for not receiving care and services to meet their needs and deficits. The findings include:1. Record review of Resident #5's Face Sheet, dated 04/02/2026, revealed a [AGE] year-old male, with an admission date into the facility of 10/17/2025. Resident #5 had diagnoses which included Encounter for other orthopedic aftercare, Unspecified fracture of left femur (longest bone extending from the hip to the knee) , Unspecified Dementia (diagnosis used when symptoms of cognitive decline, such as memory loss, confusion, and impaired thinking, are present, but the underlying cause cannot be determined or does not fit a specific pattern), unspecified severity, without behavioral disturbance, Depression, Hyperlipidemia (condition characterized by high levels of lipid in the blood), and Dysarthria (motor speech disorder) following cerebral infarction (stroke).Record review of Resident #5's Quarterly MDS assessment, dated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/19/2026, revealed Resident #5 had a BIMS score of 08, which indicated moderate cognitive impairment. Section I - Active Diagnoses revealed Resident #5's primary medical condition was Other Orthopedic Conditions, as I0020 was coded 11. Section N0415 - High-Risk Drug Classes: Uses and Indication revealed Resident #5 took medication by pharmacological classification for antidepressant and opioid.Record review of Resident #5's Care Plan, with a recent review date of 03/04/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: Resident will not exhibit s/sx of COVID-19, through next review date (risk for infections), will not experience any injuries due to the need for quarter or half side rails x 90 days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), anticipate and meet residents needs through the next review date (discharge plans are long term care), resident is able to perform self-care to optimal level and maintains strength and endurance x 90 days (resident required assist with ADLs), no contractures to become worse next 180 days (limited range of motion), the resident will participate in activities of choice by review date (the resident has little or no activity involvement), the resident will maintain current level of function through the review date (resident has an ADL self-care performance deficit r/t right femoral neck arthroplasty (surgical procedure to replace or repair a joint with an artificial prosthesis), the resident will exhibit reduction of cardiac symptoms through the review date (diagnosis of Hyperlipidemia (condition characterized by high levels of lipids and fats in the blood that often cause no symptoms but increase the risk of heart attacks or strokes), the resident will remain free of complications related to hypertension through review date (Hypertension), resident will effectively communicate simple needs to staff x 90-days (short-term memory problems); the resident will be free from discomfort or adverse reactions related to antidepressant therapy through review date (use of antidepressant), and resident will be at a tolerable level of pain x 90-days (pain management). 2. Record review of Resident #6's Facesheet, dated 04/02/2026, revealed a [AGE] year-old male, with an admission date into the facility of 10/19/2022. Resident #6 had diagnoses which included Legal blindness, Type II diabetes mellitus, Heart failure, Unspecified dementia (diagnosis used when symptoms of cognitive decline, such as memory loss, confusion, and impaired thinking, are present, but the underlying cause cannot be determined or does not fit a specific pattern), unspecified severity, without behavioral disturbance, Major Depressive Disorder, Hyperlipidemia (condition characterized by high levels of lipid in the blood), Essential (primary) hypertension (chronic high blood pressure without a known single organic cause), Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness or reduced muscle control on one side of the body) following cerebral infarction (stroke), and End stage renal disease.Record review of Resident #6's Change in Status MDS assessment, dated 12/21/2025, revealed Resident #6 had a BIMS score of 09, which indicated moderate cognitive impairment. Section I - Active Diagnoses revealed Resident #6's primary medical condition was Medically Complex Conditions, as I0020 was coded 13.Record review of Resident #6's Care Plan, with a recent review of date of 02/03/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: The resident will not show a decline in psycho social well-being or experience adverse effects through next care review (medically imposed restrictions r/t to COVID-19 restrictions), will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), anticipate and meet residents needs through the next review date (discharge plans are long term care), resident will not exhibit s/sx of COVID-19, through next review date (risk for infections), resident is able to perform self-care to optimal level and maintains strength and endurance x 90 days (requires assistance with ADLs r/t blindness, lack of coordination, and mobility, and dialysis day Tuesday, Thursday, and Saturday end stage renal disease, legal blindness), no contractures to become worse next 180 days (limited range of motion), the resident will have no evidence of behavior problems by review date (behavior problems), the resident will remain free of s/sx of hypertension through review date (Hypertension), the resident will exhibit reduction of cardiac (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	problems through the review date (diagnosis of Hyperlipidemia). 3. Record review of Resident #12's Face Sheet, dated 04/02/2026, revealed an [AGE] year-old female, with an admission date into the facility of 12/01/2020. Resident #12 had diagnoses which included Hyperlipidemia (condition characterized by high levels of lipid in the blood), unspecified, Other specified depressive episodes, Dehydration, Hypothyroidism, Essential (primary) hypertension, and Edema.Record review of Resident #12's Quarterly MDS assessment, dated 02/10/2026, revealed Resident #12 had a BIMS score of 04, which indicated severe cognitive impairment. Section I - Active Diagnoses revealed Resident #12's primary medical condition was Medically Complex Conditions, as I0020 was coded 13. Section N0415 - High-Risk Drug Classes: Uses and Indication revealed Resident #12 took medication by pharmacological classification for anticoagulant and antiplatelet.Record review of Resident #12's Care Plan, with recent review of date of 02/23/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: Anticipate and meet residents needs through next review date (discharge plans are long term care), will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), the resident will not show a decline in psycho social well-being or experience adverse effects through next care review (at risk for psychosocial well-being concern r/t medically imposed restrictions r/t to COVID-19 precautions), resident will not exhibit s/sx of COVID-19 (at risk for COVID-19), resident is able to perform self-care to optimal level and maintains strength and endurance (requires assistance with ADLs), resident will maintain current level of function through next review date (ADL self-care deficit r/t right femur fracture), the resident will have fewer episodes [of by review date] (behavior problems), the resident will effectively communicate simple needs to staff (short-term memory loss), the resident will remain free from s/sx of hypertension (hypertension), the resident will decrease fluid retention within x 90 days (Edema), the resident will be able to participate in social conversations (difficulty hearing), the resident will remain hydrated (at risk for dehydration), the resident will be compliant with thyroid replacement therapy through review date (hypothyroidism), the resident will be free from discomfort or adverse reactions related to anticoagulant use (anticoagulant therapy), the resident will be free from discomfort or adverse reactions related to antidepressant therapy (antidepressant therapy), the resident will be free from discomfort or adverse reactions related to anti-anxiety therapy (anti-anxiety therapy), and resident has desired benefit of current therapy and perceived risks are outweighed (use of opioid medication). 4. Record review of Resident #44's Face Sheet, dated 03/31/2026, revealed a [AGE] year-old female, with an admission date into the facility of 12/30/2024. Resident #44 had diagnoses which included Multiple Sclerosis (chronic, immune-mediated disease where the immune system attacks the protective myelin sheath covering nerves in the brain and spinal cord), Anxiety Disorder, GERD, Pain in right knee, and Other specified depressive episodes.Record review of Resident #44's Quarterly MDS assessment, dated 03/16/2026, revealed Resident #44's had a BIMS score of 10, which indicated moderate cognitive impairment. Section I - Active Diagnoses revealed Resident #44's primary medical condition was Medically Complex Conditions, as I0020 was coded 13. Section N0415 - High-Risk Drug Classes: Uses and Indication revealed Resident #44 took medication by pharmacological classification for antianxiety and antidepressants.Record review of Resident #44's Care Plan, with recent review of date of 03/27/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: Will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), resident will not exhibit s/sx of COVID-19 (at risk for COVID-19), Anticipate and meet residents needs through next review date (discharge plans are long term care), resident is able to perform self-care to optimal level and maintains strength and endurance (requires assistance with ADLs), prevent further contractures next 90 days (limited range of motion), the resident will participate in activities of choice (little or no activity involvement), resident will maintain current level of function through next review date (multiple sclerosis, history (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CVA), the resident will remain free from s/sx of hypertension (hypertension), the resident will effectively communicate simple needs to staff (short-term memory loss), [resident] will be able to make myself understood within the next 90 days (difficulty making self-understood and understanding others, will decrease fluid retention within 90 days (Edema), will not experience any symptoms of dehydration (dehydration), the resident will remain free from discomfort, complications, or s/sx related to GERD (GERD), the resident will be free from discomfort or adverse reactions related to anti-anxiety therapy (anti-anxiety therapy), resident will show decreased episodes of s/sx of depression through review date (use of antidepressants), and resident will be at a tolerable level of pain for 90 days (pain management). 5. Record review of Resident #58's Face Sheet, dated 03/31/2026, revealed a [AGE] year-old female, with an admission date into the facility of 03/28/2024. Resident #58's diagnoses included Heart failure, Anxiety Disorder, Altered mental status, Type II Diabetes, Essential (primary) hypertension (chronic high blood pressure without a known single organic cause), and Hyperlipidemia (condition characterized by high levels of lipid in the blood).Record review of Resident #58's Quarterly MDS assessment, dated 03/05/2026, revealed Resident #58 had a BIMS score of 07, which indicated severe cognitive impact. Section I - Active Diagnoses revealed Resident #58's primary medical condition was Medically Complex Conditions, as I0020 was coded 13. Section N0415 - High-Risk Drug Classes: Uses and Indication revealed Resident #58 took medication by pharmacological classification for antianxiety and antidepressants.Record review of Resident #58's Care Plan, with recent review of date of 03/18/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: The resident will not show a decline in psycho social well-being or experience adverse effects through next care review (medically imposed restrictions r/t COVID-19 restrictions), will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), resident will not exhibit s/sx of COVID-19, through next review date (risk for infections), anticipate and meet residents needs through the next review date (discharge plans are long term care), resident is able to perform self-care to optimal level and maintains strength and endurance x 90 days (requires assistance with ADLs), resident will maintain current level of function through next review date (ADL self-care performance deficit), the resident will remain free of s/sx of hypertension through review date (Hypertension), the Resident will improve current level of cognitive function through review date (impaired cognitive function/dementia), resident will remain free of s/sx or complications related to deep vein thrombosis through review date, the resident will remain free of symptoms of dehydration (dehydration), the resident will remain s/sx of hyperglycemia (Diabetes Mellitus), the resident will remain free from s/sx of Hypothyroidism (Hypothyroidism), the resident will remain free from discomfort, complications, and s/sx related to GERD (GERD), the resident will remain free from discomfort or adverse reactions related to antidepressant therapy (antidepressants), and the resident will remain free from discomfort or adverse reactions related to antianxiety therapy (antianxiety medication). 6. Record review of Resident #61's Face Sheet, dated 03/31/2026, revealed a [AGE] year-old female, with an admission date into the facility of 02/11/2025. Resident #61 diagnoses included Myopathy (disease of the skeletal muscles causing weakness, cramps, stiffness, and fatigues, usually affecting shoulders and hips), Other specified depressive episodes, Acute pain due to trauma, Hypothyroidism, Anxiety disorder, and Hypotension.Record review of Resident #61's Annual MDS assessment, dated 01/27/2026, revealed Resident #61's had a BIMS score of 09, which indicated moderate cognitive impairment. Section I - Active Diagnoses revealed Resident #61's primary medical condition was Medically Complex Conditions, as I0020 was coded 13.Record review of Resident #61's Care Plan, with recent review of date of 02/23/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: Will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), resident will not exhibit s/sx of COVID-19 (at risk for COVID-19), anticipate (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and meet residents needs through next review date (discharge plans are long term care), resident will maintain current level of function through next review date (ADL self-care deficit r/t Myopathy 2nd to UTI), the resident will have no evidence of behavior problems by review date (behavior problems), Resident will effectively communicate simple needs to staff (short-term memory problems), the resident will decrease fluid retention within x 90 days (Edema), will be able to make self understood within next 90 days (difficulty make self be understood), the resident will remain hydrated (at risk for dehydration), the resident will be compliant with thyroid replacement therapy through review date (hypothyroidism), will be compliant with diet through the review date (endocrine status), the resident will remain free from discomfort, complications, and s/sx related to GERD (GERD), the resident will be free from discomfort or adverse reactions related to anti-anxiety therapy (anti-anxiety therapy), the resident will be free from discomfort or adverse reactions related to antidepressant therapy (antidepressant therapy), resident has desired benefit of current therapy and perceived risks are outweighed x 90 days (opioid medication), and the resident will be at a tolerable level of pain (pain management). 7. Record review of Resident #65's Face Sheet, dated 03/31/2026, revealed a [AGE] year-old female, with an admission date into the facility of 01/03/2025. Resident #65's diagnoses included Major Depressive Disorder, Generalized Anxiety Disorder, Bradycardia, Diverticulosis of intestine (asymptotic condition where small, bulging pouches form on the colon wall), Type II Diabetes, Dehydration, and Heart failure.Record review of Resident #65's Quarterly MDS assessment, dated 02/20/2026, revealed Resident #65 had a BIMS score of 06, which indicated severe cognitive impairment. Section I - Active Diagnoses revealed Resident #65's primary medical condition was Medically Complex Conditions, as I0020 was coded 13.Record review of Resident #65's Care Plan, with recent review of date of 02/23/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: Will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), the resident will not show a decline in psycho social well-being or experience adverse effects through next care review (medically imposed restrictions r/t to COVID-19 restrictions), resident will not exhibit s/sx of COVID-19, through next review date (risk for infections), anticipate and meet residents needs through the next review date (discharge plans are long term care), resident is able to perform self-care to optimal level and maintains strength and endurance x 90 days (requires assistance with ADLs), no contractures to become worse next 90 days (limited range of motion), resident will maintain current level of function through next review date (ADL self-care performance deficit r/t Asymptomatic Bradycardia), the resident will remain free of s/sx of hypertension through review date (Hypertension), will decrease fluid retention x 90 days (Edema), the Resident will maintain improve current level of cognitive function through review date (impaired cognitive function/impaired thought processes), resident will maintain current level of communication function through review date (communication problem r/t English/Spanish speaking), the resident will remain free of symptoms of dehydration (dehydration), the resident will remain free from s/sx of Hypothyroidism (Hypothyroidism), the resident will remain free from s/sx of Hyperglycemia (high blood sugar, caused by insufficient insulin or high insulin resistance)(Hyperglycemia), the resident will remain free from any s/sx of alteration in gastro intestinal status (alteration in gastro intestinal status), the resident will remain free from discomfort, complications, and s/sx related to GERD (GERD), the resident will remain free from discomfort or adverse reactions related to antidepressant therapy (antidepressants), the resident will remain free from discomfort or adverse reactions related to antianxiety therapy (antianxiety medication), resident has desired benefit of current therapy and perceived risks are outweighed x 90 days (opioid medication), and the resident will be at a tolerable level of pain (pain management). 8. Record review of Resident #100's Face Sheet, dated 03/30/2026, revealed a [AGE] year-old female, with an admission date into the facility of 04/03/2024. Resident #100's diagnoses included Acute pain due to trauma, Type II Diabetes, Hyperlipidemia (condition characterized by high levels of lipid in the blood), Depression, unspecified, Essential (Primary) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hypertension (chronic high blood pressure without a known single organic cause), and Unspecified Dementia (diagnosis used when symptoms of cognitive decline, such as memory loss, confusion, and impaired thinking, are present, but the underlying cause cannot be determined or does not fit a specific pattern), unspecified severity, without behavioral disturbance.Record review of Resident #100's Quarterly MDS assessment, dated 02/10/2026, revealed Resident #100 had a BIMS score of 06, which indicated severe cognitive impairment. Section I - Active Diagnoses revealed Resident #100's primary medical condition was Other Orthopedic Conditions, as I0020 was coded 11. Section N0415 - High-Risk Drug Classes: Uses and Indication revealed Resident #100 took medication by pharmacological classification for antidepressants and diuretics.Record review of Resident #100's Care Plan, with recent review of date of 02/03/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: Will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), resident will not exhibit s/sx of COVID-19, through next review date (risk for infections), the resident will not show a decline in psycho social well-being or experience adverse effects through next care review (medically imposed restrictions r/t to COVID-19 restrictions), anticipate and meet residents needs through the next review date (discharge plans are long term care), resident is able to perform self-care to optimal level and maintains strength and endurance x 90 days (requires assistance with ADLs), resident will maintain current level of function through next review date (ADL self-care performance deficit r/t to dementia, difficulty walking, and history of falls), the resident will have no evidence of behavior problem by review date (behavior problem), resident will effectively communicate simple needs to staff x 90 days (short-term memory), resident will maintain level of functioning and be aware of environment and orientations preserved x 90 days (long-term memory impairment), the resident will remain free of s/sx of hypertension through review date (Hypertension), will decrease fluid retention x 90 days (Edema), the resident will remain well hydrated x 90 days (dehydration), the resident will remain free from discomfort, complications, and s/sx related to GERD (GERD), the resident will remain free from discomfort or adverse reactions related to antidepressant therapy (antidepressants), the resident will be free from discomfort or adverse side effects of diuretic therapy (diuretic therapy), and the resident will be at a tolerable level of pain x 90 days (pain management). 9. Record review of Resident #113's Face Sheet, dated 04/02/2020, revealed an [AGE] year-old female, with an admission date into the facility of 12/01/2020. Resident #113's diagnoses included Hyperlipemia, Other specified depressive episodes, Dehydration, Hypothyroidism, and GERD. Record review of Resident #113's Quarterly MDS assessment, dated 01/21/2026, revealed Resident #113 had a BIMS score of 05, which indicated severe cognitive impairment. Section I - Active Diagnoses revealed Resident #113's primary medical condition was Medically Complex Conditions, as I0020 was coded 13.Record review of Resident #113's Care Plan, with recent review of date of 02/23/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: Anticipate and meet residents needs through the next review date (discharge plans are long term care), will not experience any injuries due to the need for quarter or half side rails x 90-days (at risk for injury/immobility due to the need for quarter or half side rails to assist with turning and repositioning), the resident will not show a decline in psycho social well-being or experience adverse effects through next care review (medically imposed restrictions r/t COVID-19 restrictions), resident will not exhibit s/sx of COVID-19, through next review date (risk for infections), resident will maintain current level of function through next review date (ADL self-care performance deficit r/t right femur fracture), the resident will have fewer episodes of by review date (behavior problem-incidents), the resident will effectively communicate simple needs to staff x 90 days (short-term memory problems), will decrease fluid retention x 90 days (Edema), the resident will remain well hydrated x 90 days (dehydration), the resident will be compliant with thyroid replacement therapy through review date (hypothyroidism), the resident will remain free from discomfort or adverse reactions related t

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	676348	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Medical Resort	5001 Office Park Drive Odessa, TX 79762

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services.The facility failed to ensure floors were not soiled with food, grease, dust, and other dried substances.The facility failed to ensure floors in the walk-in refrigerator/freezer were not soiled with pieces of brown and clear plastic wrappers as well as dust buildup.The facility failed to ensure food items in the refrigerator were not opened to air.The facility failed to ensure food items were stored properly per the manufacturer.These failures could place residents at risk for foodborne illness and a decline in health status.The findings include:Observation of the kitchen on 03/30/2026 at 5:50am with the DM revealed the floors were dirty with food particles, a white dried substance, and a greasy film. The wall and floor behind the warmer oven was covered in grease and dust built up along with a white dried substance.Observation on 03/30/2026 at 5:58am of dry storage with the DM revealed food particles on the floor and under shelves. There was dust buildup in the corners, a cardboard box lined with a plastic bag contained approximately 15 large white tea bags open-to-air, 1 plastic bottle of caramel sauce with an open date of 3/5/2026, 1 plastic bottle of caramel sauce with an open date of 3/24/26, and 1 bottle of chocolate sauce with an open date of 3/24/26. All sauce bottles had manufacturer's instructions to refrigerate after opening.Observation on 03/30/2026 at 6:10am of the large walk-in refrigerator freezer with the DM revealed a large clear plastic zip lock bag in the refrigerator that was open with a large bag of shredded cheese that was open to air, and dust buildup under the storage shelves. In the freezer section there were several brown and clear pieces of wrappers under the storage shelf along with dust buildup and little white pieces of an unknown substance.Observation on 03/30/2026 at 6:15am of the dishwasher room with the DM revealed the floor had dust build up in the corner beside the dishwasher along with pieces of white and pink sugar packets.In an interview on 03/30/2026 at 6:29am with [NAME] A, she stated she has worked here for 1 year. She stated when she opens items, she labels the item with the date open and covers it as required. She stated it was all kitchen staff responsibility for checking items in the refrigerator and freezer for expired dates and to make sure everything was cleaned as needed and at the end of shift. She stated they try to clean the floors after every meal if time allows. She stated they have a schedule and sign off sheet for when a task was done. She stated a negative outcome for residents if all of that was not done correctly, was they may get sick. She stated she was not aware the chocolate and caramel syrups needed to be refrigerated but that she would pay closer attention.In an interview on 03/30/2026 at 7:24am with DON, she stated all residents ate out of the kitchen. She stated there was 1 resident with a gastric tube but that she did eat by mouth and that the gastric tube was only used to supplement tube feeding if the resident does not eat a certain percentage of her meals. She stated her expectation for the kitchen was for the staff to follow policies and procedures and was aware the staff had schedules for what needs to be cleaned or deep cleaned and when. She stated food items were to be dated, labeled, and stored properly. She further stated a negative outcome could be food borne illness. The DON also stated there had not been any outbreaks of foodborne illness.In an interview on 03/31/2026 at 9:39am with [NAME] B, she stated she had worked here for four (4) years. She stated cleaning the kitchen was a team effort but that they have assigned tasks to do daily and weekly. She stated all opened items were to be dated, labeled and sealed or stored properly. She stated a negative outcome could be the residents becoming ill. She stated they try to clean the floors as best they can daily but the area behind the warmer was just missed she guessed.In an interview on 03/31/2026 at 9:41 AM DA C stated she had worked here almost 6 months. She stated she assists with all aspects of the kitchen with cleaning, stocking, and helping any way she can. She stated she did not know why the floors were as dirty as they were. She stated they do have schedules and a log of when to clean appliances and floors as well as a deep (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clean schedule. She stated if they did not clean appropriately the residents could get sick. In a follow-up observation on 04/01/2026 at 9:30 AM with the DM, dust build up and food particles remained on the floor in the dry storage. Plastic wrappers and dirt build up remained under the storage shelves in the walk-in freezer. And dust built up with pieces of pink and white sugar packets also remained on the floor of the dishwashing room.In an interview on 04/01/2026 at 9:35 AM with DM, she stated the floors are mopped every shift and in between meals as needed. She stated deep cleanings happen once a week, the dry storage was gone through once a month to check for expired foods and thorough cleaning, refrigerators and freezers were gone through to remove expired items or leftovers once a week. She stated with the freezer that she was waiting on her dry-freeze chemical to clean it and it should arrive soon. She also stated the floor in the dishwasher room was swept and mopped twice a day, and that they did not do a good job but she was not sure why. She stated the monthly cleaning schedules for March were not signed and had no answer why it was not filled out, nor why the second shift did not initial the daily schedule for the week, stating just a lack of oversight. She stated with the cardboard box of tea bags in the dry storage, that the plastic bag that lines the box of tea bags should be wrapped up after an employee retrieves a bag to make tea and not leave it open to air. The DM further stated she has not done any in-services, trainings, or competencies for employees regarding storage, labeling, or cleaning. She stated when she had a new employee they were trained by a cook and watched to make sure they complete tasks appropriately but that she did not have a competency sheet or any kind of new hire training to provide. She stated the staff were supposed to follow the cleaning schedules posted and sign off when the task was completed. She also stated she was ultimately responsible for making sure the staff were completing tasks as assigned, according to policies, and that was her expectation. She stated a negative outcome for residents could be a food borne illness. In an interview on 04/01/2026 at 10:00 AM with the ADMN, he stated that all items in the kitchen from cleaning, labeling, and storage of foods were to be labeled and stored appropriately , and that the floors and other items were cleaned per schedule and policy. He stated a negative outcome could be the residents getting sick. He stated there has not been any outbreaks of foodborne illnesses.Record review of Cleaning schedules reviewed for 03/2026:March Monthly Deep Cleaning - Aides that included the item or area that was to be cleaned, the week it was to be done, and title of responsible party. This review revealed that there were no signature/initials on this page to show that any task had been completed for the month of March.March Monthly Deep Cleaning - Cooks that included the item or area that was to be cleaned, the week it was to be done, and title of responsible party. This review revealed that there were no signature/initials on this page to show that any task had been completed for the month of March.Daily/After Each use Cleaning Schedule that included the name of the item that was cleaned, day of the week, and title of responsible party. It revealed that only the employees on the 1st shift signed that the task was completed.Record review of the guidelines titled Dry Food Storage, not dated, revealed:All items will be dated with a receive date on the package. It is appropriate for individual/piece items to have one date on the case instead of each individual piece.Any items in dry storage without a manufacturer's used by date will be used within six months of received dates with the exception of spices and extracts. Spices and extracts will be used within a year of received dates. Items that have a manufacturer's used by date, we will honor that date.Any open items will be covered/sealed. They will be relabeled if the original label was obscured in any way.Record review of the policy titled Food Safety in Receiving and Storage, dated revised 1/1/10, revealed [in part]:Policy: Food will be received and stored by methods to minimize contamination and bacterial growth.Procedure: Dry Storage Guidelines8. Storeroom floors will be swept and mopped dailyRecord review of the policy titled Cleaning the Floor, dated revised 1/1/10, revealed [in part]:Policy: The floor will be kept in a clean and sanitary condition. Floors are to be mopped at the end of each meal.Procedure:After each meal:Sweep the floor and dispose of dirt particles. Sweep under the equipment. Move the equipment, if mobile, in order to sweep under it.Mop vigorously to remove food spills and stains. Be sure to mop under equipment. Floor ledges and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	baseboards should also be cleaned to prevent soil build up.Review of Food Code 2022 Recommendations of the United States Public Health Service Food and Drug Administration revision date 01/18/2023 revealed, in part:3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation.(A) FOOD shall be protected from cross contamination by:(4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages.