STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676390	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Medical Lodge	2000 West Audie Murphy Pkway Farmersville, TX 75442

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for three of four residents (Resident #1, Resident #2, and Resident #5) reviewed for catheter and incontinence care. 1. The facility failed to ensure CNA B provided appropriate perineal care for Resident #1 when he failed to clean the resident's penis, scrotum, and pubic area on 10/07/25. 2.The facility failed to ensure CNA B provided appropriate catheter and perineal care for Resident #2, who was being treated for a urinary tract infection, when he failed to change the surface of the peri-wipes when cleaning the resident's penis, scrotum, and perineal area, failed to wipe the catheter tubing from the tip of the penis downward and failed to keep the urinary drainage bag below the bladder while providing care on 10/07/25. 3. The facility failed to ensure CNA B and CNA C maintained the urinary catheter drainage bag below Resident #5's bladder while they transferred the resident with a mechanical lift and while providing incontinence care and a bed bath on 10/07/25. These failures could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections.Findings included: 1. Record review of Resident #1's Face Sheet dated 10/7/25 reflected a [AGE] year-old male with an admission date of 11/27/24. Diagnoses included fracture of left femur, (thigh bone) mild intellectual disability and history of trans ischemic attacks (a brief stroke-like attack resolving within minutes to hours). Record review of Resident #1's 5-day MDS assessment, dated 09/08/25, reflected a BIMS score of 9 which indicated he was moderately cognitively impaired. He was dependent on staff for toileting hygiene and was occasionally incontinent of urine and bowel. Record review of Resident #1's care plan, initiated on 08/11/25, reflected, Resident requires assistance with ADLs.Interventions. Provide level of support to complete dressing, toilet use, personal hygiene, and bathing needs every shift.Resident has been identified at risk for pressure ulcer development or skin breakdown.Interventions.Check for incontinence frequently and as needed. Provide incontinence care fer each. In an observation on 10/7/25 at 08:45 a.m. CNA B entered Resident # 1's room and asked the resident if he was ready to get up for therapy and the Resident stated no,. CNA B stated he needed to check to see if he needed changed and the Resident stated OK. CNA B put on gloves and uncovered the resident revealing he had brown rings noted on the bed pad and sheet. CNA B stated this was his first check and change on the resident since he started his 6:00 a.m. shift. CNA B unfasted the resident's brief revealing it was slightly wet. CNA B had the resident roll onto his side and then took a peri-wipe and wiped from the front to the back of the anal area, revealing light brown smears with each wipe. CNA B then pushed the soiled brief down toward the residents' buttocks and rolled the stained sheet under the resident. CNA B changed his gloves but did not perform hand hygiene. He placed a clean sheet, a draw sheet and clean brief under the resident and had him roll to the other side while he pulled the soiled linen out and pulled the clean linen out from under the resident. He had the resident roll back onto his back and fastened the brief without cleaning his pubic area, penial shaft or scrotum. CNA B then unfasted the brief and took a peri-wipe and wiped once down each groin but still did not clean the penial shaft or scrotum. CNA B refastened the brief and straightened the residents covers. In an interview with Resident #1 on 10/07/25 at 08:50 a.m. he stated he was last changed yesterday evening but could not remember the time. He stated they usually come and change him when he calls for them to come and change him. 2. Record review of Resident #2's Face Sheet dated 10/7/25 reflected a [AGE] year-old male with an admission date of 10/04/25. Diagnoses included Parkinson's disease (disorder of the central nervous system that affects movement), chronic kidney disease (long standing disease of the kidneys leading to renal failure) and severe sepsis (body's extreme reaction to an infection) Record review of Resident #2's admission MDS assessment reflected it was in process and not complete. Record Review of Resident #2's Order summary report dated 10/07/25 reflected, Catheter care. every shift. Catheter drainage bag to gravity. with a start date of 10/05/25. Record review of Resident #2's care plan dated 10/06/25 reflected, Resident utilizing indwelling urinary catheter placing resident at risk for UTI.Interventions.Provide urinary catheter care per facility protocol every shift and as needed.The resident has a Urinary Tract infection. Interventions.Check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas. In an observation on 10/07/25 at 09:10 a.m. CNA B entered Resident #2's room, put on gloves, but no gown and told him he was here to get him changed and dressed for therapy. CNA B went to the resident's bathroom to retrieve a urinal and proceeded to empty the resident's urinary drainage bag

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to 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 5 of 6 Residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) observed for infection control. 1.The facility failed to ensure CNA B performed hand hygiene during incontinence care to Resident #1 and failed to perform hand hygiene prior to leaving the resident's room on 10/07/25. 2. The facility failed to ensure CNA B used the required PPE for Resident #2, who was on Enhanced Barrier Precautions due to his urinary catheter, while providing incontinence care, failed to change gloves and perform hand hygiene during incontinence care and failed to perform hand hygiene before leaving the resident's room on 10/07/25. 3. The facility failed to ensure CNA C performed hand hygiene after assisting with Resident #3's mechanical lift transfer and before leaving the resident's room on 10/07/25. 4. The facility failed to ensure CNA D used the required PPE for Resident #4, who was on enhanced barrier precautions due to her urinary catheter and wound, while providing incontinence care, failed to change gloves and perform hand hygiene during incontinence care and failed to perform hand hygiene before leaving the residents room on 10/07/25. 5. The facility failed to ensure CNA C performed hand hygiene during incontinence care to Resident #5 and both CNA C and CNA B failed to perform hand hygiene prior to leaving the resident's room on 10/07/25. These failures could place the residents at risk of cross-contamination and development of infection.Findings included: 1. Record review of Resident #1's Face Sheet dated 10/7/25 reflected a [AGE] year-old male with an admission date of 11/27/24. Diagnoses included fracture of left femur, (thigh bone) mild intellectual disability and history of trans ischemic attacks (a brief stroke-like attack resolving within minutes to hours) In an observation on 10/7/25 at 08:45 a.m. CNA B was observed using the hand sanitizer in the hallway and then entered Resident # 1's room and asked the resident if he was ready to get up for therapy and the Resident stated no,. CNA B stated he needed to check to see if he needed changed and the Resident stated OK. CNA B put on gloves pulled out a packet of peri-wipes and a clean brief from the chest of drawers and uncovered the resident revealing he had brown rings noted on the bed pad. CNA B stated this was his first check and change on the resident since he started his 6:00 a.m. shift. CNA B unfasted the resident's brief revealing it was slightly wet. CNA B had the resident roll onto his side and then took a peri-wipe and wiped from the front to the back of the anal area, revealing light brown smears with each wipe. CNA B then pushed the soiled brief down toward the residents' buttocks and rolled the stained sheet under the resident. CNA B changed his gloves but did not perform hand hygiene. He placed a clean sheet, a draw sheet and clean brief under the resident and had him roll to the other side while he pulled the soiled linen out and pulled the clean linen out from under the resident. He had the resident roll back onto his back and fastened the brief without cleaning his pubic area, penial shaft or scrotum. CNA B then unfasted the brief and took a peri-wipe and wiped once down each groin and refastened the brief and straightened the residents covers. CNA B removed his gloves, gathered up the dirty linens and trash and left the room without performing hand hygiene. CNA B walked down the hall, opened the soiled linen room, deposited the soiled linens and trash and then used the hand sanitizer on the wall outside of the door. 2. Record review of Resident #2's Face Sheet dated 10/7/25 reflected a [AGE] year-old male with an admission date of 10/04/25. Diagnoses included Parkinson's disease (disorder of the central nervous system that affects movement), chronic kidney disease (long standing disease of the kidneys leading to renal failure) and severe sepsis (body's extreme reaction to an infection) In an observation on 10/07/25 at 09:10 a.m. signage was observed outside of Resident #2's room which indicated he was on Enhanced Barrier Precautions. CNA B entered Resident #2's room, put on gloves, but no gown and told him he was here to get him changed and dressed for therapy. CNA B went to the resident's bathroom to retrieve a urinal and proceeded to empty the resident's urinary drainage bag, which contained approximately 220 cc of clear yellow urine. CNA B emptied the urinal, changed gloves but did not perform hand hygiene. CNA B unhooked the urinary catheter drainage bag and laid it on the bed and unfastened the resident's brief and wiped across his pubic area, down each groin and then wiped up the penile shaft up and down with several swipes, using the same wipe and without changing the surface of the wipe. CNA B did not clean the catheter tubing from the tip of the penis downward. Resident's penile shaft and groin area were noted to be red and irritated. CNA B rolled the resident to his side and wiped the anal area from front to back and placed a clean