STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676415	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Medical Lodge	1119 S. Red River Expressway Burkburnett, TX 76354

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview, and record review, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 23 (Resident #3) resident's rooms observed for environmental conditions. The facility failed to ensure that Resident #3's floor was clean and sanitized. The facility's failure placed the residents at risk for diminished quality of life from environment not being kept clean. The findings included: Record review of Resident #3's face sheet dated 12/31/2024 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with most recent admission on 11/22/2022 with diagnoses to include: senile degeneration of brain (decline in mental status because of brain degeneration), colostomy status (need for external bag to collect feces), cognitive communication deficit (inability to communicate related to mental decline), anxiety disorder, and restlessness. Record review of Resident #3's significant change MDS assessment dated [DATE] revealed BIMS score of 3 which indicated severe cognitive impairment. Further review of the MDS revealed she had inattention and disorganized thinking but did not have rejection of care behaviors. Resident #3 needed helper to perform more than half of the effort for personal hygiene and was dependent on helper for toileting hygiene. Resident #3 utilized ostomy for bowel continence. Record review of Resident #3's care plan dated 12/31/2024 revealed focus that Resident #3 pulled at colostomy bag and removed appliance, she would refuse to allow staff to replace colostomy bag, and at times she would remove the colostomy bag and throw feces on the floor date initiated: 5/23/2024 and date revised: 5/3/2024. Staff interventions included May apply abdominal binder to cover ostomy due to resident removing appliance .assess me for abdominal distention .assess me for constipation .assess my bowel pattern & report any changes in condition to physician .encourage her to not remove her colostomy bag or through feces onto the floor .observe my skin daily for irritation and redness .staff to empty my colostomy bag as needed .staff to provide colostomy care as ordered. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's electronic physician orders dated 9/27/2024 revealed order for colostomy care every shift and as needed. Change colostomy bag and or wafer every 7 days and as needed. Empty colostomy bag as needed. Resident may care for colostomy as needed. During a telephone interview on 12/30/2024 at 8:22 a.m., Resident #3's representative stated she was upset with the floor and bed railing in Resident #3's room being dirty during her visits. She stated that, at one time, when she had visited, the floor was so sticky that her shoes were pulling off her feet as she walked around in the room. She stated the bed railing had been dirty with brown substance at times. She stated that she would bring up the room condition with staff and after reminding staff about it more than once, the staff would come into the room and address her concerns. She stated she did not understand why staff were not routinely checking Resident #3's room condition and did not like that they cleaned it only after her request. She stated Resident #3 did not seem bothered by it, but a reasonable person would be bothered by it and she was bothered by it during her visits with Resident #3. During an observation and interview on 12/30/2024 at 8:49 a.m., Resident #3 was lying in bed with the left side of bed against the wall. On the sheets of the left side of bed, observed a brown substance. On the left side of bed wall, observed 2 different shades of brown substance. On the floor and baseboard under the bed, observed 3 different colors (one greenish, one brownish, and one blackish) and 3 different consistencies of brown substance and touched the floor and baseboard. There was also a candy wrapper, an empty plastic and paper bag, and a see through plastic sealed bag with brown food which appeared could be brownie in it. The room had a foul odor in it. Resident #3 was lying in the bed and asking if someone would help her clean her hands because they were sticky. She had her breakfast tray in front of her on the bedside table. During an observation on 12/30/2024 at 10:49 a.m., Resident #3 lying in bed with her eyes closed and no distress observed. The wall to the left of her bed and sheets observed and no longer had brown substance on them. Under her bed the candy wrapper and bags had been removed. There was a dried circular brown ring on the floor. During an observation on 12/30/2024 at 2:46 p.m., Resident #3 lying in bed with her eyes closed and no distress observed. Under her bed there was a dried circular brown ring on the floor. During an observation and interview on 12/31/2024 at 8:25 a.m., Resident #3 was lying in bed and voiced no concerns. Observed the floor under her bed and it continued to have dried circular brown ring. During an interview on 12/30/2024 at 2:53 p.m., CNA A stated that Resident #3 had a history of removing her colostomy bag herself but didn't try to empty it on her own. During an interview on 12/31/2024 at 8:25 a.m., HK B stated she had worked on 400 hall on 12/30/2024. She stated that housekeeping was not to pick up bodily fluids such as feces. She stated CNAs were responsible for cleaning bodily fluids then housekeeping would go behind CNAs, when told, to sanitize the area if needed. She stated she had not been told to sanitize the area in Resident #3's room on 12/30/2024. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/2024 at 8:30 a.m., CNA A stated she had noticed the brown substance on Resident #3's bedding, wall, and floor on 12/30/2024. CNA A stated she was told housekeeping did not pick up bodily fluids such as feces and that she was responsible for cleaning up bodily fluids. She stated she had cleaned the bed sheets and wall using disinfectant blue top wipes the facility provided. She stated she attempted to clean up the floor area with the disinfectant wipes but could not get all the brown substance off the floor after scrubbing with disinfectant wipes. She stated housekeeping would go behind CNAs if needed to sanitize the area. She stated she had not notified housekeeping to sanitize Resident #3's room after she had attempted to sanitize it. During an interview on 12/31/2024 at 8:47 a.m., LVN C stated she had been told this morning about the brown substance on Resident #3's floor that the CNA could not remove on 12/30/2024. She stated she was not aware of the issue on 12/30/2024. LVN C stated Resident #3 had a history of taking colostomy bag off staff had interventions to try and keep her from doing so such as using extra tape and binder. She stated that nursing staff and CNAs were responsible for cleaning up bodily fluids. She stated sometimes care companions listed inside of the door of resident room would clean resident's rooms. She stated she would have gone to the ADON on 12/30/2024 had she known about dried brown substance then to ask for assistance with cleaning area. She stated she did not know why CNA did not tell her about the issue. She stated she felt no negative effect had occurred to the residents from floor not being cleaned completely of brown substance. During an interview on 12/31/2024 at 8:47 a.m., ADON D stated she expected the resident's room to be cleaned and sanitized. She stated nurses and CNAs were responsible for cleaning up bodily fluids. She stated she was responsible for monitoring that bodily fluids were cleaned up correctly and area sanitized. She stated she expected CNAs to notify her if they had issues with not being able to clean rooms after bodily fluids observed and she would have notified housekeeping to get material to clean up substance. She stated the facility ensures that residents have a clean environment by training staff members through in-services on how to clean up bodily fluids. She stated she did not know why CNA A had not asked for assistance on 12/30/2024 or why there were multiple consistencies observed under Resident #3's bed. She stated she did not feel any negative effect had been had on Resident #3 from the room not being cleaned. During an interview on 12/31/2024 at 9:28 a.m., the preceptor (trainer) DON stated she expected bodily fluids to be cleaned up from resident room and not be present for multiple shifts. She stated a reasonable person would not want to stay in a room that had dried brown substance on floor. She stated she felt the failure occurred due to staff not being trained. She stated CNAs and housekeeping were responsible for keeping rooms clean and sanitized. She stated Resident #3 had a history of removing colostomy bags and throwing feces that had been documented on care plan. She stated the housekeeping supervisor, ADON, and DON were responsible for monitoring that CNAs and housekeeping staff were cleaning bodily fluids from resident's rooms. She stated she monitored resident rooms daily. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/2024 at 12:49 p.m., the ADMN stated his expectation would be that bodily fluids were not present on the floor for multiple shifts. He stated residents will make messes and throw things on the floor, and the staff would catch it the next day. He stated the initial cleaning of bodily fluids was to be done by CNAs and then housekeeping was expected to go back and do a deep cleaning. He stated CNAs should notify housekeeping when they had completed the initial cleanup. He stated he felt communication had led to the failure. He stated supervisors should monitor that CNAs and housekeeping were cleaning rooms by performing spot room checks daily if time allowed. He stated that a reasonable person would not want to be around feces, but that Resident #3 showed no awareness that having feces on floor, was not socially acceptable. Record review of facility policy titled Quality of Life with no date revealed: The facility provides a safe, clean, comfortable, and homelike environment .Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior environment are provided. Each resident shall have bed and bath linens that are clean and in good condition. Record review of facility policy titled Infection Control Policy with no date revealed: Routine cleaning and disinfection of frequently touched or visibly soiled surfaces in common areas, resident room, and at the time of discharge are implemented and on-going.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for 3 (Resident #76, Resident #80 and Resident #99) of 32 residents reviewed for resident assessments. The facility failed to accurately assess Resident #76, Resident #80, and Resident #99's CPAP/BiPAP-use. This failure placed the residents at risk for unmet care needs and/or decreased quality of life. Findings include: Record review of Resident #76's electronic face sheet revealed, [AGE] year-old male admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (lung disease), Heart Failure, and Other abnormalities of breathing. Record review of Resident # 76's Quarterly MDS dated [DATE] revealed Section C Cognitive Patterns BIMS score 12 (moderately impaired cognition O Special Treatments, Procedures and Programs respiratory treatments G3 CPAP was not selected. MDS was signed by DON Record review of Resident #76's Physician orders dated 12/01/2024 revealed order dated 03/07/2022 CPAP/BiPAP (Continuous Positive Airway Pressure [a noninvasive breathing machine that helps people breathe when they are having trouble breathing]. Resident is to wear CPAP at HS (hours of sleep) at SELF TITRATING . (Resident able to adjust settings) Check placement, setting and functioning daily. During an observation on 12/29/2024 at 8:30 AM, Resident #76 was sitting in a recliner with CPAP on with eyes closed with breakfast tray on bedside table. During an interview on 12/31/2024 at 10:55 AM with LVN A, MDS Coordinator, she stated she did not know why Resident # 76's MDS did not have BiPap/CPAP coded on the MDS. She stated it did not affect payment or affect resident's care. She stated that MDS's were monitored by the DON. Record review of Resident # 80's electronic face sheet revealed [AGE] year-old male admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (lung disease), and Obstructive Sleep Apnea (stop breathing). Record review of Resident #80's Quarterly MDS dated [DATE] revealed Section C (Cognitive Patterns) BIMS score 12 (moderately impaired cognition). Section O Special Treatments, Procedures and Programs respiratory treatments G3 CPAP was not selected. MDS was signed by RN A Record review of Resident #80's Physician orders dated 12/01/2024 revealed order dated 08/30/2022 CPAP/BiPAP Resident is to wear CPAP at HS (hours of sleep) at Home Settings. Check placement, setting and functioning daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/29/2024 at 9:00 AM, Resident #80 was lying in a bed sleeping with CPAP at bedside and not wearing CPAP. Record review of Resident # 99's electronic face sheet revealed [AGE] year-old male admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (lung disease), and Obstructive Sleep Apnea (stop breathing). Record review of Resident #99's Quarterly MDS dated [DATE] Section C (Cognitive Patterns BIMS score 11 (moderately impaired cognition). Section O Special Treatments, Procedures and Programs respiratory treatments G2 BiPAP was not selected, and G3 CPAP was not selected. MDS was signed by DO N. Record review of Resident #99's Physician orders revealed order dated 11/12/2024 was for Resident to wear CPAP at HS (hours of sleep) with home settings. Check placement, setting and functioning daily. During an observation on 12/29/2024 at 09:15 AM, Resident # 99 was observed in room with CPAP on table beside bed and not wearing CPAP. During an interview on 12/31/2024 at 12:46 PM, the DON stated she would expect the MDS to be coded correctly. The DON stated she did not know why CPAP was not coded on the MDS. The DON stated there was no payment benefit from coding incorrectly and it did not affect the resident's care. The DON stated she was responsible for reviewing MDS for accuracy. During an interview on 12/31/2024 at 12:52 PM, preceptor DON (monitors DON in training) stated she would expect CPAP to be coded on MDS if a resident used a CPAP. The preceptor DON stated there were no negative effects on resident if CPAP was not coded on MDS, due to care would be the same. The preceptor DON stated the MDS Coordinators were responsible for accurate coding of MDS and the DON monitored that the MDS were correct. The preceptor DON stated she did not know why CPAP was not coded. Review of facility's policy titled Resident Assessment not dated. It is the policy of this facility to conduct and document, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of a resident's functional capacity on all residents admitted to the facility. The facility will electronically transmit to CMS resident-entry-and -death-in-facility tracking records required by the RAI; and OBRA assessments, including admission, annual, quarterly, significant change, significant Correction, and discharge assessments. This will provide the facility with the information. necessary to develop a care plan and to provide appropriate care and services for each resident. Accuracy of Assessments: The assessment must accurately reflect the resident's status. Each resident's comprehensive assessment is conducted or coordinated by a registered nurse with the appropriate participation of health professionals. The registered nurse who conducts or coordinates each assessment shall sign and certify the completion of the assessment. Each individual who completes a portion of the assessment will sign and certify accuracy of that portion of the assessment.

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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** 45216 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 7 of 23 residents (Residents #39, #97, #115, #227, #231, #234, and #236) reviewed for care plans in that: 1. The facility failed to ensure Resident #39 had a care plan in place for urinary incontinence, mood state, activities, or dehydration/fluid maintenance triggered on the resident's CAA. 2. The facility failed to ensure Resident #97 had a care plan in place for cognitive loss/dementia, visual, urinary incontinence, psychosocial well-being, mood status, activities, falls, or nutritional status triggered on the resident's CAA. 3. The facility failed to ensure Resident #115 had a comprehensive care plan addressing cognitive loss/dementia, psychosocial well-being, activities, or pressure ulcer/injury triggered on the resident's CAA. 4. The facility failed to ensure Resident # 227 had comprehensive care plan addressing urinary incontinence, psychosocial well-being, mood status, or activities triggered on the resident's CAA. 5. The facility failed to ensure Resident #231 had a comprehensive care plan addressing cognitive loss/dementia, communication, functional abilities (self-care/mobility), urinary incontinence, psychosocial well-being, or activities triggered on the resident's CAA. 6. The facility failed to ensure Resident #234 had a comprehensive care plan addressing cognitive loss/dementia, functional abilities (self-care/mobility), urinary incontinence, psychosocial well-being, activities, or falls triggered on the resident's CAA. 7. The facility failed to ensure Resident #236 had a comprehensive care plan addressing cognitive loss/dementia, visual, psychosocial well-being, mood state, or activities triggered on the resident's CAA. These failures could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included the following: 1. Review of Resident #39's face sheet revealed he was a [AGE] year-old male. Resident #39 was initially admitted to the facility on [DATE] and was recently readmitted on [DATE] with the medical diagnoses of dementia, glaucoma (a group of eye diseases that affect the optical nerve), epilepsy, high cholesterol, difficulty swallowing, prostate cancer, schizoaffective disorder (a chronic disorder that combines schizophrenia and a mood disorder), bipolar disorder, high blood pressure, and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #39's Quarterly MDS assessments dated 12/23/2024 revealed in Section C - Cognitive patterns subsection C0500: BIMS Score Summary revealed a score of 08 out of 15 indicating moderate cognitive loss. Record review of Resident #39 CAA Worksheet dated 11/18/24 revealed the following care areas were triggered but not addressed on the care plan: 06. Urinary Incontinence and Indwelling Catheter. The section titled Care Plan Considerations revealed Will Urinary Incontinence - Indwelling Catheter - Functional Status be addressed on the care plan? An answer of Yes was entered; 08. Mood State. The section titled Care Plan Considerations revealed Will Mood State - Functional Status be addressed on the care plan? An answer of Yes was entered; 10. Activities. The section titled Care Plan Considerations revealed Will Activities - Functional Status be addressed on the care plan? An answer of Yes was entered; 14. Dehydration/Fluid Maintenance. The section titled Care Plan Considerations revealed Will Dehydration/Fluid Maintenance - Functional Status be addressed on the care plan? An answer of Yes was entered. Record review of Resident #39's Care Plan dated 11/18/24 revealed the following focus areas without measurable goals: Focus: Resident at risk for complications associated w/ routine use of psychotropic medications with a goal of Resident has desired benefit of current therapy & perceived risks are outweighed; and Potential for weight loss due to Mechanically altered diet. Resident has a potential for malnutrition. Resident has had a decreased in appetite with a goal of Resident will maintain adequate weight. Further review revealed no evidence of care objectives, goals, or interventions for urinary incontinence and indwelling catheter, mood state, activities, or dehydration/fluid maintenance as triggered on the resident's CAA. 2. Review of Resident #97's face sheet revealed a [AGE] year-old female. Resident #97's initial admitted was 12/27/2022 and was readmitted on [DATE] with medical diagnoses of Metabolic Encephalopathy (brain disfunction caused by a chemical imbalance in the blood that affects the brain), stroke, neuropathy (nerves outside the brain and spinal cord are damaged), rheumatoid arthritis, anxiety, cataracts, high blood pressure, inguinal hernia (a bulge that occurs when a part of the intestines or fatty tissue protrude through a weak area in the abdominal muscles), fibromyalgia (a chronic condition characterized by widespread pain and tenderness in the body), low blood potassium, and high cholesterol. Record review of Resident #97's Significant Change in Status MDS dated [DATE] revealed in Section C - Cognitive patters subsection C0500. BIMS Score Summary revealed a score of 12 out of 15 indicating moderate cognitive loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #97's CAA Worksheet dated 12/23/24 revealed the following care areas were triggered but not addressed on the care plan: 02. Cognitive loss/Dementia. The section titled Care Plan Considerations revealed Will Cognitive Loss/Dementia - Functional Status be addressed on the care plan? An answer of Yes was entered; 03. Visual Function. The section titled Care Plan Considerations revealed Will Visual Function - Functional Status be addressed on the care plan? An answer of Yes was entered; 06. Urinary Incontinence and Indwelling Catheter. The section titled Care Plan Considerations revealed Will Urinary Incontinence - Indwelling Catheter - Functional Status be addressed on the care plan? An answer of Yes was entered; 07. Psychosocial Well-being. The section titled Care Plan Considerations revealed Will Psychosocial Well-being - Functional Status be addressed on the care plan? An answer of Yes was entered; 08. Mood State. The section titled Care Plan Considerations revealed Will Mood State - Functional Status be addressed on the care plan? An answer of Yes was entered; 10. Activities. The section titled Care Plan Considerations revealed Will Activities - Functional Status be addressed on the care plan? An answer of Yes was entered; 11. Falls. The section titled Care Plan Considerations revealed Will Falls - Functional Status be addressed on the care plan? An answer of Yes was entered; 12. Nutritional Status. The section titled Care Plan Considerations revealed Will Nutritional Status - Functional Status be addressed on the care plan? An answer of Yes was entered. Record review of Resident #97's Care Plan dated 11/05/24 revealed the following focus areas without a measurable goal: Focus Potential for weight loss with the goal Resident will maintain adequate weight. Further review of care plan revealed no evidence of care objectives, goals, or interventions for cognitive loss/dementia, visual, urinary incontinence, psychosocial well-being, mood status, activities, falls, or nutritional status as triggered on the resident's CAA. 3. Review of Resident #115's face sheet revealed a [AGE] year-old female, admitted on [DATE] with medical diagnoses of Kidney failure, stroke, high blood potassium, high blood pressure, dependent on renal dialysis, insomnia, anxiety, and depression. Record review of Resident #115's Admission MDS dated [DATE] revealed in Section C - Cognitive patters subsection C0500. BIMS Score Summary revealed a score of 12 out of 15 indicating moderate cognitive loss. Record review of Resident #115 CAA Worksheet dated 12/11/24 revealed the following care areas were triggered but not addressed on the care plan: 02. Cognitive loss/Dementia The section titled Care Plan Considerations revealed Will Cognitive Loss/Dementia - Functional Status be addressed on the care plan? An answer of Yes was entered; 07. Psychosocial Well-being. The section titled Care Plan Considerations revealed Will Psychosocial Well-being - Functional Status be addressed on the care plan? An answer of Yes was entered; 10. Activities. The section titled Care Plan Considerations revealed Will Activities - Functional Status be addressed on the care plan? An answer of Yes was entered. 16. Pressure Ulcer/Injury. The section titled Care Plan Considerations revealed Will Pressure Ulcer/Injury - Functional Status be addressed on the care plan? An answer of Yes was entered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #115's Care Plan dated 12/10/24 revealed the following focus areas without measurable goals: Focus Pain/Pain Management with the goal of Resident will be at a tolerable level of pain; Focus Potential for weight loss with a goal of Resident will maintain adequate weight; Focus Renal Dialysis with a goal of Resident will maintain optimal function/mobility; Focus Assist with ADLs with a goal of able to perform self care to optimal level. Further review of care plan revealed no evidence of care objectives, goals, or interventions for cognitive loss/dementia, psychosocial well-being, activities, or pressure ulcer/injury as triggered on the resident's CAA. 4. Review of Resident #227's face sheet revealed a [AGE] year-old female admitted on [DATE] with medical diagnoses of post-operative hip replacement, high blood pressure, anemia, low thyroid function, and history of falls. Record review of Resident #227's Admission MDS dated [DATE] revealed in Section C - Cognitive patters subsection C0500. BIMS Score Summary revealed a score of 10 out of 15 indicating moderate cognitive loss. Record review of Resident #227's CAA Worksheet dated 12/19/24 revealed the following care areas were triggered but not addressed on the care plan: 06. Urinary Incontinence and Indwelling Catheter. The section titled Care Plan Considerations revealed Will Urinary Incontinence - Indwelling Catheter - Functional Status be addressed on the care plan? An answer of Yes was entered; 07. Psychosocial Well-being. The section titled Care Plan Considerations revealed Will Psychosocial Well-being - Functional Status be addressed on the care plan? An answer of Yes was entered; 08. Mood State. The section titled Care Plan Considerations revealed Will Mood State - Functional Status be addressed on the care plan? An answer of Yes was entered; 10. Activities. The section titled Care Plan Considerations revealed Will Activities - Functional Status be addressed on the care plan? An answer of Yes was entered. Record review of Resident #227's Care Plan dated reviewed/revised 12/20/24 revealed the following focus areas without measurable goals: Focus Resident requires assist with ADLs with a goal of Resident will be able to perform self care to optimal level, and Focus Potential for weight loss due to altered diet with a goal of Resident will maintain adequate weight. Further review of care plan revealed no evidence of care objectives, goals, or interventions for urinary incontinence, psychosocial well-being, mood status, or activities as triggered on the resident's CAA. 5. Review of Resident #231's face sheet revealed a [AGE] year-old female admitted on [DATE] with medical diagnoses of post-operative hip replacement, high blood pressure, COPD (a lung disease that damages the airways), dehydration, and generalized weakness. Record review of Resident #231's Admission MDS dated [DATE] revealed in Section C - Cognitive patters subsection C0500. BIMS Score Summary revealed a score of 12 out of 15 indicating moderate cognitive loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676415	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Medical Lodge	1119 S. Red River Expressway Burkburnett, TX 76354

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #231's CAA Worksheet dated 12/26/24 revealed the following care areas were triggered but not addressed on the care plan: 02. Cognitive loss/Dementia The section titled Care Plan Considerations revealed Will Cognitive Loss/Dementia - Functional Status be addressed on the care plan? An answer of Yes was entered; 04. Communication. The section titled Care Plan Considerations revealed Will Communication - Functional Status be addressed on the care plan? An answer of Yes was entered; 05. Functional Abilities (Self-Care and Mobility). The section titled Care Plan Considerations revealed Will Functional Abilities (Self-Care and Mobility) - Functional Status be addressed on the care plan? An answer of Yes was entered; 06. Urinary Incontinence and Indwelling Catheter. The section titled Care Plan Considerations revealed Will Urinary Incontinence - Indwelling Catheter - Functional Status be addressed on the care plan? An answer of Yes was entered; 07. Psychosocial Well-being. The section titled Care Plan Considerations revealed Will Psychosocial Well-being - Functional Status be addressed on the care plan? An answer of Yes was entered; 10. Activities. The section titled Care Plan Considerations revealed Will Activities - Functional Status be addressed on the care plan? An answer of Yes was entered. Record review of Resident #231's Care Plan dated 12/23/24 revealed the following focus areas without measurable goals: Focus The resident is resistive to care with a goal of The resident will cooperate with care, and Focus Potential for weight loss with a goal of The resident will maintain adequate weight. Further review of care plan revealed no evidence of care objectives, goals, or interventions for cognitive loss/dementia, communication, functional abilities (self-care/mobility), urinary incontinence, psychosocial well-being, or activities as triggered on the resident's CAA. 6. Review of Resident #234's face sheet revealed a [AGE] year-old male admitted on [DATE] with medical diagnosis of Color-rectal cancer, liver cancer, Meniere's disease (an inner ear disorder that causes loss of balance), post-operative laminectomy (a surgical procedure to remove the top part of a vertebrae to relieve pressure on a nerve), high blood pressure, and chronic pulmonary embolism (a blood clot that travels to the lung causing a blockage). Record review of Resident #234's Admission MDS dated [DATE] revealed in Section C - Cognitive patters subsection C0500. BIMS Score Summary revealed a score of 11 out of 15 indicating moderate cognitive loss. Record review of Resident #234's CAA Worksheet dated 12/20/24 revealed the following care areas were triggered but not addressed on the care plan: 02. Cognitive loss/Dementia The section titled Care Plan Considerations revealed Will Cognitive Loss/Dementia - Functional Status be addressed on the care plan? An answer of Yes was entered; 05. Functional Abilities (Self-Care and Mobility). The section titled Care Plan Considerations revealed Will Functional Abilities (Self-Care and Mobility) - Functional Status be addressed on the care plan? An answer of Yes was entered; 06. Urinary Incontinence and Indwelling Catheter. The section titled Care Plan Considerations revealed Will Urinary Incontinence - Indwelling Catheter - Functional Status be addressed on the care plan? An answer of Yes was entered; 07. Psychosocial Well-being. The section titled Care Plan Considerations revealed Will Psychosocial Well-being - Functional Status be addressed on the care plan? An answer of Yes was entered; 10. Activities. The section titled Care Plan Considerations revealed Will Activities - Functional Status be addressed on the care plan? An answer of Yes was entered. 11. Falls. The section titled Care Plan Considerations revealed Will Falls - Functional Status be addressed on the care plan? An answer of Yes was entered. (continued on next page)

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	676415	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Medical Lodge	1119 S. Red River Expressway Burkburnett, TX 76354

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #234's Care plan dated 12/13/24 revealed the following focus areas without measurable goals: Focus I use colostomy with a goal of My colostomy will function properly, Focus Potential for weight loss with a goal of Resident will maintain adequate weight and Focus At risk for increased pain with a goal of Pain will be controlled with current interventions. Further review of care plan revealed no evidence of care objectives, goals, or interventions for cognitive loss/dementia, functional abilities (self-care/mobility), urinary incontinence, psychosocial well-being, activities, or falls task triggered on the resident's CAA. 7. Review of Resident #236's face sheet revealed a [AGE] year-old female admitted on [DATE] with medical diagnoses of atrial fibrillation (an irregular heart rhythm), rheumatoid arthritis, glaucoma, heart failure, celiac disease (the body's immune system reacts to gluten), and cerebral hemorrhage (bleeding in the brain). Record review of Resident #236's Admission MDS dated [DATE] revealed in Section C - Cognitive patters subsection C0500. BIMS Score Summary revealed a score of 12 out of 15 indicating moderate cognitive loss. Record review of Resident #236's CAA Worksheet dated 12/27/24 revealed the following care areas were triggered but not addressed on the care plan: 02. Cognitive loss/Dementia The section titled Care Plan Considerations revealed Will Cognitive Loss/Dementia - Functional Status be addressed on the care plan? An answer of Yes was entered; 03. Visual Function. The section titled Care Plan Considerations revealed Will Visual Function - Functional Status be addressed on the care plan? An answer of Yes was entered; 07. Psychosocial Well-being. The section titled Care Plan Considerations revealed Will Psychosocial Well-being - Functional Status be addressed on the care plan? An answer of Yes was entered; 08. Mood State. The section titled Care Plan Considerations revealed Will Mood State - Functional Status be addressed on the care plan? An answer of Yes was entered; 10. Activities. The section titled Care Plan Considerations revealed Will Activities - Functional Status be addressed on the care plan? An answer of Yes was entered. Record review of Resident #236's Care Plan dated 12/27/24 revealed the following focus areas without measurable goals: Focus Potential for weight loss with a goal of Resident will maintain adequate weight, and Focus Pain/pain management with a goal of Resident will be at a tolerable level of pain. Further review of care plan revealed no evidence of care objectives, goals, or interventions for cognitive loss/dementia, visual, psychosocial well-being, mood state, or activities as triggered on the resident's CAA. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/24 at 12:41 PM, MDS Coordinator-LVN E stated she and MDS Coordinator-LVN F were responsible for entering data for the MDS. MDS Coordinator-LVN E explained when the MDS was created, it triggered the resident's Care Area Assessment list. The care plan was developed from the CAAs identified. MDS Coordinator-LVN E stated a possible explanation for CAAs not addressed on care plan was oversight and workload. MDS Coordinator-LVN E stated training was on the job. She stated she had been doing MDSs for [AGE] years. MDS Coordinator-LVN E explained corporate provided annual training and when an important update was released, face-to-face training. She stated a corporate nurse reviewed random MDSs monthly for accuracy. MDS Coordinator-LVN F stated potential effect on residents were if a care area was not addressed on the care plan, it may lead to tasks missed because it would not be listed in the electronic record, or a resident may not achieve their full potential. MDS Coordinator-LVN E stated the goals on care plans were selected using the available choices in the electronic record template. MDS Coordinator-LVN F stated modifying the prepopulated goals had not been done. LVN E stated she could not think of how unmeasurable goals may affect residents. During a group interview on 12/31/24 at 01:15 PM, the Administrator and DON stated care areas identified on CAAs should be addressed on the care plan. The Administrator and DON could not explain why care areas triggered were not addressed on care plans. The Administrator stated periodic checks for accuracy were performed by leadership. The DON stated during daily morning meetings resident changes such as new orders were discussed, and care plans were updated during the meeting as needed. The DON stated she did not feel missed care areas on the care plan would affect a resident. The DON stated training was provided by a corporate representative at least annually. The DON and Administrator were not able to explain why goals on the care plans were not measurable. The Administrator stated he felt goals were appropriate if a resident was assessed and findings supported stated goals and/or interventions documented. He stated an example of pain due to the subjectivity of assessing pain and an example of maintaining weight due to various methods of assessing nutritional status and effects of disease processes on body weight. Review of facility undated policy titled Care Plan policy Comprehensive Person-Centered Resident Care Planning, revealed: A comprehensive person-centered care plan is developed and implemented for each resident, consistent with the resident's rights and will incorporate resident-centered goals and wishes about their care, activities, and lifestyle to include measurable short-term and long-term objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.