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	03/11/2026

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, for 1 of 24 residents (Resident #120) whose records were reviewed for comprehensive care plans. Resident #120's comprehensive care plan was not revised to resolve a care plan addressing an indwelling urinary catheter after the catheter was removed and the order for the catheter was discontinued. This facility failure placed the residents at risk of not having individual care needs met.The findings included: Record review of Resident #120's admission Record, dated 3/11/2026, indicated a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included dementia (cognitive impairment and memory problem), depression, atrial fibrillation (irregular heart beat), hypertension (high blood pressure), hip fracture (6/25/2025), and neuromuscular dysfunction of bladder (neurological disorder affecting bladder function). Record review of Resident #120's current order summary report, dated 3/11/2026, indicated orders had been received on 3/05/2026 for the following: -Acidophilus/Pectin capsule - Give 1 capsule by mouth two times a day for urinary antibiotic stewardship for 14 days (end date of 3/19/2026), and-Cranberry tablet 450 mg - Give 1 tablet by mouth three times a day for urinary antibiotic stewardship for 14 days (end date of 3/19/2026). Record review of Resident #120's discontinued physician orders indicated the urinary catheter for the diagnosis of neurogenic bladder (nerve damage that leads to loss of bladder control) had been ordered on 6/25/2025 and had an end date of 9/07/2025. Record review of Resident #120's significant change MDS assessment, dated 6/30/2025, indicated a fall related fracture with hospitalization and surgery, an indwelling urinary catheter, an infection diagnoses of MDRO and UTI, and the resident received antibiotic medication. Record review of Resident #120's quarterly MDS assessment, dated 3/06/2026, indicated a BIMS (Brief Interview for Mental Status) score of 3 out of 15 (severe cognitive impairment), the resident was always incontinent of urine, did not have a UTI diagnosis, and received antibiotic medication.Record review of Resident #120's comprehensive care plan indicated a care plan dated 6/26/2025 that documented the resident utilized an indwelling urinary catheter placing the resident at risk for UTI. The goal documented the resident would be free of signs and symptoms of UTI. The approaches included to monitor the urinary catheter for proper placement and patency every shift and as needed, provide catheter care per facility protocol every shift, administer Acidophilus/Pectin and cranberry supplements as ordered, monitor for signs and symptoms of UTI, obtain labs as ordered and notify the physician of results, and offer and encourage fluids. Observation on 03/08/2026 at 2:08 PM, revealed Resident #120 was seated in a wheelchair in her room. The resident did not have a urinary catheter.During an interview and record review on 3/11/2026 at 11:14 AM, MDS Coordinator A stated she started in the position of MDS Coordinator during August 2025. She proceeded to review Resident #120's comprehensive care plan and stated she noticed the resident's care plan still addressed an indwelling catheter and stated it needed to be resolved. MDS Coordinator A stated she would add a new care plan for the resident's UTI risk and the antibiotic stewardship protocol. In an interview on (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676415	A. Building B. Wing	03/11/2026

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Sheridan Medical Lodge	1119 S. Red River Expressway Burkburnett, TX 76354

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/11/2026 at 2:30 PM, the RN Corporate Nurse Consultant stated the MDS assessment nurse completed the comprehensive care plans based on the comprehensive assessment triggered care areas on the CAA Summary. She stated the expectation was for the MDS nurse to revise and update the comprehensive care plan as changes occurred and not wait until the next assessment was completed. She stated acute condition care plans were not completed as the change in condition progress note was used for that. The DON was present during the interview and stated resident changes were discussed during the morning staff meeting. Record review of the facility policy for Resident Care Plans, not dated, specified [in part]:Purpose:To identify resident real and potential needs.To set achievable short and long term outcome goals.To document interdisciplinary interventions to achieve stated goals and approaches.Procedure:MDS/CP nurse and Care Plan Team members will utilize the RAP Summary to identify triggered problems, real and potential . 5. Care plans will be updated to reflect changes in resident needs. 6. Care plan goals and approaches will be reviewed and revised at least every 90 days. New admissions will have a comprehensive care plan in place by day 21. A new care plan will be written annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain accurately documented medical records for 1 of 24 (Resident #70) residents reviewed for accurate medical records.The facility failed to revise Resident #70's comprehensive care plan addressing the administration of anti-anxiety medication after the medication order was discontinued.This placed residents at risk of inaccurate representation of their care.The findings included:Record review of Resident #70's admission Record, dated 3/11/2026, indicated a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included vascular dementia (memory and cognitive impairments due to decreased blood flow to the brain caused by small strokes), heart failure, heart disease, hyperlipidemia (high cholesterol), type 2 diabetes mellitus (insulin resistance with high blood sugar levels), osteoarthritis (cartilage erosion in the joints causes the bones to rub against each other), chronic obstructive pulmonary disease (progressive lung disease with difficulty breathing), anxiety, depression, and mood (affective) disorder (psychiatric condition characterized by disturbance in emotional state). Record review of Resident #70's current order summary report, dated 3/11/2026, indicated medication orders as follows: - 12/29/2025 Quetiapine Fumarate 50 mg (Seroquel - antipsychotic medication) - Give 1 tablet by mouth at bedtime for major depressive disorder. - 12/29/2025 Divalproex Sodium delayed release 250 mg (Depakote - anticonvulsant medication used for mood stabilization) - Give 1 tablet by mouth at bedtime related to mood (affective) disorder. - 12/29/2025 Duloxetine HCl (Hydrochloride) capsule delayed release particles 60 mg (Cymbalta - antidepressant medication) - Give 1 capsule by mouth one time a day for major depression. Record review of Resident #70's admission MDS assessment, dated 1/04/2026, indicated a BIMS (Brief Interview for Mental Status) score of 3 out of 15 (severe cognitive impairment), the diagnoses of depression, anxiety, and affective mood disorder, and the resident had received antipsychotic, antianxiety, and anticonvulsant medication with indication for use. Record review of Resident #70's comprehensive care plan, dated 1/02/2026, indicated a care plan that addressed the resident's use of the anti-anxiety medication Alprazolam. The goal was for the resident to be free from discomfort or adverse reactions related to anti-anxiety therapy. The approaches included administering Alprazolam as ordered by the physician and to monitor for side effects and effectiveness every shift. During an interview and record review on 3/11/2026 at 5:14 PM, the RN Corporate Nurse Consultant reviewed the medication orders for Resident #70. She stated the resident had an order dated 12/29/2025 for Alprazolam 0.25 mg (Xanax - anti-anxiety medication) 1 tablet by mouth every 4 hours as needed for anxiety for 14 days. The RN Corporate Nurse Consultant stated Resident #70's order for Alprazolam ended on 1/12/2026 and the care plan for Alprazolam should have been resolved due to the medication not being an active order. Record review of the facility policy for Resident Care Plans, not dated, specified [in part]:Purpose:To identify resident real and potential needs.To set achievable short and long term outcome goals.To document interdisciplinary interventions to achieve stated goals and approaches.Procedure:MDS/CP nurse and Care Plan Team members will utilize the RAP Summary to identify triggered problems, real and potential . 5. Care plans will be updated to reflect changes in resident needs. 6. Care plan goals and approaches will be reviewed and revised at least every 90 days. New admissions will have a comprehensive care plan in place by day 21. A new care plan will be written annually.