STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676430	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashton Medical Lodge	801 South Loop 250 West Midland, TX 79703

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766 Based on interview and record review, the facility failed to ensure the right to be free from abuse was provided for 1 (Resident #1) of 15 residents reviewed for abuse, in that: The facility failed to protect Resident #1 from abuse on 4.24.25 when Resident #1 was handled roughly by CNA A. These failures could place residents at risk of abuse, injury, intimidation, fear, agitation, and psychological harm. Findings included: Resident #1 was an [AGE] year-old female admitted to the facility on 1.24.22 with diagnoses of lack of coordination, urinary tract infection, anxiety disorder, and type 2 diabetes mellitus. Resident #1's quarterly BIMS status was completed on 4.9.25 with a score of 5, indicating severe cognitive impairment. Record review of CPS report dated 4.24.25 indicated PRIMARY CONCERNS: Today was 04/24/2025, MF contacted LA. MF stated NR was being aggressive CL. MF took off CLs shirt aggressively and grabbed her by the waste and was placed on the bed making a sound. NR was able to observe the incident through a curtain and saw a shadow of what happened. It was unknown if CL has any injuries. NR stated CL was very combative when female nurses try to assist her. It was unknown what was the name of the MF that physically abused CL. NRs in the facility are investigating the incident. IP stated that NR has been suspended. There was no video of the incident. NR that witnessed that incident did not have a clear view of the incident. It was unknown if this was the first time this has happened. CL does get combative with NRs in the facility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of statement given by CNA A dated 4.24.25 regarding incident indicated involving Resident #1: I CNA A was laying down my resident per usual she was fighting as being on the hall 200 I know the resident very well so it didn't alarm me while I was taking resident jacket off resident started to yell and hit, per usual like I said the resident was known for this behavior as I do chart in every night I work when the behavior happens. As I got her jacket off, resident stared to kick and continue to call me names. As I got read to transfer my resident, I talked clear on what I was doing and letter her know it was not ok to kick me while I got resident on bed after transfer and resident attempted to kick me again I spoke loud and clear it wasn't ok to kick and told her she was wet and needed to be changed as I got ready to take residents pants off I stopped because my curtain was not shut all the way while I stopped to close the curtain I see a housekeeper watching me. As I continue to change my resident I spoke loud and clear on everything that I was doing. Attempted to contact CNA A on 5.14.25 at 9:16 a.m., with no answer. Voicemail message with call back information was left. During an interview on 5.14.25 at 1:55 pm HK B stated that she normally works 8-5pm Monday through Friday at the facility. She stated that the night of the incident she was called in to help and was working 6p to 9p. she stated she was cleaning the room and noticed behind the curtain that an aid was changing resident. She stated Resident #1 was not very verbal, but that night Resident #1 was saying the words, No and Stop, which caught her attention. She stated that she saw the aid through the curtain removed the resident's shirt by pulling the resident forward and hunching her over and yanking off the shirt. She stated that when the shirt came off the resident slammed back into the wheelchair. She stated that CNA A then picked up Resident #1 out of the wheelchair and slammed Resident #1 down on the bed roughly, shaking the bed. She stated she was shocked/stunned and was not sure what to do. She stated she went and reported what she had seen to the charge nurse at the time. Record review of statement by HK B regarding incident dated 4.24.25 indicated: I was standing at 200 hall showers getting ready to clean it when I heard Resident #1 yelling. When I looked up at her room, I saw the back of Resident #1 chair and part of Resident #1 back. I watched someone aggressively taking off her shirt and throw it on the floor at the end of her bed. Resident #1 was continuously loudly yelling to stop. Then I saw the shadow get closer to Resident #1 and aggressively put her on the bed. The aide looked around the curtain and made eye contact with me. That's when I saw that the aide in the room was CNA A. Once CNA A saw me staring at her she closed the curtain more and began speaking extremely loud at Resident #1 to stop hitting her. Which CNA A was not saying before she saw me. Even though there was a curtain I could still see shadows and I never saw Resident #1 striking out. I stayed where I was until CNA A left the room. Administrator was notified immediately. During an interview on 5.14.25 at 10:45 am Resident #1 was unable to communicate any answers to investigator. Resident #1 only made noises towards investigator when asked questions. During an interview on 5.15.25 at 2:30 pm DON stated that this was more of a resident right then an abuse case because she stated the witness was in the shower room not in the room. She stated she has no idea if the witness was in the room. She stated that CNA A should have stopped what she was doing when Resident #1 told her no and stated stop. She stated CNA A should have gone and got help at this point or left the room and returned later to assist Resident #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5.15.25 at 4:20 pm administrator stated he received a call on 4.24.25 at roughly 7:15 pm that CNA A had been seen by another employee being aggressive and rough with Resident #1. He stated that CNA A was suspending immediately, and he started his investigation. He stated that his investigation was targeted for resident rights issue, not abuse, but he stated that CNA A should have stopped working with Resident #1 when Resident #1 told her no and stop. Record review of in-service dated 4.16.25 titled abuse/neglect indicated: Abuse Coordinator (administrator). Abuse must be reported immediately to the abuse coordinator. Record review of facility Abuse/Neglect policy, undated, reflected the following: Each resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. Mental abuse includes, but was not limited to, abuse that was facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other resident, contractors, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals.:

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766 Based on observation, interview, and record review, the facility failed to ensure the resident's right to be free from misappropriation of resident property for 1 of 16 residents (Resident #3), reviewed for drug diversion. The facility failed to prevent the misappropriation of an unknown number of Resident #3's Lorazepam Oral Concentrate 1MG/0.5ML (Controlled Substance requiring double lock and count every shift) on 08/03/2024 from the medication cart that was never found. This failure could place residents at risk of misappropriation, and could result in increased pain, and poor quality of life. Findings included: Review of Resident #3's face sheet revealed a [AGE] year-old female admitted to the facility on 10.31.23 with the diagnoses of fracture of sacrum, pressure ulcer of sacral region, dementia, and anxiety disorder. Resident #3's quarterly BIMS status was completed on 4.28.25 with a score of 1, indicating severe cognitive impairment. Review of Resident #3's Comprehensive Care Plan last revised 10.20.24, revealed: Focus: Pain/Pain Management. Administer pain medications as ordered. Describe pain scale used and location of pain and any pain behaviors observed. Review of Resident #3's electronic physician orders revealed: Lorazepam Oral Concentrate 1MG/0.5ML give 0.75 ml by mouth every 3 hours as needed for Anxiety, order date 3.20.25. Record review of Packing Slip dated 4.15.25 indicated: Controlled Substances, for Resident #3, Lorazepam 2mg/ml. Signed by LVN C. Review of the provider investigation report dated 4.18.25 revealed facility investigation findings confirmed misappropriation of property and drug diversion. On 4.15.25 the lorazepam was never found, facility unsure of its whereabouts. Nursing staff educated on control medication storage double lock system. Facility found that a control medication was not in a double lock system due to it being broken and the narcotics were not counted correctly. Resident never went without meds. Record review of in-service dated 4.18.25 titled medication room indicated: if you are not a licensed/certified to handle medications you can not go into the medication room. Record review of Resident #3's MAR dated 4.13.25 through 4.21.25 indicated Lorazepam Oral Concentrate 1MG/0.5ML was not given any day due to no pain notated by Resident #3. Attempted to contact LVN C on 5.15.25 at 4:05 pm, no answer, left message. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5.14.25 at 1:20 pm ADON stated all nurses and medication aides have access to the medication room and there are only 2 keys to the lock box in the refrigerator. She stated one key was on the 100-hall key ring and the DON has a key. Observation of lock box on 5.15.25 revealed no medications at this time. During an interview on 5.14.25 at 3:00 pm DON stated medications delivered on 4.15.25, LVN C signed for the medications which came in in bottle, LVN C put medication in refrigerator in medication room not in lock box. She stated LVN C couldn't get lock box open. She stated the medication was not missed until a few days later. She stated the Resident #3 never missed any doses because the medication was as needed for pain. She stated this was missed through multiple narcotic counts. She stated all medication aides and all nurses had access to the refrigerator. She stated only 1 key to lock box. She stated 1 CMA, and 2 nurses have access to hall 300 medication cart, and she did not see any concern with that. She stated the nurse do the oncoming narcotic count and the ongoing narcotic count. During an interview on 08/15/24 at 03:20 PM, the Administrator stated was expectation was to not have any medication errors and for staff to follow protocol and policies when administering medications. The Administration stated was DON and ADON oversaw overseeing medication errors and properly signing and counting narcotics. Record review dated 4.18.25 titled confidential employee corrective action form signed by LVN C indicated: Not counting narcotics per policy and procedure. Request for policy from Administrator and DON for Controlled Substances was requested on 5.15.25 at 4:35 pm. The policy was not provided by the time of exit.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766 Based on interviews and record reviews the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated, for 1 (Resident #4) of 8 residents reviewed for investigating alleged verbal abuse. On Tuesday 4.15.25 Resident #4 reported that she was hit by an employee at night. The Facility did not investigate the allegation of physical abuse. The failure could place residents at risk for abuse. The findings included: Resident #4 was an [AGE] year-old female admitted to the facility on 10.30.20 with diagnoses of Parkinson's disease, hypertension, dementia, and chronic pain. Resident #4's quarterly BIMS status was completed on 4.28.25 with a score of 7, indicating moderate cognitive impairment. Record review of facilities incident report dated 4.15.25 at 9:00 pm indicated: Resident states that she was hit by an employee last night. She was unable to give a name or description of an alleged perpetrator. During an interview of Resident #4 on 5.15.25 at 3:45 pm Resident #4 stated she did not remember the incident and does not remember being hit by anyone. Progress note dated 4.16.25 at 5:13 pm indicated: Note Text: This WCN completed skin assessment today on resident d/t DON reporting that an allegation was made by resident. Resident skin warm/dry. Turgor WNL. NPE noted to BLE. Resident has no new open areas to note. Skin against bony prominences remains intact. Resident has no bruising throughout body at this time. This nurse observed redness to bilateral buttocks, which barrier cream was given to CNA staffing to apply Q brief change. Reported findings to resident, advising no bruising noted, however will be continued to be monitored for any latent bruising. During assessment, the resident voiced concerns of staff member being too rough and rushing me and stated in the shower, she experienced rough care from same staff member. She also included that she believed staff had bruised her buttocks, however, this nurse advised she currently has no bruising present to buttocks. This nurse reported findings to ADON, LVN, DON, RN/BSN. Attempted to contact WCN D on 5.15.25 at 2:05 pm, no answer, left message. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5.15.25 at 3:00 pm DON stated that the only employee that matched the identity of any nurse working the night of 4.15.25 was LVN C. She stated but after interviewing Resident #4 and that the resident could not give any identifying features of the nurse, the investigation was completed. She stated no employee was suspended during the investigation. She stated LVN C was not suspended because she was off work the next two days anyways. She stated she did not know about the progress note dated 4.16. 25. DON stated knowing that information she would have suspended LVN C and done a more through investigation. She stated she felt the facility did do a through investigation but based on the documentation provided in the investigation, it was not very thorough. During an interview on 5.15.25 at 4:20 pm Administrator stated that due to Resident #4 not being able to identify anyone there was not much they could do. He stated he did not know about the progress note from 4. 16.25. He stated that based on that note, and evidence a more thorough investigation should have been done. He stated he does check progress notes, but he has a lot of residents and can't go through all of them. He stated that the nursing staff should be the ones that brought this to his attention. Record review of facility Abuse/Neglect policy, undated, reflected the following: Each resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. Mental abuse includes, but was not limited to, abuse that was facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other resident, contractors, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals.