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	04/10/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments for 1 of 4 nurse medication carts reviewed for medication storage and for 2 of 4 nurse medication carts (hall 1 cart and hall 4 cart) observed for medications stored and properly labeled. LVN A failed to ensure her nurse medication cart was secured when it was left unattended on [DATE]. The hall one nurse medication cart had one insulin pen that belonged to Resident #100 that had been opened but not dated when it was placed into use. This these failures could place clients at risk for drug diversion or accidental ingestion and could place residents at risk of receiving medications that were expired and not produce the desired effect. Findings included: Unlocked and unattended medication cart. Observation and interview on [DATE] at 09:55 AM the nurse medication cart for hall 5 was seen unlocked and unattended for at least 10 minutes. The cart was parked in the hallway and there were no staff that were supervising it. LVN A passed by the nurse medication cart and did not notice the cart was unlocked. LVN A then came back to the cart and was in the process of unlocking the cart. The LVN was told that the medication cart had been unlocked and unsupervised for at least 10 minutes. LVN A said she normally locked her cart when she stepped away but had forgotten to lock it. Observation of the items inside the medication cart revealed several insulin pens and other medications. The LVN said that leaving the cart unlocked could give access to unauthorized people that could have opened the medication cart including residents. Interview on [DATE] at 11:42 AM ADON G said the medication carts were expected to be locked if unattended. The ADON said LVN A should have locked the medication cart when she stepped away. ADON G said she would monitor the medications carts on a daily basis when she was there. The ADON said possible negative outcomes could be that another resident can have access to the medications in the cart. ADON G said that family members or unauthorized staff could also have access to the unlocked medication cart. Interview on [DATE] at 3:22 PM, the DON said the nurse medication carts were expected to be locked when unattended. The DON said that they conducted rounds throughout the day to ensure that the nurses were following procedures. The DON said that possible negative outcomes could be that anybody could have access to the cart including residents that might get something from the cart. Interview on [DATE] at 3:30 PM, the Administrator said it was expected for the nurses to lock their medication carts when they were away from the cart. The Administrator said if the medication cart was left unlocked and unattended then there was a possibility of residents opening the drawers and taking some of the medications. Expired and undated insulin pens. Review of Resident #100's admission record dated [DATE] revealed she was admitted to the facility on [DATE] with diagnosis of diabetes type 2. She was [AGE] years of age. Review of the current care plan for Resident #100, last reviewed/revised: [DATE], revealed in part: The resident had diabetes. Fiasp FlexTouch Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: subcutaneously (Under the skin) at bedtime for type 2 diabetes. Review of Resident #100's physician orders dated [DATE]. Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspart) Inject as per sliding scale: if Humalog KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale subcutaneously before meals and at bedtime for type 2 diabetes. Observation and interview on [DATE] at 11:38 AM of the nurse medication cart for hall 1 was checked with RN B present. Inside the cart was an insulin pen that belonged to Resident #100 that had been opened but had no open date found on the pen. RN B said it was usually each nurses responsibility to date the insulin pens when they were first opened so that they would know when the pen expired. RN B said if the pen was not dated when opened then how would they know when it was expired. RN B said she did not know who had opened that insulin pen. Interview on [DATE] at 11:44 AM ADON G said the nurse managers would check the nurse medication carts to check if there were any opened medications, that they were dated when opened. ADON G said the insulin should have been removed from the cart. ADON G said a possible negative outcome could be that the medication could not cause the desired effect. Interview on [DATE] at 2:24 PM with ADON F said it was the responsibility of each nurse to check for expired on undated insulins in the nurse medication carts. The ADON aid she did random checks of the nurse medication carts. ADON F said if an insulin was not dated then the staff would not know when it was expired. The ADON said if the insulin had expired then it could possibly have led to the medication not causing the effect of what it was meant to do. ADON F said once the insulin pen was opened they were usually good for 28 to 30 days and then it would expire. Interview on [DATE] at 3:36 PM, DON said it was expected for the nurses to check the medication carts when they took their cart. The DON said they would check the nurse medication carts at random times. The DON said if an insulin had no open date then there was a possibility that the medication would not cause the desired effect. The DON said an opened insulin was good for 30 days after it was opened. Interview on [DATE] at 3:40 PM, the Administrator said it was expected for nurses to date the insulin pens when they opened them. Review of the facility's undated policy titled Medication Cart indicated in part: To administer medication more quickly and efficiently. If the cart is left at any time during medication pass due to an emergency, it must be locked. Record review of the Fiasp insulin pen manufactures pamphlet date 2025 indicated in part that the insulin was good for 28 days after opening. Review of the Humalog insulin pen manufactures pamphlet date 2026 indicated in part that the insulin was good for 28 days after opening. Record review of the facility's undated document titled Insulin med administration indicated in part: Med cart no missing or expired supplies, items dated when opened. Obtain pen device or vial date vial/pen after first use if required.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #64) reviewed for transfers. CNA H and CNA I performed an incorrect two-person transfer on Resident #64 on 4/6/26. This failure could place residents who required assistance during transfers at risk of pain and injury. Findings included:Record review of Resident #64's admission Record, dated 4/8/26, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, arthritis, weakness, and abnormalities of gait and mobility. Review of Resident #64's Quarterly MDS Assessment, dated 2/6/26, revealed:She had a BIMS score of 3 of 15 (indicating severe cognitive impairment)She needed substantial assistance with transfers. Review of Resident #64's Care Plan, last updated 4/6/26, revealedFocus: Resident requires assistance with late loss ADL's and use of wheelchair for locomotion/2-person transfer and able to use sit to stand [lift].Interventions included: 12/23/25 May use sit to stand for transfers and Resident is a 2-person assist any use sit to stand with transfers. Revised 4/6/26.Focus: Limited range of motion related to functional mobility, revised 9/16/24.Interventions included May use sit to stand for transfers, initiated 9/5/25. Review of Resident #64's Order Summary Report, dated 4/8/26, revealed order stated 12/13/25 May use Sit to Stand for Transfers. Review of the electronic ADL flow sheets on 04/08/20 for April 2026 the CNAs revealed a Sit to Stand Lift was indicated. Observation of a two-person gait-belt transfer on 04/06/2026 at 1:57 PM revealed CNA I locked Resident #64's wheelchair. CNA I placed the gait belt around Resident #64. CNA I hooked her arm under Resident # 64's arm/shoulder and held the gait belt behind Resident #64. CNA H hooked her arm under Resident #64's arm/shoulder and grabbed the back of Resident #64's pants. On the count of three, the aides assisted Resident #64 to stand and pivot onto the bed. Resident # 64 complained of pain by yelling ow ow ow. The aides positioned Resident #64 in bed and Resident #64 stated she no longer hurt. Interview on 4/06/2026 at 2:57 p.m. Resident #64's RP stated Resident #64 always complained of pain when transferred. The RP stated Resident #64 had as-needed pain medication but Resident #64 only complained of pain during transfers when the aides hooked under her arms. The RP stated all the aides hooked under the arms but did the transfer differently. The RP said once the pulling on the arms went away, Resident #64 quit hurting. The RP stated it was due to the diagnosis of arthritis, and she did not have diagnosis of osteoporosis. Interview on 04/08/2026 at 2:12 PM CNA I stated she worked at the facility for 13 months. CNA I said she thought the transfer went pretty well. CNA I said it was not unusual for Resident #64 to complain of pain during a transfer. CNA I said during the transfer she did hook her (CNA I) arms under Resident #64 and grabbed the gait belt. CNA I said Resident #64 could bear weight. CNA I said Resident #64 always said ow, ow, ow on transfers and had pain in her shoulders. CNA I said they would let the nurses know and she did not know if anything happened after that. CNA I said Resident #64 had pain in her shoulders. CNA I said Resident #64 complained of pain worse while using the sit to stand lift. CNA I said she trained to do a two-person gait belt transfer by putting the gait belt on, one person stood on each side of the resident and hooking their arms under the resident. CNA I said the lead CNA would check on the aide's skills pretty often, but a nurse had never done a skill check off with her. Interview on 04/08/2026 at 2:54 PM CNA H stated she worked at the facility as an as-needed CNA for three years. CNA H stated Resident #64 used to help with transfers a lot more. CNA H stated Resident #64 said she was hurt and could not do the transfer and was weak and scared. CNA H stated Resident # 64 was always a two-person transfer. CNA H said she would use the sit to stand lift with Resident # 64, but Resident # 64 complained it made her arms hurt and preferred the two-person transfer. CNA H stated when she did a transfer, she preferred to leave the wheelchair unlocked because it was easier to move out of the way, but CNA I locked it. CNA I (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated when CNA I told Resident #64 she was going to transfer her, Resident #64 said she was afraid and it hurt while transferring, but Resident #64 always did that. CNA I said Resident #64 would get confused and think the aides put her on the floor, but the RP would reassure Resident #64. CNA I said Resident #64 received pain medications and transferring her was stressful because the aides did not want to hurt her. CNA I said she hooked her arm under Resident #64's arm and grabbed Resident #64 pants. CNA I said she always grabbed a resident's pants. CNA I said if someone pulled up on the pants it would give the person a wedgie. CNA I stated it did happen to some people. CNA I said a wedgie would not be comfortable especially with a brief on. Interview on 04/08/2026 at 3:44 PM the PTA stated the facility had periodic in-services on transfers. The PTA said the staff would come into the therapy room and the therapy department would show the staff body mechanics with a gait belt. The PTA said the therapy department trained the staff to do a two-person gait belt transfer by placing the gait belt snugly on the resident, position the wheelchair as close to where the resident was being transferred to, lock the brakes and preferably remove the wheelchair arms. The PTA said the staff should then stand in front of and to the side of the resident, hold the gait belt, count to three, help the resident stand and pivot. The PTA said the consequences of an under-arm transfer was the risk of shoulder dislocations, skin tears or pain. The PTA said this was covered during in-services. The PTA said she had previously worked with Resident #64. The PTA said Resident #64 was pleasantly confused, was able to bear weight, and able to follow simple one-step instructions. The PTA said Resident #64 thought she could not bear weight, but she could. The PTA said the observed transfer was not a correct transfer because the staff hooked their arms under Resident #64's, and they should have held onto the gait belt. The PTA said holding the pants increased the risk of skin shearing (a specific type of skin tear). The PTA said the last training the therapy department did was about 9 months. The PTA said she did not do skill checkoffs about transfers with the staff. Interview on 04/08/2026 at 4:07 PM the DON stated her expectation for a two-person gait belt transfer was to let the resident know what the staff were doing, place the belt on the resident and have a second person. The DON said staff should hold onto the belt because that was what it was there for. The DON said she expected the staff to hold the gait belt on the sides or the back, count to three and move the resident. The DON stated hooking under the arms or grabbing a resident by the seat of the pants was not ok. The DON said holding a resident under the arm could dislocate the arm. The DON stated grabbing a resident by the seat of the pants did not provide a secure grip on the resident. The DON described Resident #64 as having an order for a sit to stand but could be a two-person transfer depending on how Resident #64 was doing. The DON stated sometimes Resident #64 could transfer herself, but the facility had her identified as a two-person transfer due to Resident #64's fall risk. The DON stated Resident #64 fluctuated between a two-person transfer and a sit to stand lift. The DON stated if a Resident complained of pain, she expected the aides to stop as soon as it was safe to do so and address the pain. The DON stated she expected the aides to get Resident #64 positioned and if Resident #64 still complained of pain to get the nurse. The DON stated the facility did a proficiency check on hire during orientation and if there were issues, they would do education with that specific aide. The DON stated aides had proficiency checks each year. The DON stated she thought the last in-service was a month prior to the survey.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one Resident (Resident #16) of two reviewed for Percutaneous Endoscopic Gastrostomy (PEG-a tube inserted through the abdomen into the stomach for the purpose of administering liquid nutrition and medications) received the appropriate treatment and services to prevent complications and aspiration. LVN E failed to check PEG tube placement by auscultating (Listening with stethoscope) and checking for residual prior to administering Resident #16's medication as ordered by the physician. This failure placed residents who had a PEG tube at risk for complications, aspiration, and pneumonia. Findings include.Record review of Resident #16's admission record dated 04/07/2026 revealed she was admitted to the facility on [DATE] with diagnosis of gastrostomy status (Gastrostomy status indicates that a person has a surgically placed tube providing direct access to the stomach for nutrition, hydration, or medication). She was [AGE] years of age. Record review of the current care plan for Resident #16, last reviewed/revised: 03/26/2026, revealed in part: The resident requires tube feeding. The resident will remain free of side effects or complications related to tube feeding through review date. HOB elevated 30-45 degrees at all times. Check tube placement prior to each feeding, meds and fluids per auscultation and residual Q shift. If 100cc, HOLD feeding. Record review of Resident #16's physician orders dated 04/09/2026 revealed: HOB elevated 30-45 degrees at all times. Check tube placement prior to each feeding, meds and fluids per auscultation and residual Q shift. If 100cc, hold feeding. Start date 04/01/2026. Observation on 04/09/2026 at 12:25 PM revealed LVN E administered Resident #16's medication Loperamide via the residents PEG tube. LVN E poured 30ml of the Loperamide medication into a medication cup then entered Resident #16's room. LVN E then took a syringe and used it to pour some water into the resident's PEG tube and flushed it. LVN E then took the 30ml cup of Loperamide and poured it into the resident's PEG tube. LVN E then finally flushed the PEG tube with some more water and was done with the medication administration. LVN E did not check for tube placement prior to the medication administration. Interview on 04/10/2026 at 11:36 AM LVN E said she had gotten nervous and forgotten to check Resident #16's PEG tube placement before she administered the medication. LVN E said if PEG tube placement was not checked then it was possible the tube was not in the right place and the medication could go in the wrong area instead of the stomach. Interview on 04/10/2026 at 11:40 AM ADON G said LVN E should have checked for PEG tube placement before she administered the medication. The ADON said a possible negative outcome could be that the PEG tube would not be placed where it was supposed to be and it could have led to the medication not going to the right area. Review of the facility's undated policy Tube medication administration indicated in part: To safely and accurately administer medications to residents who receive their entire oral intake via enteral feeding tube. Procedure: confirm physician order. Place each medication in a separate cup. Check for correct placement of tune by injecting air and listening with stethoscope to abdomen. Unclamp tube and use either one of the following procedures Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds or aspirate stomach contents with a syringe.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for 1 of 7 residents (Resident #51) reviewed for respiratory care in that: Residents #51's oxygen nasal cannula tube was not bagged when not in use. This failure could place the residents at risk of infection. Findings included: Review of Resident #51's admission record, dated 04/09/2026, indicated she was admitted to the facility on -05/10/2024 with diagnoses of lack of coordination and muscle weakness. She was [AGE] years of age. Review of Resident #51's physician order report dated 04/09/2026 indicated in part: Oxygen - continuously = Oxygen at 2L/PM via nasal cannula continuously. Check every shift. Check O2 sats Q shift and keep O2 at or greater than 92% Record O2 sats every shift. every shift related to heart failure. Review of Resident #51's care plan revised on 04/02/2026 indicated in part: The resident is at risk for alteredrespiratory status/difficulty breathing r/t recent surgical procedure. The resident will have no signs and symptoms of poor oxygen absorption through the review date. Respiratory therapy: Complete respiratory assessment and document findings and interventions Q Shift. Review of Resident #51's annual MDS dated [DATE] indicated in part: BIMS of 8 indicating the resident was moderately impaired. Respiratory treatments - Oxygen therapy. Observation and interview on 04/09/2026 at 9:04 AM revealed Resident #51's oxygen nasal cannula on the bed and not stored in a bag which was located on the oxygen concentrator machine. Resident #51 was seen sitting up in her wheelchair awake and alert. The resident was wearing an oxygen nasal cannula that was connected to an oxygen tank that was located on the back of the resident's wheelchair. Resident #51 said she had not placed the oxygen nasal cannula on the bed and that the staff who had helped her out of bed were probably the ones that placed it there. Observation on 04/09/2026 at 10:08 AM Resident #51's oxygen nasal cannula's was observed resting on the wheelchair and not stored in a bag which was located on the back of the wheelchair. Observation and interview on 04/09/2026 at 10:42 AM revealed Resident #51 was in her bed awake and alert. The resident said she had not placed the oxygen nasal cannula on the back of the wheelchair. Resident #51 said the staff that had assisted her to her bed were the ones that must have placed it there. Interview on 04/09/2026 at 10:48 AM CNA D said he had assisted Resident #51 into her bed. CNA D said he had placed Resident #51's oxygen nasal cannula on the back of the wheelchair and had not stored it on the bag as he should have. CNA D said if the oxygen nasal cannula was not stored in the bag it could lead to infections as the oxygen nasal cannula could get contaminated Interview and observation on 04/09/2026 at 1:42 PM Resident #51 was in her room, in bed awake and alert. The resident said the staff were the ones that removed the oxygen nasal cannula from her. Resident #51 said she had not removed the oxygen nasal cannula herself and left it to the staff to do that. Interview on 04/09/2026 at 4:34 PM ADON F said whenever a resident was not using the oxygen nasal cannula it was supposed to be stored in the bag. The ADON said that if the oxygen nasal cannula was not stored in the bag and left out that could lead to possible respiratory infections to the resident using them. Interview on 04/10/2026 at 3:22 PM, the DON said it was expected for the oxygen nasal cannulas to be stored in the plastic when hot in being used. The DON said if the cannulas were not stored in the bag it could cross contamination and respiratory infections. The DON said the policy provided regrading storage of the oxygen nasal cannula did not indicated how it should be stored when not in use but that was the only policy they had. Interview on 04/10/2026 at 3:34PM, the Administrator said it was expected for the oxygen nasal cannulas to be stored in the bags. The Administrator said if the cannulas were not stored it could possibly lead to some form of infection. Record review of the facility's undated policy titled Administration of cannula did not indicate about how to store the cannula when not in use. (There was no indication of how the cannula should be stored).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services for 1 (Resident #8) of 1 resident reviewed for expired medications. The hall four nurse medication cart had one insulin pen that belonged to Resident #8 that had expired. This these failures could place clients at risk for drug diversion or accidental ingestion and could place residents at risk of receiving medications that were expired and not produce the desired effect. Findings included:Review of Resident #8's admission record dated 04/08/2026 revealed he was admitted to the facility on [DATE] with diagnosis of diabetes type 2. He was [AGE] years of age. Review of the current care plan for Resident #8, last reviewed/revised: 06/12/2025, revealed in part: The resident had diabetes. Humalog KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale subcutaneously before meals for diabetes. Review of Resident #8's physician orders dated 04/08/2026. Humalog KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale subcutaneously before meals for diabetes. Observation and interview on 04/08/2026 at 11:50 AM the nurse medication cart for hall 400 was checked with LVN C present. Inside the cart was an insulin pen that was dated as opened on 02/26/26 which belonged to Resident #8. LVN C said she had not noticed that the insulin pen had expired and that Resident #8 hardly required insulin. LVN C said the insulin pen was good for 30 days after they were opened. LVN C said it was each nurse's responsibility to check for expired insulins. LVN C said a negative outcome could be that the insulin may not be as effective as it should be if it was expired. Interview on 04/10/2026 at 11:44 AM ADON G said the nurse managers would check the nurse medication carts to check if there were any expired medications had been removed. The ADON was made aware of the observation of an expired insulin pen in one of the nurse medication cart used for hall 4. ADON G said the insulin should have been removed from the cart. ADON G said a possible negative outcome could be that the medication could not cause the desired effect. Interview on 04/10/2026 at 2:24 PM with ADON F said it was the responsibility of each nurse to check for expired on undated insulins in the nurse medication carts. The ADON aid she did random checks of the nurse medication carts. The ADON said if the insulin had expired then it could possibly have led to the medication not causing the effect of what it was meant to do. ADON F said once the insulin pen was opened they were usually good for 28 to 30 days and then it would expire. Interview on 04/10/2026 at 3:36 PM, DON said it was expected for the nurses to check the medication carts when they took their cart. The DON said they would check the nurse medication carts at random times. The DON said if an insulin had expired then there was a possibility that the medication would not cause the desired effect. The DON said an opened insulin was good for 30 days after it was opened. Interview on 04/10/2026 at 3:40 PM, the Administrator said it was expected for nurses to date the insulin pens when they opened them. The Administrator said if an insulin pen had expired then there was a possibility of some sort of negative effect or it may not do what it was meant to do. Record review of the facility's undated document titled Insulin med administration indicated in part: Med cart no missing or expired supplies, items dated when opened. Obtain pen device or vial date vial/pen after first use if required.