

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Princeton Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 W Princeton Dr Princeton, TX 75407	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the resident environment remained free of accident hazards and each resident received adequate supervision for 1 of 2 residents (Resident #1) reviewed for accidents and hazards. The facility left Resident #1 in a wheelchair unattended on the night of 7/15/26 and early morning on 7/16/26 and failed to check on her during that time. These failures could put residents at risk of frequent accidents and decline in health. Findings included: Record review of Resident #1's face sheet, dated 7/20/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had the following pertinent diagnoses: unsteadiness on feet, lack of coordination, dependence on wheelchair, unspecified dementia (a clear memory loss and thinking problem), anxiety disorder (a condition involving excessive, ongoing fear or worry that is hard to control), and insomnia (trouble falling asleep, staying asleep or waking up too early). Record review of Resident #1's Quarterly MDS Assessment, dated 6/24/26, reflected Resident #1 had severe cognitive impairment with a BIMS of 5. Section GG reflected Resident #1 required maximal assistance with ADLs and transfers. Record review of Resident #1's Care Plan Report, revised on 4/16/26, reflected .Resident requires assist with ADLs -prefers female staff for all care, 2 people in room when providing care Date Initiated: 11/14/2024 Revision on: 04/16/2025 Resident requires assist with ADLs - prefers female staff for all care, 2 people in room when providing care Date Initiated: 11/14/2024 Revision on: 04/16/2025 . Encourage independence in performance of self-care and mobility within limitations. Date Initiated: 11/14/2024 Female staff to provide care Date Initiated: 04/16/2025 Provide level of support to complete dressing, toilet use, personal hygiene, and bathing needs Q shift Date Initiated: 11/14/2024 resident is to use double handed cup with a lid to prevent spilling d/t tremors Date Initiated: 12/10/2024. Record review of video evidence from Resident #1 room, dated 7/15/26 at 6:33 p.m., reflected Resident #1's relative left the room and Resident #1 was sitting in her wheelchair. Record review of video evidence from Resident #1's room, dated 7/15/26 at 6:57 p.m., reflected an unknown staff member entered the room, checked Resident #1, who was sitting in her wheelchair, and talked to her. Record review of video evidence from Resident #1's room, dated 7/15/26 at 6:59 p.m., revealed RN A entered the room, assisted Resident #1's roommate and exited the room without checking on Resident #1. Resident #1 was sitting in her wheelchair. Record review of video evidence from Resident #1's room, dated 7/15/26 at 7:59 p.m., revealed Resident #1 was sitting in her wheelchair. Record review of video evidence from Resident #1's room, dated 7/15/26 at 11:58 p.m., revealed Resident #1 was sitting in her wheelchair. Record review of video evidence from Resident #1's room, dated 7/16/26 at 12:58 a.m., revealed Resident #1 was sitting in her wheelchair. Record review of video evidence from Resident #1's room, dated 7/16/26 at 1:08 a.m., revealed Resident #1 was sitting (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in her wheelchair bending forward in her wheelchair and stated help repeatedly, but the door was closed and no staff entered. Record review of video evidence from Resident #1's room, dated 7/16/26 at 2:45 a.m., revealed Resident #1 was sitting in her wheelchair still leaning forward with her torso bent on her lap and she rolled out of the wheelchair to the floor. Resident #1 was heard yelling help, but the door was still closed and no staff entered. Record review of video evidence from Resident #1's room, dated 7/16/26 at 3:17 a.m., revealed Resident #1 was not visible in her wheelchair and her legs and part of her feet were observed on the floor, laying underneath the wheelchair. CNA B entered the room observed Resident #1 on the floor and walked quickly to the door. Record review of video evidence from Resident #1's room, dated 7/16/26 at 3:18 a.m., revealed Resident #1 continued on the floor; CNA B returned and assisted her roommate. RN A rushed in and immediately called Resident #1's name and asked CNA B why wasn't she in bed, no response heard from CNA B. RN A asked Resident #1 if she was okay and what happened, Resident #1's response was unheard. RN A asked if she was in pain and if she was hurt, Resident #1 responded let me think, RN A told her she was going to move her leg and proceeded to move her leg. RN A spoke to CNA B and while RN A was holding Resident #1's hand and the video ended. An observation of Resident #1's room on 7/28/26 at 10:34 a.m. revealed the resident was not in her room. The room was observed to be free of hazards. An interview with LVN E on 7/28/26 at 11:30 a.m. revealed Resident #1 was usually very vocal about what she wanted and would tell staff when she was ready to be put in the bed. LVN E stated Resident #1 had been struggling recently with increased behaviors at night and at times would refuse to be transferred to her bed. LVN E stated she typically saw Resident #1 in her bed by the end of her shift at 6:00 p.m. daily. LVN E stated she typically checked on Resident #1 hourly due to her memory loss. An interview with CNA F on 7/28/26 at 11:36 a.m. revealed she checked on Resident #1 constantly due to her memory issues. CNA F stated she made it a habit to check on Resident #1 every time she passed her room. CNA F stated Resident #1 was unable to transfer herself and needed assistance to get from her wheelchair to her bed. CNA F stated she would try to put Resident #1 in her bed before the end of her shift at 6:00 p.m., but many times Resident #1 would refuse to be moved to her bed. CNA F stated if Resident #1 refused to go to bed she would have notified the nurse in charge. An interview and observation with Resident #1 with a relative on 7/28/26 at 1:31 p.m. revealed Resident #1 was very confused and unable to recall any events that had occurred. Resident #1 was sitting in her wheelchair in a common area of the building with her relative and was muttering random words. Resident #1's relative reported she was concerned and had video footage with Resident #1 in her wheelchair all night from 7/15/26 to 7/16/26 and no one ever checked on her. Resident #1's relative stated she was notified on 7/16/26 that Resident #1 had a fall at about 3am and when she looked at the video from Resident #1's room she saw no staff had ever put her to sleep and left her in her wheelchair all night. Resident #1's relative reported she was with her relative at the facility on 7/15/26, had fed her dinner and when she left, she told RN A her relative had gotten sleepy and was ready to be put in bed. Resident #1's relative stated when she reviewed the video footage staff had not entered Resident #1's room after about 7:30 p.m. on 7/15/26. A telephone interview with CNA B on 7/28/26 at 1:44 p.m. revealed on 7/15/26, she came on shift at 6:00 p.m. several hours into her shift she was informed she had to cover Resident #1's room because the assigned CNA had not showed up. CNA B was unable to recall the exact time she was assigned Resident #1's room. CNA B stated one of her colleagues took her to all the rooms she was covering and she glanced into Resident #1's room. CNA B stated she was busy that night taking care of another resident who needed close supervision and had not been able to check on Resident #1. CNA B stated at about 3:00 a.m. on 7/16/26, she walked into Resident #1's room and Resident #1 was on the floor and appeared to have (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident rights and rounding for residents on her shift. RN A stated the expectation was that she did rounds every 2 to 3 hours with her residents. RN A stated residents had the right to be checked on and their needs met; if they were not checked on, they could have gotten injured. RN A stated she completed an assessment of the resident and there was no injuries. An interview with the DON on 7/29/26 at 12:21 p.m. revealed the expectation for staff rounding at night and during the day was every 2-3 hours. The DON stated their investigation of Resident #1's fall revealed the RN A and CNA B failed to put Resident #1 in bed. The DON stated had the CNA and Nurse rounded they would have observed the resident was still in her wheelchair and could have put her in the bed sooner. The DON stated once the investigation was over the Administrator allowed RN A and CNA B to return to work and the DON provided them with one-on-one training. The DON stated she completed one on one training with RN A and CNA B on rounding, communication and charge nurses following up on delegated tasks. The DON stated the risk to the residents of not being checked on throughout the night would have been they could have fallen and gotten injured. The DON stated Resident #1 had no injury. An interview with the Administrator on 7/29/26 at 1:33 p.m. revealed he had investigated Resident #1's fall and had determined the nurse and CNA had not transferred Resident #1 back to bed and had not rounded resulting which resulted in her falling out of her wheelchair. The Administrator stated the expectation of rounding, was staff needed to round on residents every two hours throughout the day and at night. The Administrator stated a resident should not be in their wheelchair from 6:30 p.m. to 3:00 a.m. The Administrator stated he included education with all staff on leaving residents in wheelchairs for extended periods when he discussed the expectation of frequent rounding. The Administrator stated the risk to the residents of not being transferred to their bed timely was falls. Record review of facility's Fall Investigation and Intervention Policy and Procedure with not revised date reflected. Investigate root cause of the fall. Enter any new orders to Nurse Task and to the CNA, provide proof of education for any staff related incident, including therapy education when appropriate.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and observation the facility failed to provide residents with the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living for 1 of 2 residents (Resident #2) reviewed for ADLs. The facility failed to assist Resident #2 for several hours in transferring from her bed to her wheelchair after she requested it on 7/28/26. This failure could place residents at risk of skin breakdowns, falls and affect their dignity and self-esteem. Findings included: Record review of Resident #2's face sheet, dated 7/28/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had the following pertinent diagnoses: multiple sclerosis (disease in which the body's immune system attacks the brain and spinal cord, disrupting the signals between the body and brain), other spondylosis (degenerative wear and tear of the spine) cervical region (neck), stiffness of unspecified joint, pain, nondisplaced fracture of neck of left radius (crack or break in the narrow part of the left arms radius bone), displaced intertrochanteric fracture of left femur (broken hip where the upper left thigh bone is cracked between its two outer bony knobs), nondisplaced fracture of left radial styloid process (a crack in the thumb-side wrist bone), and anxiety disorder (a condition involving excessive, ongoing fear and worry that do not go away and interfere with daily life). Record review of Resident #2's Quarterly MDS Assessment, dated 4/24/26, reflected Resident #2 was moderately cognitively impaired with a BIMS of 10. Section GG reflected Resident #2 she needed maximal assistance with ADLs which involved the use of her lower extremities and was fully dependent on staff for transfers. Record review of Resident #2's Care Plan Report, revised 9/22/25, reflected .Resident requires assist with ADLs Date Initiated: 08/29/2022 Resident is able to perform self-care to optimal level and maintains strength and endurance x 90 days Date Initiated: 08/29/2022 Revision on: 08/30/2023 Target Date: 07/12/2026 9/22/25- Hoyer lift for all transfers Date Initiated: 09/23/2025 Encourage independence in performance of self-care and mobility within limitations. Date Initiated: 08/29/2022 Provide level of support to complete dressing, toilet use, personal hygiene, and bathing needs Q shift Date Initiated: 08/29/2022 Provide level of support to complete transferring needs Q shift. Date Initiated: 08/29/2022 Reinforce use of aids to mobility as indicated Date Initiated: 08/29/2022. Record review of Report of Grievance/Complaint completed on 7/29/26 by Resident #2 reflected .[Resident #2] reporting issues with CNAs getting them up when requested.[Resident #2] state they are given the answer, 'I don't have time, I'm doing showers.' [Resident #2] state this happened the day shift of 6/22/26 and some weekends. An observation and interview with Resident #2 on 7/28/26 at 11:51 a.m. revealed Resident #2 was lying in her bed. Resident #2 stated she relied on staff for everything, could not walk or get out of bed unassisted. Resident #2 stated her concern was she had been waiting since 9:00 a.m. to get out of her bed. Resident #2 stated she told CNA C at about 9:00 a.m. she was ready to get out of bed and into her wheelchair and CNA C told her she needed to finish with a resident and would come and help her later. Resident #2 stated she then rang the call light again but could not provide a time and stated an unknown CNA responded and she once again told her she was ready to get out of bed. Resident #2 stated the unknown aid told her CNA C had been giving showers and when she was done, she would help her. Resident #2 stated she had also told LVN D she was ready to get out of bed when LVN D came to her room to ask when she wanted her breathing treatment. Resident #2 stated her preference to get out of the bed would be that she was assisted with getting out by 9 a.m. Resident #2 stated she was aware it took a lot of people to get her out of bed and therefore the (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff typically would have her out of bed by 11 a.m. or after lunch. Resident #2 stated she felt as though staff had not wanted to assist her and staff did not care about her. An interview and observation of Resident #2 on 7/28/26 at 12:42 p.m. reflected Resident #2 was still in her bed. Resident #2 stated she had been waiting forever to get out of bed and LVN C had just responded to her call light and told her she was going to check on the CNAs to see what they were doing. An interview with CNA C on 7/28/26 at 12:46 p.m. revealed she came on shift at 6:00 a.m. and checked on Resident #2 at about 9:30 a.m. and at that time Resident #2 stated she wanted to get out of bed. CNA C stated she told Resident #2 she would get her out of bed when they were less busy. CNA C stated she had not been able to get her out of the bed because she had been giving other residents showers but planned to get her out of bed at lunch. CNA C stated she typically had gotten Resident #2 out of bed after lunch because Resident #2 had never told her she liked to be out of bed early. CNA C stated it was normal for Resident #2 to have to wait to get out of bed because she would wait until all her tasks were completed before she helped Resident #2 out of bed. CNA C stated the other CNA on the hall could not have helped Resident #2 get out of bed because they had also been doing showers. CNA C stated LVN D could not have assisted with getting Resident #2 out of bed sooner because she was busy passing out medications. CNA C stated Resident #2 told her in the past it was okay if she waited until she completed all her tasks to help her get out of bed. CNA C stated the resident having had to wait for 3 hours could have affected her in that she would feel like she was being neglected. An interview with LVN D on 7/28/26 at 12:56 p.m. reflected she had given Resident #2 breathing treatment mid-morning and stated Resident #2 had not mentioned wanting to get out of bed. LVN D stated about 12:00 p.m. she responded to Resident #2's call light and Resident #2 stated she had been waiting to get out of bed and told CNA C she was ready to get out of bed but she was still waiting. LVN D stated she told Resident #2 the CNAs would assist with getting her out of bed after lunch. LVN D stated she had two CNAs in the hall with her, and they were busy, so residents needed to tell them ahead of time when they wanted to get out of bed. LVN D stated she was not aware Resident #2 had expressed wanting to get out of bed at 9:00 a.m. nor was she aware Resident #2 stated it was her preference. LVN D stated the resident had refused to get out of bed early in the past. LVN D stated if the resident had waited since 9am to get out of the bed then it could have affected the resident by making them unhappy or mad. An interview with Resident #2 on 7/29/26 at 12:13 p.m. revealed staff transferred her out of bed on 7/28/26 at about 1:00 p.m. Resident #2 stated she was upset yesterday (7/28/26) that she had waited a long time to have been transferred out of her bed. An interview with the DON on 7/28/26 at 1:07 p.m. revealed the expectation of getting a resident out of bed would depend on what was going on in the hall the resident resided in; however, she would have expected the assistance to be timely or as soon as possible. The DON stated if staff were unable to assist a resident with a transfer when the resident requested it, the expectation was that staff would have communicated to the resident and notified them they were not able to transfer them immediately and sought out available staff that could have assisted with the task. The DON stated a resident waiting several hours to get out of bed would need to have been investigated to determine if it was acceptable and would look into the reason Resident #2 waiting that long. The DON stated her expectation on a regular day, if there wasn't a lot happening, would have been for the staff to get the resident out of bed within an hour of the resident request. The DON stated Resident #2 had a history of requesting to get out of bed frequently and only staying out of bed for a few minutes before requesting to go back to bed, having made it difficult to transfer her every time she requested. The DON stated residents had to wait a long time to get out of bed could have affected their resident rights. The DON stated she did not believe residents waiting several hours could have affected them (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in any other way besides violating their rights. An interview with the Administrator on 7/29/26 at 1:33 p.m. revealed he was not aware Resident #2's preference was to be out of bed by 9:00 a.m., he stated it was unlike her to have requested to get out of bed early in the morning. The Administrator stated when a resident requested to get in and out of bed the expectation was that staff got them out of bed as soon as possible. The Administrator stated he expected staff to notify residents when they were busy and could not transfer them and to notify another staff member to assist the resident with the transfer if the staff member was busy providing care and would have taken too long to transfer the resident. The Administrator stated the length of time Resident #2 waited to be transferred from her bed to her chair was not ideal and should have been done sooner. The Administrator stated he could not think of any negative effects to the resident of waiting a long time to get out of bed. The Administrator stated anything could have the potential for psycho-social harm, but he didn't believe the resident had to wait to get out of bed constituted psycho-social harm. Record review of the facility's, undated, Resident Right policy reflected The facility protects and promotes the rights of each resident admitted in order to provide a dignified existence, self-determination and communication with and access to person and services inside and outside the facility.		