STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 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 observations, interviews, and record review the facility failed to ensure that all drugs and biological were stored in locked compartments in accordance with State and Federal laws for three of eight residents (Resident #74, Resident #62 and Resident #69) reviewed for the storage of drugs and biologicals. The facility failed to ensure Resident # 74, Resident #62 and Resident #69 to have prescription and over the counter medication in a locked compartment. This failure could place residents at risk of medication misuse, administration of incorrect dosage of medications which could result in non-therapeutic treatments or injuries.Findings included: 1. Record review of Resident #74's Quarterly MDS assessment, dated 01/20/26, reflected a [AGE] year-old male with an admission date of 08/12/25. Resident had a BIMS of 13 which indicated he was cognitively intact. Diagnoses included coronary artery disease (damage or disease in the heart's major blood vessels), diabetes and gastroesophageal reflux disease (heartburn and acid regurgitation).During an observation and interview on 03/10/26 at 1:30 p.m. revealed Resident #74 in his room lying in bed. Resident stated he was doing fair but stated he had a sore throat and had been coughing. A bottle of over-the-counter cough and congestion syrup and a bottle of Vapor Cool throat spray was noted to be on his over the bed table. The resident stated he had been taking the cough syrup about three times a day and was using the throat spray daily, but stated his throat was still sore. He stated he had told one of the nurses about his cough but was not sure which one and they told him he needed a prescription for cough syrup, so he called his family member and asked him to bring him some. Record Review of Resident #74's Physician order summary report dated 03/11/26 reflected an order for Guaifenesin Liquid 100/mg 5ml- give 10 ml by mouth every 4 hours as needed for cough.with a start date of 03/10/26 and an order for Chloraseptic mouth/throat liquid 1.4 % Give 4 spray by mouth every 4 hours as needed for sore throat. with a start date of 03/10/26. There were no orders for any medication at bedside.During an observation and interview made with LVN E on 03/11/26 at 1:50 p.m. in Resident #74's room. LVN E picked up the bottle of cough syrup and throat spray and stated the resident should not have the cough syrup at bedside and instructed the resident he needed to let them know if he needed something for his cough. Resident stated he had asked a nurse previously and she had told him he needed a prescription for cough syrup, so he just called his family member to bring him some. LVN E stated Resident #74 did have a previous order for the throat spray and he had been allowed to have that at bedside but stated the order had had not continued on the current orders. LVN E informed Resident #74 she would notify the doctor about his cough and sore throat and get something ordered for him. LVN E removed the items from the resident's room.2. Record review of Resident #62's quarterly MDS assessment dated [DATE] reflected an [AGE] year-old female with an admission date of 09/30/24. Resident had a BIMS of 2 which indicated she was severely cognitively impaired. She was independent to limited supervision for her ADLS. Diagnoses included Alzheimer's, osteoarthritis (wear-and-tear arthritis where the cartilage cushioning the ends of the bones wears down) and chronic obstructive pulmonary diseases (chronic airflow blockage, making it difficult to breath).During (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
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an observation and interview on 03/10/26 at 9:44 a.m. revealed Resident #62 in her room sitting on her bed. Resident was alert and very pleasant. Resident #62 stated she was doing good and had no complaints. A Proair HFA (albuterol sulfate) inhaler (used as short acting bronchodilator) was observed on her bedside table. She stated she had not used it in a while.Record review of Resident #62's Physician order Summary report dated 03/10/26 reflected an order for Albuterol Sulfate HFA Inhalation.1 puff inhale orally every 4 hours as needed for Shortness of breath.with a start date of 09/30/24. There were no orders for any medication at bedside.During an observation and interview with LVN E on 03/11/26 at 1:55 p.m. in Resident #62's room, LVN E picked up the ProAir HFA inhaler and informed Resident #62 she could not have it in her room. Resident #62 stated she had it ever since she had been here but stated she does not recall using it. In addition, the resident had a bottle of Bio Freeze (a topical menthol-based pain reliver) with a prescription label from Resident #62's previous facility and a fill date of May 2024. LVN E instructed Resident #62 she had orders for her inhaler and if she needed the Bio Freeze she could contact the physician.3. Record review of Resident #69's Annual MDS assessment dated [DATE] reflected a [AGE] year-old male with an admission date of 02/07/26. Resident #69 had a BIMS of 9 which indicated he was moderately cognitively impaired, required partial to moderate assistance with ADLS. Diagnoses included anxiety and chronic obstructive pulmonary diseases (chronic airflow blockage, making it difficult to breath).Record review of Resident #69 Physician order Summary report dated 03/10/26 reflected an order for Ventolin HFA Inhalation Aerosol solution ((Albuterol Sulfate) .2 application inhale orally every 4 hours as needed for wheezing/ Shortness of breath.with a start date of 02/07/26. There were no orders for any medication at bedside.During an observation and interview with Resident #69 on 03/10/26 at 10:18 a.m. Resident #69 opened his chest of drawers to show where he kept his nebulizer mask. In addition to the nebulizer mask, there was an albuterol sulfate inhaler. Resident #69 stated he used the inhaler in an emergency situation when he was short of breath. Resident #69 stated he used the inhaler a couple of times a day due to his chronic obstructive pulmonary disease. He stated he had not told the nurse when he used the inhaler. During an observation and interview with LVN E on 03/11/26 at 2:15 p.m. in Resident #69's room, LVN E picked up the Albuterol inhaler and informed Resident #69 he could not have it in his room. Resident #69 asked what he was supposed to do if he needed it and LVN E informed him he was to call them and they would provide him with his ordered breathing treatments. During the observation a bottle of over the counter sleep aid (doxylamine succinate) was also found on his bedside table. LVN E informed resident she would have to contact his physician for an order for a sleep aid if he was having trouble sleeping. Resident #69 stated he had not taken one for several weeks. LVN E removed both of the medications from Resident #69's room.During an interview with LVN E on 03/11/26 at 2:30 p.m. she stated none of the residents had been assessed to be able to self-administer medication and stated they were responsible for all of the medications the residents were to take. She stated having additional medication they were not aware of could pose a serious risk of overmedicating and or having a drug reaction with medications they were being given. She stated she was going to do a sweep of her hall to ensure no other medications were at residents' bedside. During an interview with the Regional Nurse Consultant and the new DON on 03/12/26 at 12:25.p.m., the Regional Nurse Consultant stated for a Resident to be able to leave medication at the bedside the facility had to complete a resident assessment to determine if the resident understood the directions for the use of the medication and the resident still must let the nurse know when they had administered the medication so it could be documented in the record. She stated none of the Residents had been assessed to have the capacity to manage their own medications. She stated the risk of leaving medications at the bedside was the resident could use the medication improperly, or some other resident could have access to a medication not prescribed for them. She stated it was the staff's responsibility to ensure the medications were kept secure and stored properly. She stated going forward they were starting at admission, going over with the resident and their family about the responsibility of the facility in managing all of their medications and instruct family to not bring in any (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication including over the counter medications. She stated the staff should also be observing while in the Resident's room and reporting any medication they see at bedside to the Charge nurse and DON. Record review of the facility undated policy Drug Security, reflected, The facility establishes procedures for storing and disposing of drugs and biological in accordance with federal, state and local laws. A drug distribution cart is used by the facility and when not in use it will be locked and secured in the locked medication room.Self-administration medications will be kept in a locked cabinet in the resident's room. The facility will be responsible for medication security, accurate information, and medication compliance.All drugs must be prescribed by the resident's physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store food in accordance with professional standards for food service safety for the facility's only kitchen in that:The facility failed to ensure food items in the kitchen were appropriately covered on 3/10/2026.These failures could affect residents who received their meals from the facility's kitchen, by placing them at risk for food-borne illness, if consumed and food contamination. Finding included: Observations on 03/10/2026 at 9:17 AM of the walk-in refrigerator revealed 6 heads of lettuce left open in a storage bin and 2 boiled eggs were left open in a plastic bag. Observations on 03/10/26 at 9:22 AM of the dry storage revealed a bulk container of thickener left open with lid not fully closed, 1/2 bag of pecans in a Ziplock bag left open to air, about 3/4 bag of cereal left in a plastic bag left open to air. In an interview on 03/11/2026 at 1:59 PM with the Dietary Manager revealed her expectation was all foods in the kitchen should be covered at all times. She stated that everyone in the kitchen including cooks, dietary aides, and herself were responsible for covering food items. She stated the risk of not appropriately covering food items was cross contamination of food, decreased freshness, and could make the residents sick. She stated that as a Dietary Manager she provided frequent in-services to all kitchen staff on appropriate food storage. In an interview on 03/11/2026 at 2:06 PM with [NAME] B stated all food items in the kitchen should be covered appropriately. She stated she had been a cook for 5 years in the kitchen. She stated that everyone who worked in the kitchen was responsible for covering food items. She stated that if the food was not covered, it needed to be discarded since it posed a risk of cross contamination and food borne illness to residents. In an interview on 03/11/2026 at 2:10 PM with Dietary Aide C stated that she had been working in the facility for about 3 years. She stated that everyone in the kitchen was responsible for covering food items She stated the risk of not appropriately covering food items was food contamination and food borne illness. She stated that she received in-services about appropriate food storage from the Dietary Manager at periodic intervals. Record review of facility policy operation/ resident care policies undated, reflected, .Food is stored, prepared, distributed and served to residents in accordance with professional standards for food service safety. Non-perishable foods must be maintained in air-tight closed containers to ensure freshness and for proper pest control measures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 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 with such care, consistent with professional standards of practice and the comprehensive person-centered care plan, for one of four residents (Resident #10) reviewed for quality of care. The facility failed to ensure the supplemental oxygen was provided at the physician ordered rate for Resident #10. This failure could place residents who received oxygen therapy at risk of oxygen toxicity. Findings included: Record review of Resident #10's quarterly MDS assessment, dated 02/02/26, reflected a [AGE] year-old female, admitted to the facility on [DATE]. She had a BIMS score of 3 which indicated she was severely cognitively impaired. Diagnoses included chronic obstructive pulmonary disease (chronic airflow blockage, making it difficult to breath), dementia and acute upper respiratory infection (a viral infection affecting the nose, throat and sinuses). Resident #10 required moderate to maximum assistance with ADLS. Resident #10 had received oxygen therapy in the past 14 days. Record review of Resident #10's care plan, dated 01/28/26, reflected, Use of Oxygen Therapy continuous.Goal.Resident will maintain within normal respiratory functions x 90 days.Interventions.Apply oxygen as needed. Record review of Resident #10's Physician order summary report, dated 03/12/26, reflected, OXYGEN-CONTINUOSLY= Oxygen at 3 Liters per minute via nasal cannula continuously. Check every shift ., with a start date of 02/04/26. Record review of Resident #10's MAR, dated March 2026, reflected, .Oxygen at 3 liters per minute via nasal cannula continuously. with a start date of 02/04/26. The MAR was signed off by staff on the day shift and night shift from 03/01/26 through the day shift on 03/12/26 which indicated Oxygen was administered at 3 liters per minute. During an observation and interview on 03/11/2026 at 10:01 a.m. Resident #10 was sitting up in her wheelchair, next to her bed. Resident #10 was utilizing oxygen via nasal cannula at 2 liters per minute. Resident #10 had an E-tank (portable oxygen tank) attached to the back of her wheelchair. There was an oxygen concentrator in the corner of the room which was not running. Resident #10 stated she was doing well and had no concerns. During an observation on 03/11/2026 at 04:30 p.m. Resident #10 was observed up in her wheelchair in her room. Resident #10 had a nasal cannula connected to the E Tank on the back of her wheelchair. The E-tank was set to deliver 2 liters per minute. The dial on the E-tank indicated the tank needed to be refilled. During observation and interview on 03/11/2026 at 4:40 p.m. LVN F entered Resident #10's room and observed the E-Tank on the back of Resident #10's wheelchair and stated, that's not good. LVN F stated the resident should had been put back on her oxygen concentrator when they brought her back to her room from lunch. LVN F verified the E-tank was set to deliver 2 liters per minute. She placed the resident back on the oxygen concentrator. Resident #10 was not in distress and stated she has had some trouble getting a deep breath but denied any shortness of breath. LVN F stated she was going to come back and check the resident's Oxygen saturation level. LVN F went to the nurse's station and checked the computer and verified the resident was supposed to be on 3 liters per minute. LVN F then returned to Resident #10's room and checked the resident's oxygen saturation level which was at 98 % and verified the oxygen concentrator was set to deliver 3 liters per minute. In an interview with LVN F on 03/11/26 at 4:45 p.m. she stated the nurses were responsible for checking and verifying that residents receiving oxygen were receiving the physician prescribed amount of oxygen. She stated they will place residents on an E-Tank when they want to go out of the room for activities or go to the dining room for meals. She stated the CNAs could switch the residents from the concentrator to the portable tank but stated the Nurses were responsible for setting up the tank with the correct amount of oxygen per minute. She stated the CNAs would usually let her know when they had placed someone on an E-tank. She stated she was not sure who set up the tank Resident #10 was using. She stated not providing the resident with the prescribed amount of oxygen could lead to low oxygen levels, confusion and difficulty breathing. During an interview on 03/11/2026 at 4:50 p.m. with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA G she stated she was assigned to Resident #10 today (03/11/26). She stated she was not the one who brought Resident #10 back to her room after lunch. She stated the CNAs can switch a resident from the E-Tank and put them back on the oxygen concentrator. She stated she checked and changed Resident #10 around 3 p.m. and got her back up in her wheelchair. She stated she did not check the E-Tank to see if it had air or not. During an interview with the Regional Nurse Consultant and new DON on 03/11/2026 at 4:55 p.m., the Regional Nurse Consultant stated oxygen should be set at the physician ordered delivery rate. She stated Resident #10 had not been using oxygen until last month when she had an upper respiratory infection. She stated the Nurses were responsible for monitoring any resident who was receiving oxygen and were supposed to check the oxygen levels each shift and as needed. She stated the CNAs could switch residents from the concentrator to an E-tank but stated they could not set the oxygen delivery rate. She stated all of the staff were able to check the gauge on the E-tank and change it out when it was empty. She and the DON would in-service the staff on the expectation of monitoring while a resident was receiving oxygen. She stated the risk of a resident not receiving the prescribed amount of oxygen was low oxygen levels, increased confusion and difficulty breathing. Record review of the facility's undated policy titled, Administration of Oxygen, reflected, Purpose- to aid in breathing as ordered by the physician.Equipment: Oxygen per tank or oxygen converter.Check doctor's order.The flow of oxygen is started and regulated at the rate ordered by the doctor.Report immediately to charge nurse all signs or symptoms or any failure of equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not 5% or greater. The facility had a medication error rate of 6.25 %, based on 2 errors of 32 opportunities, which involved one of five residents (Resident #74) and one of five staff (MA D) reviewed for medication errors, in that: The facility failed to ensure MA D administered Resident #74's 7 a.m. dose of Alpha-Lipoic Acid 600 mg (antioxidant use to treat nerve pain) and Protonix oral packet 40 mg (proton pump inhibitor used to treat acid reflux) on 03/11/26 as ordered by the physician. This failure could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions.The findings include: Record review of Resident #74's Quarterly MDS assessment, dated 01/20/26, reflected a [AGE] year-old male with an admission date of 08/12/25. Resident had a BIMS of 13 which indicated he was cognitively intact. Diagnoses included coronary artery disease (damage or disease in the heart's major blood vessels), diabetes and gastroesophageal reflux disease (heartburn and acid regurgitation). A record review of Resident #74's Physician's order summary report, dated 03/11/2026, reflected Resident #74 was to receive the following medications: Alpha-Lipoic Acid Oral Tablet 600 mg .Give 1 tablet by mouth one time a day related to nerve pain due to diabetes.with a start date 11/13/25.Protonix Oral Packet 40 mg.Give 1 tablet by mouth two times a day for gastroesophageal reflux disease.with a start date of 02/22/26. During a medication pass observation on 03/11/26 at 07:43 a.m., revealed MA D administered the following medications to Resident #74:Aspirin 81 mg 1 tabletVitamin D2 25 mcq (1000 units) 1 tabletEmpagliflozin 25 mg 1 tabletLactobacillus 1 capsuleMultivitamin 1 tabletSertraline HCL 50 mg 1 tabletSingular 10 mg 1 tabletMiraLAX oral powder 17 gm/ scoop -1 scoopCetirizine 10 mg 1 tabletMetoprolol Tartrate 25 mg 1 tabletGabapentin 300 mg 1 capsuleTramadol HCL 50 mg 1 tabletMA D did not administer Alpha-Lipoic Acid Oral Tablet 600 mg and Protonix Oral Packet 40 mg. Record review of Resident #74's March 2026 medication administration record on 03/11/26 at 03:23 p.m. reflected Alpha-Lipoic Acid Oral Tablet 600 mg 1 tablet and Protonix Oral Packet 40 mg oral packet 1 tablet was signed out as given on 03/11/26 at 07:00 a.m. by MA D During an interview with MA D on 03/11/2026 at 03:30 p.m. she stated she had not administered any additional medications to Resident #74 since her morning medication administration. Upon reviewing the medication administration record and searching the medication cart for the Alpha-Lipoic Acid and Resident #74's Protonix she acknowledged she could not find the medications in the cart and had not administered the Alpha-Lipoic Acid oral tablet and stated she thought the Protonix had been administered earlier by the night shift staff. She stated she had signed them both out as administered. She stated by signing the medication off as given, it would not have triggered to indicate it still needed to be administered, and no one would be aware the medication was missed. She stated the risk of not administering the resident's medication as ordered would be the resident would not receive the medication that was ordered for him. During an interview with the Regional Nurse Consultant and the new DON on 03/12/26 at 12:20 p.m., the Regional Nurse Consultant stated she expected the staff to follow the 5 rights of medication administration which were right drug, right dose, right route, right patient, and right time. She stated failing to follow these rights put residents at risk of not receiving all their medications or could lead to a worsening of the condition the medication was intended to treat. She stated they do skills checks annually and the pharmacy consultant observed medication administration monthly with random staff. She stated in reviewing the issue with Resident #74's medication and in talking with the pharmacy it was determined the order had been put in as Protonix packet instead of tablet and the pharmacy had requested clarification and no one from the facility had gotten back with the pharmacy, so the medication was not sent to the facility. She stated they would be in-servicing all of the medication aides as well as the nursing staff on follow up with the pharmacy to ensure the correct medications were submitted to the pharmacy and available for the resident. She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they had implemented a new staffing ADON who would be responsible for staff training and proficiency checks. Record review of the facility undated policy titled Medication Cart, Administration of Drugs, reflected, .Read medication orders on medication sheet and have medication cup ready.Place appropriate dosage into souffle cup. Re-read label and medication sheet and return drug to its proper location.Administer medication to resident.Mark appropriate entry on E-MAR.