STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745017	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge of Saginaw Health and Wellness	848 W McLeroy Blvd Saginaw, TX 76179

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility and protect and promote the rights of each resident for 1 of 9 residents (Resident #3) reviewed for resident rights. The facility failed to ensure Resident #3 did not remain covered in a substance, which appeared to be dried vomit and other detritus, for an extended period. This failure could place residents at risk of psychosocial harm. Findings included:Record review of Resident #3's admission sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included malignant neoplasm of unspecified part of unspecified bronchus or lung (a type of cancer that originates in the lungs, but the exact location within the lungs is unknown); methicillin susceptible staphylococcus aureus infection (a common bacterial infection caused by Staphylococcus aureus bacteria); secondary malignant neoplasm of right lung (a cancerous tumor that has spread to the right lung from another part of the body); moderate protein-calorie malnutrition (a nutritional deficiency state characterized by an inadequate intake of both protein and calories, resulting in muscle wasting, weight loss, and other health problems); benign prostatic hyperplasia without lower urinary tract symptoms (refers to a condition where the prostate gland is enlarged but the individual does not experience any urinary difficulties.); dysphagia (medical term for difficulty swallowing food or liquids.); and cognitive communication deficit (a communication challenge resulting from impaired thinking skills, such as memory, attention, and problem-solving, rather than a language disorder.). Record review of Resident #3's hospital medical records, dated 09/26/25, reflected Prognosis is guarded. D/w [Family Member]. Palliative care team consulted. Record review of a document titled After Visit Summary for Resident #3, dated 10/07/25, reflected Overall prognosis poor, patient has done advanced care planning.patient will continue with palliative chemotherapy for now.Advise consideration of hospice once patient and family are ready. Record review of Resident #3's MDS, dated [DATE], reflected Resident #3 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with self-care, to include upper body dressing, shower/bathe self, roll left and right, sit to lying, and lying to sitting on the side of bed. Record review of Resident #3 progress note, authored by RN B, dated 10/11/25 at 12:14 PM, reflected Resident noted vomiting this morning, coffee ground emesis (emesis-the action or process of vomiting; definition added), dark brown in color, VS sound is stable, no fever. NP contacted and new order to start Zofran 4mg Q4 hours PRN for 5 days: to do CBC. RP [Family Member] notified. Record review of Resident #3 CIC (Change in Condition) notification, authored by RN B, dated 10/11/25 at 1:25 PM, reflected Resident #3 was observed to be nauseous and vomiting which started in the morning on 10/11/25. Record review of Resident #3 progress note, authored by RN B, dated 10/11/25 at 3:15 PM, reflected .No repeat episode of emesis noted after PRN Zofran is administered. Record review of Resident #3 progress note, authored by LVN I, dated 10/12/25 at 9:40 AM, reflected Emesis was brown in color that was observed on bed and second emesis had a yellow mucus in mouth. Record review of Resident #3's second progress note, authored by LVN I, dated 10/12/25 at 9:40 AM, reflected Resident has emesis X2, gave Zofran and tolerated well. Record review of photo provided by complainant titled 20251012_134427, with metadata (the data that describes a photograph, providing details about the image itself, the equipment used to capture it, and its content. This information can include camera settings like aperture and shutter speed, keywords, captions, copyright, GPS location, date and time) indicated the date and time the photo was taken was on 10/12/25 at 1:44 PM. The photo was of Resident #3 from his mid thighs up, lying in bed shirtless, with just his head raised. Along the left side of Resident #3 was a blue vomit bag with a significant amount of a brown substance contained inside the bag. The bag was lying next to Resident #3 on the bed and the substance contained inside appeared to be close to leaking out onto the resident. Resident #3's left thumb, left index finger, left middle finger were seen stained by a dried brown substance. Record review of a photo provided by the complainant titled 20251012_134528, the metadata indicated the date and time the photo was taken was on 10/12/25 at 1:45 PM, reflected Resident #3 lying in bed. The photo was of Resident #3 from the waist up, shirtless. A dried brown substance could be seen on the center of Resident #3's chest. A dried brown substance could also be seen on the center of his stomach. A dried brown substance could be seen underneath his chin and along his left clavicle (commonly referred to as the collarbone), left shoulder, left arm pit, and inner upper left arm

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to be informed of, and participate in, his or her treatment, including: The right to be fully informed in language that he or she could understand of his or her total health status, including but not limited to, his or her medical condition. for 2 of 12 residents (Residents #1 and #2) reviewed for resident rights. The facility failed to ensure the staff was adequately able to communicate with Residents #1 and #2 in their primary language, Spanish, for their care and service needs. This failure place residents at risk of their needs not being met, which could decrease their health and psychosocial well-being.Findings included: A)Record review of Resident #1's admission assessment dated [DATE] revealed a [AGE] year old Mexican American female with a preferred language of Spanish who admitted [DATE]. She had a BIMS score of 11 (Moderate impairment) and for daily preferences it was very important to make decision about choosing clothes to wear and taking care of personal belongings. She had lower extremity functioning impairment on one side and no upper impairment and used a walker and wheelchair. She needed substantial/maximal assistance with most ADLS's for self-care and mobility. She was always incontinent with bowel and bladder and had medically complex conditions. She was diagnosed with hypertension, renal insufficiency, urinary tract infection, hyperlipidemia, arthritis, enterocolitis, Osteoarthritis, obesity, pain in right knee, muscle weakness, lack of coordination, cognitive communication deficit, Right artificial knee joint. She was at risk of developing pressure ulcer/injuries and took antibiotics in the past 7 days. Record review of Resident #1's Care Plan dated 10/06/25 revealed ADL Self-care performance deficit related to muscle weakness, other lack of coordination, potential for pain related to chronic kidney disease, cystitis, right knee and osteoarthritis and at risk for falls related to history of fall, muscle weakness. She had potential for skin impairment related to decreased mobility, incontinence, potential for pain related to chronic kidney disease, acute cystitis, right knee pain and potential for nutritional problem related to clostridium difficile, hyperlipidemia, chronic kidney disease. And dated 10/07/25 revealed a potential for pressure ulcer development related to decreased mobility, renal insufficiency related to chronic kidney disease, altered cardiovascular status related to hyperlipidemia, hypertension. (There was no Spanish language care plan) Interview and observation on 10/16/25 at 5:35 pm Resident #1 was sitting up in bed but did not speak English and was not able to answer questions. There was not any communication boards, binders or devices anywhere on the bedside table or nightstand to communicate with. B) Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed, an [AGE] year old Mexican female who had a primary language of Spanish. She admitted [DATE] with a BIMS score of 10 (Moderate cognitive impairment). She had upper and lower functioning impairment of both side and used a wheelchair, and partial/moderate assist for self-care and mobility assistance. She was occasionally incontinent with bladder and occasionally incontinent with bowel, none Alzheimer's dementia, hemiparesis, depression, schizophrenia, asthma, third lumbar wedge compression fracture, right foot drop. Record review of Resident #2's Care Plan dated 02/19/25 revealed, The resident has an altercation in musculoskeletal status required use of Knee ankle foot orthoses. On 03/19/25 Resident was on anticonvulsant medication related to nerve pain. On 05/15/25 The resident has arthritis. (There was no Spanish language care plan). Interview and observation on 10/16/25 at 5:40 pm Resident #2 spoke Spanish and was not able to answer any questions. There was not any communication boards, binders or devices anywhere on the bedside table or nightstand to communicate with. Interview on 10/16/25 at 3:50 pm, ADON F stated for their Spanish speaking residents they had Spanish speaking staff to translate for them. She stated they had communication boards at the nurses station and therapy room, but not in the resident's rooms. She stated if the staff spoke English to the Hispanic residents, it could result in them not understanding their care and needs. She stated she had used a translator on her phone to communicate with the Hispanic residents. Interview on 10/16/25 at 4:19 pm, MDS RN G stated for the Spanish speaking residents she would get a Spanish speaking CNA to help translate for her. Interview on 10/16/25 at 5:20 pm, SW H stated she had no complaints from anyone about the staff not knowing how to communicate in Spanish. She stated she did not know if the Hispanics had communication boards so they could visualize the picture to choose what their needs were. She stated it depended on the situation on how it could affect the residents. She stated the harm could be minimum or serious, such as needing to be changed more often. She stated the Hispanic residents needs would not be met if they were not able to figure out what the residents' needs were. Interview on 10/16/25 at 5:48 pm, the

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 12 residents (Residents #1 and #2) reviewed for care plans.The facility failed to ensure their IDT created a communication care plans for their Spanish speaking Residents #1 and #2.This failure could place residents at risk of their needs not being met, which could decrease their health and psychosocial well-being.Findings included: A)Record review of Resident #1's admission assessment dated [DATE] revealed a [AGE] year old Mexican American female with a preferred language of Spanish who admitted [DATE]. She had a BIMS score of 11 (Moderate impairment) and for daily preferences it was very important to make decision about choosing clothes to wear and taking care of personal belongings. She had lower extremity functional impairment on one side and no upper impairment and used a walker and wheelchair. She needed substantial/maximal assistance with most ADLS's for self-care and mobility. She was always incontinent with bowel and bladder and had medically complex conditions. She was diagnosed with hypertension, renal insufficiency, urinary tract infection, hyperlipidemia, arthritis, enterocolitis, Osteoarthritis, obesity, pain in right knee, muscle weakness, lack of coordination, cognitive communication deficit, Right artificial knee joint. She was at risk of developing pressure ulcer/injuries and took antibiotics in the past 7 days. Record review of Resident #1's Care Plan dated 10/06/25 revealed ADL Self-care performance deficit related to muscle weakness, other lack of coordination, potential for pain related to chronic kidney disease, cystitis, right knee and osteoarthritis and at risk for falls related to history of fall, muscle weakness. She had potential for skin impairment related to decreased mobility, incontinence, potential for pain related to chronic kidney disease, acute cystitis, right knee pain and potential for nutritional problem related to clostridium difficile, hyperlipidemia, chronic kidney disease. And dated 10/07/25 revealed a potential for pressure ulcer development related to decreased mobility, renal insufficiency related to chronic kidney disease, altered cardiovascular status related to hyperlipidemia, hypertension. (There was no Spanish language care plan) Interview and observation on 10/16/25 at 5:35 pm Resident #1 was sitting up in bed but did not speak English and was not able to answer questions. There was not any communication boards, binders or devices anywhere on the bedside table or nightstand to communicate with. B) Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed, an [AGE] year old Mexican female who had a primary language of Spanish. She admitted [DATE] with a BIMS score of 10 (Moderate cognitive impairment). She had upper and lower functioning impairment of both side and used a wheelchair, and partial/moderate assist for self-care and mobility assistance. She was occasionally incontinent with bladder and occasionally incontinent with bowel, none Alzheimer's dementia, hemiparesis, depression, schizophrenia, asthma, third lumbar wedge compression fracture, right foot drop. Record review of Resident #2's Care Plan dated 02/19/25 revealed, The resident has an altercation in musculoskeletal status required use of Knee ankle foot orthoses. On 03/19/25 Resident was on anticonvulsant medication related to nerve pain. On 05/15/25 The resident has arthritis. (There was no Spanish language care plan). Interview and observation on 10/16/25 at 5:40 pm Resident #2 spoke Spanish and was not able to answer any questions. There was not any communication boards, binders or devices anywhere on the bedside table or nightstand to communicate with. Interview on 10/15/25 at 3:35 pm, CNA A stated he did not know Spanish but used a phone translator for communicating with the Hispanic residents. Interview on 10/15/25 at 4:52 pm, RN B stated he could not speak Spanish to the Hispanic residents. He stated two of the Hispanics spoke a little English but the others did not understand English. He stated he was effective with speaking to the resident in Spanish with a translator assist on his phone. Interview on 10/16/25 at 9:54 am, CNA C stated she did not speak Spanish but used a translator on her phone if there did not have other staff to help translate. Interview on 10/16/25 at 10:30 am, CNA D stated Resident #1 needed a translator because she only spoke Spanish. Interview on 10/16/25 at 3:24 pm, CNA E stated there was no communication binder in the resident's rooms who spoke other languages. Interview on 10/16/25 at 3:50 pm, ADON F stated for their Spanish speaking residents they had Spanish speaking staff to translate for them. She stated they had communication boards at the nurses station and therapy room, but not in the resident's rooms. She stated if the staff spoke English to the Hispanic residents, it could result in them not