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	06/18/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #3) of six residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #3's rooms were in a position that was accessible to the resident on 06/18/2026. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Record Review of Resident #3's Face Sheet, dated 06/18/2026, reflected a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with muscle weakness and abnormalities of gait and mobility. Record Review of Resident #3's Comprehensive Care Plan, dated 04/23/26, revealed the resident has an ADL self-care performance deficit r/t decreased mobility, other lack of coordination with intervention to Encourage the resident to use bell to call for assistance. It revealed the resident is at risk for falls r/t History of falls at home, muscle weakness, other lack of coordination, with intervention to Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance and Follow facility fall protocol. Record Review of Resident #3's Quarterly MDS assessment dated [DATE], revealed the Resident had a BIMS score of 7 (severe cognitive impairment). The Quarterly MDS Assessment indicated that the residents required substantial assistance for toileting, hygiene, dressing, bed mobility, and transfer. During an observation and interview on 06/18/26 at 10:55 a.m. revealed Resident #3 was in his bed, awake. It was observed that the resident's call light was on the floor. When asked about his call light, the resident pointed to it hanging on off the wall, he did not give any verbal response. During an interview and observation with CNA D on 06/18/26 at 10:57 a.m. She stated that the policy is that all call bells should always be reachable by residents. She stated that for Resident #3, she should check him every hour to make sure the call bell is in place, she stated that all staff are responsible for making sure the call bell is in place. She stated that the call light should be in place for residents who are dependent on staff to call help. She stated that if the call light is not reachable the resident could fall and injure themselves trying to reach it. During an interview with Housekeeper M on 06/18/26 at 11:30 a.m. She stated that the call bell should always be within reach of the resident. She stated that the call bell should be in place just in case the resident need help with something or if they fall. She stated everyone is responsible to make sure that the call bell is in place. She stated that if the call bell is not within reach it could be a fall risk and the resident could be hurt and not have a way to call for help. During an interview with LVN A on 06/18/26 at 11:40 a.m. she stated that Resident #3 throws his call bell away from himself.She stated that the resident is educated on the need to have call bell within reach so he can reach it to call for help, but he keeps throwing it away. She stated that no other intervention has been implemented to make sure the call bell is in place. She stated that the policy is that the call bell has to always be within reach. She stated that the call bell should be withing reach for safety and the resident can call for help when needed. She stated that the resident can fall and injure themselves if the call bell is not withing reach for the resident to call for help. During an interview with the DON on 06/18/26 at 4:00 p.m. She stated that the call bell should always (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be within reach of the resident. She stated that it should be within reach for residents to call for assistance She stated that the call bell not within reach will be potential for the resident needs not being met. She stated that all facility staff are responsible for making sure the call bell is within reach Record review of the facility's policy Answering the Call Lights revealed: Purpose:The purpose of this procedure is to ensure timely responses to the resident's requests and needs.General guidelinesUpon admission and periodically as needed, explain use of the call light to the resident.Ask the resident to return demonstrationExplain to the resident that a call system is also located in the bathroom.Be sure that the call light is plugged in and functioning at all times.When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.Some residents may not be able to use the their call light. Be sure you check on these residents fre.Report all defective call lights to the nurse supervisor promptly.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (Resident #2) of six residents reviewed for wound care. The facility failed to follow the facility's wound cleaning protocol for Resident #2's left above the knee amputation stump dressing change on 06/18/26. This failure put Resident #2 at risk of not receiving necessary treatment and a worsening of their wound.Findings included: Record review of Resident #2's face sheet dated 06/18/26 revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included Acquired Absence of Left Leg Below Knee, Acquired Absence Of Right Leg Below Knee. Record review of Resident #2's MDS dated [DATE] revealed that the resident had a BIMS score of 15 (indicates no cognitive impairment). It revealed that the Resident has surgical wounds. Record Review of Resident #2's Physician Order dated 06/08/26 revealed Left leg/AKA stump: Cleanse area with NS, pat dry,apply Betadine and leave open to air daily. one time a day for wound care. Review of Resident #2's care plan dated 06/05/26 revealed the resident has an alteration in musculoskeletal status bilateral lower leg r/t Right BKA and S/P left AKA with the goal of the resident's wound will heal and progress without complications through the review date. Observation and Interview with Wound Nurse J on 06/18/2026 from 10:25 a.m. to 10:50 a.m. The Wound Nurse cleansed the left AKA stump with wound cleanser, applied betadine solution and covered with 4-inch x 4-inch bordered gauze. When asked about the danger of giving treatment without a physician's order, she stated it is important to follow the wound order by the wound doctor to make sure the wound heals. She stated per Resident #3's request she covered the wound with a bordered gauze which was not part of her wound care orders. She stated she should check with the doctor first to make sure the resident request is applicable for her wound care and then she writes an order before implementing the order. She stated that the resident should be educated per the request and call the doctor to make sure the request is ok before carrying out resident request. During an interview with the DON, she stated that the procedure is to notify the physician of the resident request to get a one time /prn order for the request. She stated that the Resident's should be called in to the physician, obtain an order before the treatment request is carried out by the wound nurse. She stated that everything that is done for the residents is physician driven so an order is needed for any treatment provided. She stated treatment without an order could result in potential for the wound not to heal. A Record review of the facility's Medication and Treatment Orders revealed : Medications and other treatments should be administered only upon the written, verbal or electronic order of a person duly licensed and authorized to prescribe such medications in this state.2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record.3. Drug, biological orders and intervention orders are recorded on the physician's order sheet in the resident's chart or in the physician order tab of a residents' electronic medical record. Such orders are by Nursing and reviewed by the consultant pharmacist on a monthly basis.4. All drug, biological orders and intervention orders are written, dated, and signed (electronic signature allowed in PCC) by the person lawfully authorized to give such an order.5. The signing of orders are to be by signature or a personal computer key. Signature stamps may not be used.6. The staff and practitioners should use only approved abbreviations and symbols when ordering and/or charting medications.7. Verbal orders are to be recorded immediately in the resident's chart by the person receiving the order and includes prescriber's last name, credentials, the date and the time of the order.8. Verbal orders are to be signed (written or e-signed) by the prescriber at his or her next visit or electronically.

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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** Tag: F689 /4027S/S= D Surveyor Name(s): [NAME] NnadiImmediate Supervisor: Verlair AsheBased on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 2 of 6 residents (Resident #3 and #6) reviewed for accident prevention. The facility failed to ensure Resident #3's fall mat was placed alongside his bed while she was lying in the bed on 06/18/26. 2. The facility failed to ensure Resident #6's bed was in a low position for fall prevention per the care plan while he was lying in bed on 06/18/26. This failure could prevent the residents from having an environment that was free from hazards.Findings include: Record Review of Resident #3's Face Sheet, dated 06/18/2026, reflected a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with muscle weakness and abnormalities of gait and mobility. Record Review of Resident #3's Comprehensive Care Plan, dated 04/23/26, revealed the resident has an ADL self-care performance deficit r/t decreased mobility, other lack of coordination with intervention to Encourage the resident to use bell to call for assistance. It revealed the resident is at risk for falls r/t History of falls at home, muscle weakness, other lack of coordination, with intervention to Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance and Follow facility fall protocol. Record Review of Resident #3's Quarterly MDS assessment dated [DATE], revealed the Resident had a BIMS score of 7 (severe cognitive impairment). The Quarterly MDS Assessment indicated that the residents required substantial assistance for toileting, hygiene, dressing, bed mobility, and transfer. During an observation on 06/18/26 at 10:55 a.m., Resident #3 was in his bed with his fall mat leaning against the wall. During an interview on 06/18/26 at 11:15 a.m., with CNA D she stated that the fall mat should be by the bedside, she stated that the housekeeper moved it while cleaning the floor. She stated that everyone is responsible for making sure the fall mat is in place and that she should have put it back next to the resident when she noticed it leaning on the floor. She stated the resident throws things off his side, and they must go put things back in place. She stated the fall mat should be in place for Resident #3's safety and avoid serious injury when he falls. During an interview on 06/18/26 at 11:30 a.m. with Housekeeper M, she stated the fall mat should be in place to protect the residents if they fall. She stated everyone is responsible to make sure they are in place including myself. She stated she should have put the fall mat back in place when she noticed it was on the wall and not next to the residents' bed. She stated the resident could break a bone or hit his head on the floor if he fall mat is not in place. During an interview on 06/18/26 at 11:40 a.m. with LVN A, she stated that the resident has a history of weakness and has fallen since he has been here and he has been educated to use his call light when he needs to transfer. She stated that the fall mat should be to both sides of bed and bed in lowest position when the resident is in bed. She stated that not having the fall mat could cause the resident to hit his head on the floor and will need to be sent to the hospital. She stated that the nurse is responsible for making sure that the fall mat is in place. 2. Record Review of Resident #6's Face Sheet, dated 06/18/2026, reflected a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with Parkinson's disease, fracture of left Femur (long bone of the thigh), multiple fractures of ribs. Record Review of Resident #6's Comprehensive Care Plan, dated 05/15/26, revealed 1) the resident has an ADL self-careperformance deficit r/t Parkinson's disease, Dementia, fall with left Femur and right sided multiple ribs fracture, S/P ORIF leftFemur, muscle weakness, 2) The resident is at risk for falls r/t history of multiple falls, recent fall at home with fracture, muscle weakness, Other lack of coordination, Muscle weakness, Orthostatic Hypotension (abnormal drop in blood pressure when standing), 3) with intervention to Follow facility fall protocol. 3) The resident has had an actual fall on: 06/06/2026, 06/13/2026 with intervention of Bed changed for safety and fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions. Record Review of Resident #6's Quarterly MDS assessment dated [DATE], did not reveal a BIMS assessment score. The Quarterly MDS Assessment indicated triggered care area of falls with fall-related fracture in the last 6 months. During an interview and observation on 06/18/26 at 1:52 p.m. with CNA M, the bed position was called to the attention of CNA M and he proceeded to put the bed in the lowest position. He stated that the policy is that the bed should be in the lowest position and fall mat in place. He states that if the bed is not at the lowest position, it could cause serious injury to the residents. He stated that the CNA /Nurse are responsible for making sure the bed is in the lowest position for fall risk residents. He stated that if the care plan is not followed it could lead to serious injuries and the resident could be hospitalized During an interview on 06/18/26 at 1:57 p.m. with LVN S, she stated the bed should be in the lowest position and floor mats in place with call light within reach. She stated that following the care plan is to prevent injury. She stated that it can affect the residents' mobility, independence and emotionally if they fall and injure themselves. She stated that anyone that comes in contact with the resident is responsible for making sure that the bed is in the lowest position. During an interview on 06/18/26 at 4:00 p.m. with the DON, she stated that the fall protocol should be always followedShe stated that the bed should be in the lowest position and fall mat in place. She stated that if the care plan is not followed it could be a risk for injury for the residents. She stated that all facility staff going into the room are responsible for making sure the care plan is followed. A record review of the facilities Fall -Clinical Protocol revealed: Treatment/Management1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). Monitoring and Follow-Up1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. 2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls.b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented. 3. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause.

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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 that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #4 and Resident #5) of six residents reviewed for respiratory care. 1. The facility failed to ensure Resident #4 's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was stored properly when not in use on 06/18/26. 2. The facility failed to ensure Resident #5 's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) and BiPAP mask was stored properly when not in use on 06/18/26. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings include: 1. Record review of Resident #4's Face Sheet, dated 06/18/26, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease COPD (a chronic inflammatory disease that causes obstructed airflow from the lungs), Chronic Respiratory failure with Hypoxia (long-term low oxygen in the blood) Record review of Resident #4's Quarterly MDS Assessment, dated 05/16/26, reflected that the resident had a a BIMS score of 08 indicating moderate cognitive impairment. The Quarterly MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #4's Comprehensive Care Plan, dated 05/16/26, reflected the resident had oxygen therapy and one of the interventions was provide oxygen therapy as ordered. The Comprehensive Care Plan did not indicate that the resident was the one taking off her nasal canula. Record review of Resident #4's Physician's Order, dated 05/16/26, revealed the following orders; O2@ 3 Liters via Nasal Canula Continuous every shift related to Acute Respiratory Failure with Hypoxia and Change O2 tubing/water. every night shift every Satlabel/date bag. 2. Record review of Resident #5's face sheet, dated 06/182026, reflected an [AGE] year-old male admitted to the facility on [DATE]. Diagnosis included COPD. Record review of Resident #5's Quarterly MDS Assessment, dated 05/14/26, reflected that the resident had a a BIMS score of 11 indicating moderate cognitive impairment. The Quarterly MDS Assessment indicated the resident is coded for Debility, Cardiorespiratory Conditions, Acute Respiratory failure with Hypoxia. Record review of Resident #5's Comprehensive Care Plan, dated 03/05/26, reflected the resident had BIPAP Therapy. Care plan dated 03/04/24 revealed the resident has the potential for shortness of breath with oxygen therapy Per MD's orders as one of the interventions. Record review of Resident #5's Active Physician's Order on 06/18/26, revealed the following orders: Oxygen PRN @ 2 L/NC for ease of breathing, SOB or saturations less than 92% every 8 hours as needed for SOB, easy of breathing or low SaO2 less than92%. Noninvasive ventilation via BiPAP, Change Nasal Cannula and Humidifier Every Week on Sundays. Date Tubing AndHumidifier When changing. Clean O2 Filter and Concentrator every night shift every Sat, Sun for O2 therapy, During an observation and interview on 06/18/26 at 1:00 p.m. it was revealed Resident 4 was lying in her bed. The oxygen tubbing connected to the Oxygen tank on the wheelchair was draped across the wheelchair. It was not stored in a bag. Resident #4 stated she does not know how the Oxygen tube should be stored. During an observation and interview on 06/18/26 at 1:17 p.m. Resident #5 was sitting in his wheelchair, it was observed that his oxygen tubbing connected to his oxygen machine was laying on his nightstand and not stored in a bag. The BiPAP machine and breathing mask were on the nightstand. The breathing mask was not bagged. He stated he uses oxygen every time he lays in bed.He stated that the staff makes his bed for him. He stated no one had told him the oxygen tube and the BiPAP mask should be in a bag. During an interview on 06/18/26 at 1:25 p.m. with CNA A, she stated that she changed Resident #4 and left her in bed per Resident request and did not notice the nasal canula connected to the oxygen tank on the wheelchair was exposed. She stated that the facility policy is that the nasal canula and any breathing Masks should be bagged when not in use. She stated that the nurses and CNAs are responsible for (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	making sure it is bagged. She stated that bagging the canula is to prevent contamination. She stated that if not bag it could cause infection and make the resident sick. She stated she had the training at school and at the facility. During an interview on 06/18/26 at 1:44 p.m. with LVN S, she stated that the facility policy is that the Oxygen tubes and BIPAP mask should be bagged. She stated that it should be bagged for infection control. She stated that the nurse and the CNA's are responsible for making sure it is bagged. She stated that if the canula is not bagged it could cause the residents to have respiratory infection. She stated that they have educated Resident #5 to put his oxygen tube in a bag, but not sure if it was documented. During an interview on 06/18/26 at 4:00 p.m. with the DON, she stated that anytime the oxygen tube and the BiPAP mask is not in use it should be placed in a bag to prevent bacterial contamination. She stated that all facility staff doing round are responsible for making sure that the cannulas are bagged when not in use. She stated that the risk of not having the cannula bagged could be potential for infection for the residents. Record review of the facility's policy Oxygen Concentrator & Other Respiratory Equipment. Revealed: Oxygen Concentrator & Other Respiratory Equipment - continued1. Change the oxygen cannula and tubing every seven (7) days and date or as needed. NOTE: Night shift may crossover from one day into the next day.2. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use or cover tubing with [NAME] poly tubing cover.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Residents #1and #2) of six residents reviewed for infection control. 1. The facility failed to ensure Wound Nurse J performed hand hygiene and changed her gloves during Resident #1 and #2's wound care on 06/18/26. 2. The facility failed to ensure CNA D performed hand hygiene and changed her gloves during Resident #1's incontinent care on 06/18/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings include: 1. Record review of Resident #1's face sheet dated 06/18/26 revealed a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included pressure ulcer of sacral region, stage 4. Record review of Resident #1's MDS dated [DATE] revealed no BIMS evaluation score. It revealed that the Resident has pressure ulcer care and is at risk to develop pressure ulcers. Record Review of Resident #1's Physician Order dated 04/13/26 revealed: Cleanse Sacrum with NS, pat dry, apply calcium alginate and cover with dry dressing daily. Review of Resident #1's care plan dated 04/06/26 revealed the Resident is at risk for significant infections and/or recurrent infections r/t compromised medical condition r/t Acute Cystitis (bladder infection or a common urinary tract infection). 2. Record review of Resident #2's face sheet dated 06/18/26 revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included Acquired Absence of Left Leg Below Knee, Acquired Absence Of Right Leg Below Knee. Record review of Resident #2's MDS dated [DATE] revealed that the resident had a BIMS score of 15 (indicates no cognitive impairment). It revealed that the Resident has surgical wounds. Record Review of Resident #2's Physician Order dated 06/18/26 revealed Left leg/AKA stump: Cleanse area with NS, pat dry,apply Betadine and leave open to air daily. one time a day for wound care. Review of Resident #2's care plan dated 06/05/26 revealed the resident has an alteration in musculoskeletal status bilateral lower leg r/t Right BKA and S/P left AKA with the goal of the resident's wound will heal and progress without complications through the review date. During an Observation and interview on 06/18/26 at 10:16 a.m. to 10:25 a.m. it revealed that Wound Nurse J performed hand hygiene, put on clean gloves, she failed to remove soiled gloves after removing Resident #1's soiled dressing and proceeded to clean the wound with the same soiled gloves. She failed to sanitize hands before putting on clean gloves after she cleaned Resident 2's sacral area and proceeded to cleanse the Left AKA stump surgical wound. During an interview with the wound nurse She stated I should put gloves on, cleanse, change gloves, sanitize hands before putting on new gloves. She stated it is important to change gloves when doing wound care from dirty to clean procedure to prevent wound from getting worse and infected. She stated that not following procedure can affect the resident's health and skin and make them worse. During an observation and interview on 06/18/26 at 10:45 a.m. to 10:55 a.m. with CNA D, she performed incontinent care on Resident #1 and did not change her gloves throughout the observation. During ad interview with CNA D She stated that she should wash hands and change gloves and keep hands clean and not touch the resident with dirty gloves and change gloves throughout the care. She stated that it is important to change gloves to keep the residents safe and free from germs as much as possible. She stated that the resident could develop an infection if gloves are not changed throughout the care. She stated she has received training on incontinent care and that she should have followed the training instructions. During an interview on 06/18/26 at 11:40 a.m. with LVN A She stated that everyone who is incontinent is changed every 2 hours or be helped to go to the toilet. She stated that the CNA should report any changes in skin condition to the charge nurse.She stated that gloves should be changed during the care to prevent infections. She stated that the CNA's are trained periodically on incontinent care. She stated that if gloves are not changed during care it will result in increased chances for infection.She stated that the biggest danger is that (continued on next page)

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	06/18/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they could become septic on top of the infection. During an interview on 06/18/26 at 4:00 p.m. with the DON She stated that gloves should be changed and hand sanitized when going from dirty to clean area or task during wound care and incontinent care. She stated that it is the expectation that the staff follow the training. She stated that the risk to the resident will be potential for infection, prolonged wound healing. Record review of the facility's policy Hand - Washing Skill Checklist revealed: Purpose:To remove germs from hands and prevent the spread of infection. Guidelines and Precautions:1. Hand-washing is the single most important method in the prevention and control of infection.2. Hand-washing should be done at the following times:a) When coming on and going off duty.b) Before and after caring for each residentc) Before applying gloves and after removing gloves.d) Before and after eating, drinking, smoking, using lip balm, touching contact lenses, wiping nose, using toilet.e) After contact with blood, body fluids and contaminated items (Procedural Guideline #9).f) Whenever hands are obviously soiled.3. Precautions:a) Always keep your fingertips pointed down while washing your hands.b) Avoid leaning against sink or splashing uniform during Hand-washing.c) Do not touch the inside of sink or faucet handles with clean hands.4. Handwashing with soap and water or Alcohol Based Gel is approved for cleansing of hands (see number 5)