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	06/30/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, maintain medical records that were complete and accurately documented for 1 of 11 residents (Resident #1) reviewed for clinical records. The facility failed to ensure facility staff documented bruising on Resident #1's Weekly Wound Progress Report during his admission from 04/04/26 - 06/23/26. This failure could place residents at risk for inaccurate assessments and monitoring.Findings include: Record review of Resident #1's face sheet, dated 06/30/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE] for rehabilitation after a significant cerebral infarction. Resident #1 had relevant diagnoses which included cerebral infarction (interruption of blood flow to the brain,) acute cystitis (inflammation of bladder,) atherosclerotic heart disease (accumulation of cellular waste in arteries,) and benign prostatic hyperplasia (non-cancerous enlargement of prostate gland.) Record review of Resident #1's MDS, dated [DATE], revealed he was severely impaired with cognitive skills for daily decision making, with short- and long-term memory problems. He required a wheelchair for mobility; and was totally dependent upon staff for toileting, bathing, and other personal hygiene tasks. Record review of Resident #1's Comprehensive Care Plan, on 06/30/26, revealed the resident was on anticoagulant therapy related to CVA (interruption of blood flow to brain.) Record review of Resident #1's Provider Orders on 06/30/26 included: Aspirin 81 mg oral via g-tube one time a day for atherosclerotic heart disease dated 04/07/26. Clopidogrel Bisulfate 75 mg oral via g-tube in the morning for atherosclerotic heart disease dated 04/08/26. Enoxaparin Sodium 40 mg/0.4 ml inject subcutaneously at bedtime to prevent DVT (blood clot) and help with circulation dated 04/04/26. Monitor for signs and symptoms of [bleeding] adverse reaction. abdominal pain. headache, lethargy, dizziness, hematuria (blood in urine,) anemia (decrease in healthy red blood cells, decreasing the ability for the body to carry oxygen efficiently to tissues). hemorrhage (bleeding) . for anticoagulant monitoring dated 04/07/26. Peripheral IV - monitor for s/s of infection every shift . for fluids dated 05/18/26. Sodium Chloride Solution. 75 ml/hr. for volume depletion. 1 liter. dated 05/18/26. Record review of the facility Braden Scale Assessment, dated 05/02/26, revealed Resident #1 was at moderate risk for skin breakdown. Record review of facility provided documentation commonly known as shower sheets for Resident#1 dated 06/13/26 at 2:00 PM revealed bruising with the resident's arms circled bilaterally. Record review of facility provided documentation commonly known as shower sheets for Resident #1 dated 06/16/26 at PM revealed bruising with the resident's arms circled bilaterally. Record review of facility provided documentation commonly known as shower sheets for Resident #1 dated 06/18/26 at 6:00 PM revealed bruising with resident's forearms circled on the left side. Record review of Weekly Wound Progress Report, dated 06/16/26 at 3:09 PM revealed no evidence of documentation related to Resident #1's arms. Record review of Weekly Wound Progress Report, dated 06/22/26 at 11:40 AM revealed no evidence of documentation related to the bruising on the Resident #1's arms. Record review of [Provider] Surgical Note from Wound Care, dated 06/15/26, revealed no documentation related to the bruising to Resident #1's arms. Record review of [Provider] Surgical Note from Wound Care, dated 06/22/26, (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
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no documentation related to the bruising to Resident #1's arms. Attempts to interview Wound Care Provider on 06/30/26 at 5:47 PM and 07/01/26 at 10:00 AM were unsuccessful. Attempts to interview Resident #1 on 06/30/26 at 10:00 AM were not successful due to his cognitive limitations. In interview with facility's Treatment Nurse on 06/30/26 at 1:59 PM, she stated she was aware of Resident #1's arms and it was typical of any AC therapy in addition to his age and skin fragility. She stated it was very common and would not necessarily be required to document on the weekly skin assessment. In interview with the DON on 06/30/26 at 5:18 PM, she stated she reviewed the shower sheets daily in the morning meeting. She stated she was aware of the bilateral discoloration due to his age, medical conditions, blood lab draws, IV fluid, and regimen of blood thinners; but she did not feel it required further assessment at that time. She stated she was confident it was not trauma related and only related to his medical condition. She further stated it was her responsibility to review the skin sheets and determine if further assessment and documentation was warranted. She stated Resident #1's bruising was not required to be further documented. Review of facility policy System Pathway #1 Guide - Skin and Wound Management, rev. 06/26 revealed 14. Residents with newly identified or known pressure injuries, ulcers, wounds, etc. should be reviewed by the IDT upon notification and weekly thereafter, and a care plan should be developed, implemented, evaluated, and re-evaluated to treat actual the site(s) and reduce further pressure injuries, ulcers, wounds, etc This will include but not be limited to review of lab results, risk factors, positioning, etc.