

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER The Lodge of Saginaw Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 Residents (Resident #63 and Resident #5) of 23 residents reviewed for bowel and bladder incontinence. 1. The facility failed to ensure Resident #63 was not left in soiled briefs, or being double briefed. 2. The facility failed to ensure Resident #5 had physician's order for an indwelling catheter (device used to drain urine from bladder). This failure could place residents at risk of skin breakdown, infections and improper treatment. Findings included: 1. Record review of Resident #63's quarterly MDS, dated [DATE], reflected Resident #63 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included heart failure, dementia, and cognitive communication deficit. The resident had severe cognitive impairment with a BIMS score of 2. The MDS reflected that the resident required moderate assistance with toileting, and she had frequent bladder and bowel incontinence. The resident was not on a toileting program. Record review of Resident #63's care plan, dated 10/09/25, reflected that she had the potential for skin impairment, and she had an ADL self-care deficit related to dementia. She also had impaired cognitive function. Observation and interview on 12/15/25 at 11:00 AM revealed Resident #63 was in bed with a brown ring around her on her fitted sheet and an odor of urine about her. The resident was not responsive to questions. Interviews of other residents of the hall revealed no issues with their briefs being doubled. Observation on 12/15/25 at 11:45 AM revealed Resident #63 remained with the brown ring on her sheet. Observation on 12/15/25 at 12:04 PM revealed RN A was bedside with Resident #63 to take the resident's vital signs. She noted the brown ring on the sheet, and RN A called for assistance for changing the resident. Observation on 12/15/25 at 12:10 PM revealed RN A and CNA B were at Resident #63's bedside to change the resident. When the bedding was removed, it revealed the fitted sheet, the top sheet, and the bottom of the resident's shirt were all wet with urine. The resident was also noted to have two briefs on (double briefing) with the inner brief soaked with urine. No skin breakdown noted. Interview on 12/15/25 at 12:36 PM, CNA B stated double briefing the residents was not allowed, she stated it could cause skin breakdown. She stated she was not the CNA for Resident #63 and did not know the last time the resident had been changed. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/15/25 at 1:20 PM, CNA-C she stated she had checked Resident #63 around 8:00 AM and the indicator strip on the outside of the brief had not changed colors, indicating she was not wet. She stated she did not see a brown ring around the resident at that time. She was also unaware the resident had two briefs on; she stated that must have been done on the night shift. Interview on 12/15/25 at 1:26 PM, ADON D stated double briefing a resident was not allowed. She stated it could cause skin breakdown and wounds. She stated residents who were incontinent were to be checked every two hours. She stated just observing the indicator strip was not enough to determine if the resident was wet or dirty. Interview on 12/16/25 at 11:06 PM, the DON stated it was not acceptable to double brief residents with the intent to not have to change the resident as often. She stated in rare cases the resident might be care planned for double briefing if they request to do so, but it was not appropriate for residents with cognitive impairment. 2. Record review of Resident #5's re-entry MDS assessment dated [DATE] reflected Resident #5 was [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #5 had a blank BIMS score of 00 indicating Resident #5 could not complete the assessment. Resident #5's MDS further revealed he had short term memory problems and moderately impaired cognitive skills for daily decision making. Resident #5's diagnoses included hypertension (high blood pressure), Hypo-Osmolality and Hyponatremia (low sodium levels in the blood). The MDS reflected Resident #5 was dependent on staff for personal hygiene and toileting assistance with use of an indwelling catheter. Record review of Resident #5's undated care plan revealed Resident #5 had activities of daily living performance deficit related muscle weakness and other abnormalities. Goal: Resident #5 will maintain/improve current level of function. Interventions included assistance of 1 staff with personal hygiene and toilet use. Resident #5 is on enhanced barrier precautions related to Foley Catheter use. Goal: Enhanced barrier precautions to be utilized during activities of daily including but not limited to: Dressing, bathing, transferring, providing hygiene, changing linens/briefs or when toileting, care of indwelling medical device. Record review of Resident #5's undated care plan revealed Resident #5 had Indwelling Catheter: related to Urinary Retention. Goal: The resident will be/remain free from catheter-related trauma. Interventions included Catheter: Position catheter bag and tubing below the level of the bladder and away from entrance room door. refer to physician orders for size and changing the schedule. Check tubing for kinks each shift. Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to physician for signs and symptoms Urinary Tract Infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Privacy bag for drainage bag at all times while in bed, while walking or in wheelchair every shift. Check for privacy bag every shift. Record review of Resident #5's undated care plan revealed Resident #5 had over reactive bladder. Goal: Resident #5 will remain free from skin breakdown. Interventions included to monitor and document intake and output as per facility policy. Monitor/document for signs and symptoms Urinary Tract Infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	status, change in behavior, change in eating patterns. Record review of Resident #5's December 2025 Treatment Administration Record reflected there was no treatment order regarding his catheter or catheter care. Record review of Resident #5's physician's orders reflected there was not an order for catheter use, what French gauge required, or any care or treatments. Record review of Resident #5's progress note written by LVN J reflected: [AGE] year-old male admitted /readmitted from Hospital under physician care. Diagnosis: Low blood sodium, High blood pressure, High Cholesterol. Resident is alert and oriented by 1-2 with intermittent confusion; requires 2 person assist with transfer and Activities of Daily Living, incontinent of bowel and bladder, has foley catheter, 16 French [catheter size with a diameter of approximately 5.3 mm], inserted on 12/02/2025. Resident is on fluid restriction 1200 milliliter/day. Resident needs follow up appointment with urology and nephrology with in 1-2 weeks. Vital Signs; Blood Pressure 119/76, Pulse 69, Respiratory 18, Temperature 97.0, oxygen saturation 93 percent. Resident is stable, no respiratory distress noted, denies pain. Resident is oriented to call light, room and bed is in low position, no distress noted. Physician/Nurse Practitioner notified of admission and order received to continue current med orders. Interview on 12/15/25 at 12:00 PM with Resident #5 revealed he did have a catheter, had no issues or concerns with it. Resident #5 stated staff was very helpful with it. Resident #5 was not able to express his need for the catheter. Interview on 12/16/25 at 3:45 PM, CNA I revealed she was aware that Resident #5 required use of a catheter. According to CNA I she was responsible for checking Resident #5's catheter at least every two hours for draining needs, cleanliness and to ensure there were no signs of infection. CNA I stated if she saw anything of concern like unusual urine color, no draining, or signs of infection she would report her findings to the nurse. CNA I stated not following those responsibilities would place Resident #5 at risk of urinary tract infections and perhaps pain. Attempted phone interview on 12/17/25 at 9:55 AM with LVN J was unsuccessful. Interview on 12/17/25 at 10:04 AM, LVN K revealed she could not locate an order for use of the catheter, which should have included the proper gauge to use for replacement. LVN K stated she checked him earlier and she did not have any concerns with his catheter. LVN A stated the admitting nurse was responsible for ensuring the catheter order was entered upon admission. LVN K stated the ADON, and the DON would be responsible for verifying that all orders were entered. LVN K said not having an order for use of the catheter placed Resident #5 at risk of staff using the wrong supplies, and not able to monitor his input and output. Interview on 12/17/25 at 12:20 PM, ADON G revealed she expected nurses to enter all orders upon admission of each resident. ADON G stated she was responsible for checking orders the following business day after admissions, she ensured an order would be entered for catheter use and it included the gauge to use. ADON G stated she had been having issues with entered orders saving due to internet issues; however, she was not sure if that was the reason the orders weren't showing. ADON G stated not having catheter orders placed Resident #5 at risk of not having the right plan of care and the treatment he needed. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/17/25 at 1:14 PM with the DON revealed there should be an order for catheter use and care and it should include the gauge. The DON stated the admitting nurse should have entered the order upon his admission and the ADON should have reviewed the orders within 24 hours to ensure the orders for his care were entered. The DON added upon review the orders were in the queue; however, they had not been approved and needed to be activated. The DON stated the omission placed Resident #5 at risk of inadequate care to the foley (medical device that helps drain urine from the bladder), monitoring, and infections. Record review of the facility's Briefs/Under Pads policy, dated September 2010, reflected: .11. Apply one new appropriate size of brief and/or one under pad. Record review of the facility's Medication and Treatment Orders policy, dated July 2016, reflected: Orders for medications and treatments should be consistent with principles of safe and effective order writing. 1. 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 .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 32 residents (Residents #13 and #98) reviewed for pharmacy services. The facility failed to administer the morning medications on time resulting in Residents #13's hydrocodone scheduled for 2:00 PM not being administered and Resident #98's hydralazine not being administered at 2:00 PM on 12/15/25. This failure could cause residents to develop changes in their medical conditions. Findings included:Record review of Resident #13's quarterly MDS, dated [DATE], reflected Resident #13 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic pain, rotator cuff pain, and Alzheimer's Disease. Her BIMS score was 11, indicating she had moderate cognitive impairment. Her Functional Ability assessment revealed she used a walker and a wheelchair for mobility, and she required moderate assistance with her ADLs. Her Pain Management assessment indicated she received both scheduled pain medications, as well as pain medications when needed or requested. Record review of Resident #13's care plan, dated 11/03/25, reflected she had an ADL self-care deficit related to her Alzheimer's, and she was on pain medications for chronic pain. Record review of Resident #13's physician orders revealed orders, dated 11/07/25, for Hydrocodone-Acetaminophen 10-325 mg, one table three times a day, and Hydrocodone 10-325 mg one tablet every 24 hours as needed. Record review of Resident #13's medication administration record for December 2025 revealed on 12/15/25 the resident did not receive her hydrocodone scheduled for 2:00 PM as evidenced by no documentation of the medication being administered. Record review of Resident #98's quarterly MDS, dated [DATE], revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included high blood pressure, surgical repair of fractures of the left leg and right pelvis, and dementia. His BIMS score was 10, indicating he had moderate cognitive impairment. His Functional Abilities assessment revealed he used a walker and a wheelchair for mobility, and he required substantial assistance with his ADLs. Record review of Resident #98's care plan, dated 11/05/25, reflected he had an ADL self-care deficit related to mobility issues related to his fractures, and high blood pressure with the potential for abnormal blood pressures, impaired vision, headaches and stroke. Record review of Resident #98's physician orders revealed an order, dated 01/31/25 for Hydralazine 50 mg, one tablet three times a day. Record review of Resident #98's December 2025 MAR reflected on 12/15/25 he was not administered his 2:00 PM dose of Hydralazine as evidenced by no documentation of the medication being administered. Record review of Resident #98's vital signs revealed on 12/15/25 his blood pressure was within normal limits with a blood pressure of 122/61. Interview on 12/15/25 at 12:00 PM, LVN-E stated she was still administering the morning medications for the 400 Hall. She stated an Agency Medication Aide had not shown up that morning. The medication aide was supposed to cover [NAME] 200 and 400. She stated an agency nurse, who was working, was pulled off her assignment of the 200 Hall, to administer medications for 200 and 400 Halls. Around 11:30 AM, she stated she realized the morning medications had not been given on the 400 Hall, so she began to administer them. Interview on 12/15/25 at 12:10 PM, ADON-D stated she had been notified around 7:00 AM of the Agency Medication Aide not showing up for work. She stated she spoke with an agency nurse already working on the 200 Hall, pulling her off patient care to pass medications instead for the 200 and 400 Halls. ADON-D stated around 11:30 AM she realized the agency nurse had not made it to the 400 Hall, so she asked the nurse for the 400 Hall to pass the medications instead. ADON-D stated she contacted the physicians about the issue of the morning medications being given late, the physicians stated to not give any medications due in the afternoon, just the morning and evening doses were to be given. ADON-D stated there were other (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses, including herself, who were in the building and could have assisted with medication administration to get the medications administered in a timelier manner. Observation on 12/15/25 at 1:10 PM revealed the last morning medication for the 400 Hall was administered. Interview on 12/16/25 at 10:59 AM, Resident #98 stated he was not aware he did not receive his blood pressure medicine at 2:00 PM on 12/15/25. He denied any headache. Interview on 12/16/25 at 11:04 AM Resident #13 stated she had not received her mid-day pain medication on 12/15/25. She stated she did not know why it was skipped. She stated she had chronic pain and really did not notice any difference in her pain by missing the dose. She rated her pain a 4 out of 10. Interview on 12/16/25 at 11:10 AM the DON stated she was made aware of the situation around 11:45 AM on 12/15/25. She stated ADON-D had coordinated with the staff to cover the morning medication pass. The DON stated there appeared to have been miscommunication with the agency nurse about the expectation she would cover the 200 and 400 Halls, not just the 200 Hall. The DON stated there were other nurses in the building that could have started helping with medications, but she was not made aware of the situation until 11:45 AM. She stated the risk of the residents not receiving their morning medications on time, and not getting their midday medications could be a worsening of medical problems the medications were prescribed for. Record review of the facility's Medication and Treatment Orders policy, dated July 2016, reflected it did not address medications being administered by the frequency ordered, or the timeliness of medication administration.		

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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 observation, interview, and record review the facility failed to ensure food, subject to spoilage and removed from its original container, was kept sealed, labeled, and dated in 1 of 1 kitchen. The facility failed to ensure various foods stored in the kitchen freezer inside the walk-through fridge were sealed, dated and labeled and remove items opened past 7-day time frame. This failure could place all residents at risk for food contamination and food borne illness. Findings included: Observation and interview of the walk-through fridge on 12/15/25 at 9:00 AM with the Dietary Manger revealed a container of red sauce, corn, gravy, and green beans were not labeled identifying the contents and did not have a disposal date. The fridge also had open, exposed diced ham, and sliced turkey in their original packaging that was not sealed and open to air nor did it have a disposal date. The fridge also had link sausage in its original packaging that was open to air and did not have a disposal date. Observation of the freezer inside the walk-through fridge two clear bags of unknown/unlabeled white balls and the bags were not sealed and opened to air. According to the Dietary Manager she had been out of work for a week and returned 12/15/25 and had not completed her daily walk through the kitchen. The Dietary Manager stated the red sauce was enchilada sauce, Mexican Corn, gravy and the green beans were leftovers that could be used throughout the week and would be disposed after the 7th day. The Dietary manager stated the cooks, and all kitchen staff were responsible for properly labeling, dating and removing items for the past 7 days. The Dietary Manager further stated food items should be properly labeled, dated and sealed so that everyone knew what it was, and to prevent items from spoiling or having salmonella. Interview on 12/17/25 at 4:07 PM with the Administrator revealed he was not aware food was found to be opened and not sealed, had missing labels such as contents and open or disposal dates. The Administrator stated the Dietary Manager was responsible for ensuring food was kept in a safe manner to prevent foodborne illnesses. The Administrator stated that not properly sealing, labelling, and dating food items could cause staff to use outdated food items potentially causing an allergy or negative reactions in residents. Review of the facility's Food Storage policy, revised June 1, 2019, reflected: Foods shall be received and stored in a manner that complies with safe food handling practices. Food Services, or other designated staff, should always maintain clean food storage areas. Date, label and tightly seal all refrigerated foods using clean, non-absorbent, covered containers that are approved for food storage. Use all leftovers within 72 hours. Discard items that are over 72 hours old. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to provide in-service training that was sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year and included dementia management training, resident abuse prevention training and care of the cognitively impaired for 2 (CNA G and CNA H) of 5 CNAs reviewed for annual training. The facility failed to provide CNA G and CNA H with 12 hours per year of annual training. This failure could place residents at risk of being cared for by untrained staff. Findings included: Review of CNA G's personnel record revealed a hired date of 10/24/23. The annual training in-service provided by the facility did not include evidence of 12 hours of annual training. Review of CNA H's personnel record revealed a hired date of 02/28/23. The annual training in-service provided by the facility did not include evidence of 12 hours of annual training. Interview on 12/17/25 at 4:27 PM with ADON G who stated inservices with the CNA's were provided by ADON's and DON collectively. ADON G said she was aware all CNA's had to have 12 hours annually, but she was not aware CNA G and CNA H had been short training hours. ADON G said she was unsure who kept up with the number of inservices hours to ensure they were complete, and she said it was important for CNAs to have the proper number of inservices hours, so they were up to date on their care education. Interview on 12/17/25 at 4:33 PM with the DON revealed she and the ADONs provided in person monthly CNA inservices and the company also had a computerized program that sent emails to the aides with certain inservices to complete. The DON said she was not aware CNA G and CNA H did not have their 12 hours of annual inservices and she said it was important for the CNAs to be up to date with their training so they could provide adequate training. Interview on 12/17/25 at 4:44 PM with the Regional Corporate RN revealed the company used a computerized program to keep track of CNA inservices and it appeared the system was corrupted because they could not find the complete 12 hours for CNA G and CNA H. Review of the facility's policy titled In-Service Training Program, Nurse Aide revised 05/2019 reflected the following: All nurse aide personnel participate in regularly scheduled in-service training classes. 3. In-service training is based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews. 4. Annual in-services: are no less than 12 hours per employment year.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 of 5 residents (Resident #54) whose drug regimens were reviewed. The facility failed to clarify Resident #54's orders for KCL (potassium chloride, which is used to treat and prevent low blood potassium levels) and Clonidine (a medication used to treat hypertension) when the facility's Pharmacy Consultant made the recommendation for the change on 09/29/25 when the order was to give the medications by mouth. This failure could place residents receiving medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition. Findings included: Record review of Resident #54's Quarterly MDS Assessment, dated 11/05/25, reflected he was a [AGE] year-old male who was readmitted to the facility on [DATE]. He had a BIMS score of 10 which indicated moderate cognitive impairment. His active diagnoses included hypertension (high blood pressure), stroke (a brain injury that occurred because the brain supply was interrupted), and anxiety disorder (a group of mental health conditions characterized by excessive fear, dread, or apprehension). Resident #54 also used a feeding tube while being a resident at the facility, receiving 51% or more of his total calories through tube feeding. Record review of Resident #54's Order Summary Report, dated 12/17/25, reflected the following:- Nothing By Mouth (NPO) Diet with a start date of 06/09/25- Clonidine HCl Oral Tablet 0.1 MG (Clonidine HCl), Give 0.1 mg by mouth every 8 hours as needed for HBP with a start date of 09/25/25- Potassium Chloride Liquid 20 MEQ/15ML (10%) Give 20 mEq by mouth one time a day for Low Potassium with a start date of 09/05/25 Record review of Resident #54's December 2025 Medication Administration Record reflected he received potassium chloride each day but did not receive any clonidine . Record review of Resident #54's undated Care Plan reflected the following: Focus: The resident requires tube feeding r/t Dysphagia, [sic] esophageal varices/ Record review of Resident #54's Quality Assurance- Nursing Recommendations from the pharmacy, dated 09/29/25, reflected the following: .resident receives medication via PEG tube, order for KCL and Clonidine PRN reads to give by mouth, please clarify. There was a check mark in the next column labeled Follow-through. Observation and interview on 12/15/25 at 10:55 AM with Resident #54 revealed he was lying in bed and his tube feeding machine was off and not connected to him. Resident #54 said he was not feeling well and did not want to talk to the surveyor. Interview on 12/17/25 at 10:55 AM with LVN F revealed she was an agency nurse and this was her first shift at the facility and was not familiar with Resident #54, except that he used a g-tube. LVN D said she could not answer any questions about his medications because she just did not know anything. Interview on 12/17/25 at 11:21 AM with ADON G who said that all pharmacy recommendations were reviewed monthly. ADON G said Resident #54 used a g-tube and could not have anything by mouth, including medications. ADON G said she and the other ADON were responsible for reviewing the pharmacy recommendations and making the necessary changes. ADON G said the purpose of following pharmacy recommendations was to ensure that all orders were correct and if changes needed to be made those were addressed with the doctors. ADON G said she had been trained to review the pharmacy recommendations and make whatever changes needed to be. ADON G said if the pharmacy recommendations were not completed the resident could either miss something, get the wrong medication, or get the wrong dose. Interview on 12/17/25 at 1:11 PM with the DON who said Resident #54 used a g-tube and could not have anything by mouth, including medications. The DON said the ADON's were responsible for following-up on an pharmacy recommendations. The DON said she sometimes spot checks the pharmacy recommendations but not often because she trusted the ADON's to complete them accurately. The DON said the purpose of the pharmacy recommendations was for the accuracy of medications and contraindication for treating disease management. The DON said if pharmacy (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER The Lodge of Saginaw Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations were not acted upon it could be detrimental to the resident, in this case with Resident #54 it could have led to him receiving something by mouth which could lead to aspiration or pneumonia. The DON said both the ADON's have been trained to review and follow-up on any pharmacy recommendations. Record review of the facility's policy, revised April 2007, titled Medication Therapy reflected: 6. The consultant pharmacist shall review each resident's medication regimen monthly, as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected. [BH3]		