| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455477 | A. Building<br>B. Wing | 11/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lake Jackson Healthcare Center | 413 Garland Dr<br>Lake Jackson, TX 77566 |

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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>(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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (CR#1) of 1 resident reviewed for baseline care plans. -CR#1 was admitted on [DATE] and his baseline care plan was not completed until 8/19/2025. This failure could lead to residents not receiving necessary care timely and decreased quality of life. Findings include:Record review of CR#1 admission record dated 8/8/2025 revealed an [AGE] year-old male admitted to the facility on [DATE] at 5:30 pm and was discharged on 8/12/2025. His diagnoses included: Left intertrochanteric femur fracture (left hip fracture), metabolic encephalopathy (refers to change in brain function due to metabolic disturbances in the body), chronic kidney disease 4 with acute kidney injury now with end stage renal disease (gradual kidney damage with a sudden and severe kidney injury requiring dialysis), and diabetes mellitus type 2-insulin dependent (a condition where the body does not use insulin effectively or does not produce enough of the hormone insulin which leads to high blood sugar levels). Record review of CR#1's baseline care plan indicated a start date of 8/19/2025 which was 10 days after CR#1 was admitted to facility. Record review of the CR#1's hospital records indicated resident was diabetic-insulin dependent. admission orders do not reflect a physician order for blood sugar checks, nor any diabetic care. An interview with CR#1's FM on November 24, 2025, at 4:45 pm, he stated he advocated to the charge nurse behind the nurse's station for CR#1 glucose to be checked since he was a diabetic and had been on insulin. He denied the facility ever reaching out to him to review a baseline care plan for CR#1. Record review of nursing notes indicate that CR#1 had two fingerstick blood glucose checks on August 11, 2025, at 6:30 pm and 8:00 pm. At 6:30 pm CR#1 fingerstick blood glucose was 412 and at 8:00 pm it was 337.Record review of nursing notes indicate on August 12, 2025, CR#1 had two fingerstick blood glucose checks at 4:46 am and 7:20 am. At 4:46 his blood glucose was 233 and at 7:20 it was 296.An interview on 11/25/2025 at 12:52 pm with ADON revealed the baseline care plan was completed late by the DON who is no longer employed at the facility as of November 17, 2025. The ADON stated the admitting nurse is responsible for admitting and taking orders for the newly admitted residents. The ADON stated that the admitting nurse contacts the physician on arrival of newly admitted residents to review medications but does not review the resident's diagnoses. The ADON stated that the admitting nurses do not review the resident's discharge packet from the hospital. The ADON stated the administration is the DON and ADON. The ADON stated that CR#1 was admitted on a Saturday when administration was not present. The ADON stated she does not know what transpired that led to CR #1 hospital records not being reviewed and baseline care plan not being created on time. When asked if she thought it was acceptable for a resident to be admitted to the facility and nursing staff was not aware the resident was diabetic and a baseline care plan not being created timely according to regulations, the ADON stated no it is not.Interview with Administrator #1 on 11/26/2025 at 12:36 pm indicated that he does not oversee how nurses perform admissions, care plans, or receive orders for new admissions. He stated that during morning meetings during weekdays, new admissions are discussed. For residents admitted over the weekend, they are discussed the following Monday. He stated that for anything of a clinical nature such as a plan of care, nursing department is responsible for. Interview on 11/26/2025 at 6:30 pm with LVN #1 indicated she was the admitting nurse for CR#1. She stated that she has looked at her admitting note but does not remember the resident. She stated that when she called the provider for orders, she reviewed the medications and diagnoses with the provider. She does not know why the baseline care plan was not created on time. She stated that after she gets orders from the provider, she places the hospital packet that comes with the resident inside a basket by the nurses' station for the ADON or the DON to retrieve. |