STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (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
	455477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr 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 0636 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 conduct a comprehensive assessment, within 14 calendar days after admission, for 2 of 13 residents (Resident #8 and resident #156) reviewed for comprehensive annual assessments and transmitted MDS data to the CMS System. The facility failed to complete Resident #8's admission MDS assessment within 14 days of admission. The facility failed to complete Resident #156's admission MDS assessment within 14 days of admission. This failure could place residents at risk of not having their assessments completed and transmitted timely which could result in a delay in treatment, denial of payment and or resident services. The findings included: Record review of Resident #8's face sheet dated 07/02/25 revealed a -[AGE] year-old male admitted to the facility on [DATE]. Her diagnoses included cerebral palsy, (a group of neurological disorders that appear in infancy and permanently affect body movement and muscle coordination.), abnormalities of gait and mobility, essential hypertension (High blood pressure), gastro-, type 2 diabetes mellitus (adult onset of high blood sugar) history of falling, overactive bladder, retention of urine, and muscle weakness Record review of Resident #48's admission MDS assessment, dated 01/04/25, revealed the signature page indicated it was signed as completed on 01/13/25, 16 days after admission. During an interview with the DON on 07/02/25 at 11:00 AM, the DON said she started working at the facility in January and started signing off on all the MDS. During interview on 07/02/25 5 at 2:40PM, The MDS Coordinator said the MDS was late because there was no RN to sign off on the MDS at the time of completion. She said not completing the MDS in a timely may delay the care plan and service to residents. Resident #156 Record review of Resident #156's admission Record revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and his diagnoses included: other secondary hypertension (high blood pressure caused by an identifiable or known underlying condition), hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormones to meet the body's needs) and overweight. Record review of Resident #156's admission MDS assessment with an ARD date of 6/23/25, revealed Resident had a BIMS score of 13 out of 15 indicating he was cognitively intact and was coded as independent for oral hygiene, dressing and transfers, set-up assistance for eating, toileting and personal hygiene and required supervision for showers/bathing. Section Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion was dated as signed and completed by DON, on 7/1/25, 15 days after Resident #156's admission. Record review of Resident #156's EMR and interview with MDS Coordinator on 7/2/25 at 1:13 pm revealed MDS Summary page for Resident #156's admission MDS with and ARD of 6/23/25 had the following area highlighted in red: MDS Completion 07/01/2025. The MDS Coordinator said the red highlighted date of 07/01/2025 indicated the assessment was late. The MDS Coordinator said they had Resident #156's admission assessment on her MDS calendar to complete, but had an unplanned, unforeseen absence on the date the assessment was due to be completed. The MDS Coordinator said they were the only MDS Coordinator for the facility and there was no one designated to complete MDS assessments in her absence, unless the absence was pre-scheduled such as PTO /vacation. The MDS Coordinator said during the pre-scheduled absences the Regional MDS would find coverage to complete MDS assessments as needed. The MDS Coordinator said the Regional MD did not complete facility MDS assessments and to her knowledge there was no one else designated to complete facility MDS assessments. The MDS Coordinator said late MDS assessments could delay resident care or could lead to a delay in residents' care planning and possibly impact reimbursement. The MDS Coordinator said followed the RAI Manual for MDS completion and that admission assessments should be completed by the 14th day from resident admission. Record review of Facility's provided policy on MDS completion dated 2001with a revision date of December 2010 revealed Policy Interpretation and Implementation; Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes 1 The Assessment Coordinator or designee shall be responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2 The following timeframes will be observed by this facility: Record review of CMS LTC RAI 3.0 User's Manual dated October 2025 revealed in part on page 2-17 Type of Assessment. admission (Comprehensive) Assessment Reference Date (ARD) No Later Than 14th calendar day of the resident's admission (admission date + 13 calendar days) MDS Completion Date (Item Z0500B No Later Than 14th calendar day of the resident's admission (admission date +13 calendar days)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr 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 0657 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 observation, interview and record review, the facility failed to ensure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 20 residents (Resident #41) reviewed for care plans. The facility failed to revise Resident #41's comprehensive care plan to reflect the resident's discontinued catheter use. This failure could place resident at risk of isolation and not receiving needed care and services to improve their health. The findings included: 1. Record review of Resident #41's face sheet dated 07/02/25 revealed a-[AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Essential (primary) hypertension (High blood pressure), major depressive disorder), morbid obesity due to excess calories, retention of urine, type 2 diabetes (A chronic condition characterized by insulin resistance and elevated blood sugar levels). intertrochanteric fracture of left femur, and urinary tract infection, cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die). Record review of Resident #41's comprehensive care plan, revised 04/11/25 revealed she was care plan for catheter as Resident requires Enhanced Barrier Precautions related to urinary catheter Date Initiated: 04/11/2025 Created on: 04/11/2025.Goal: Reduce the potential spread of MDRO. Date Initiated: 04/11/2025 Created on: 04/11/2025Interventions: Apply signage outside resident room. Date Initiated: 04/11/2025 Created on: 04/11/2025 EBP (Enhanced Barrier Precautions) used during high-contact resident care activities as applicable, such as:- Dressing - Bathing/Showering - Transferring - Providing hygiene - Changing linens. Notify MD of any change in conditionDate Initiated: 04/11/2025, Created on: 04/11/2025. Record review of Physician orders dated 04/01/25 indicated there was an order for catheter on 03/31/25 and an order to discontinue the catheter on 04/23/25. Record review of Resident #41's Quarterly MDS dated [DATE] revealed she had a BIMS score of 10 out of 15 which indicated she was moderately impaired on cognition. Review of section H bowel and bladder revealed she was coded for no catheter [] . Sections on bowel and blader, she was coded as always incontinent Observation and interview on 06/30/25 revealed Resident #41was in bed alert and oriented. Attempt was made to have an interview, resident said she was sleeping and left alone. Observation and interview on 07/01/25 at 12:30PM revealed Resident #41 was up on a chair beside her bed. Observation revealed no evidence of catheter. During an interview, she said she had a catheter at appoint but had been removed and she does not have any at present. She said she wanted to use her phone and was left. In an interview with MDS Coordinator on 07/02/25 at 2:00PM she said she was responsible for ensuring that the care plans are updated to reflect resident's conditions. She said the care plan was an oversight, and she would correct the care plan to reflect Resident #41's condition. She said revision of the care plan was the responsibility of the interdisciplinary team and any nurse that was present during the changes. She said Resident #41 would not be affected in any way because the care was not being provided.] Record review of facility's provided policy on care plan dated 10-2022 and revised 06/21/25 revealed Care Plans, Comprehensive Person-Centered. Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care planning process will: Facilitate resident and/or representative involvement. Include an assessment of the resident's strengths and needs; and . Incorporate the president's personal and cultural preferences in developing the goals of care. The comprehensive, person-centered care plan will: Include measurable objectives and timeframes. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; .Assessments of residents are on going and care plans are revised as information about the residents and the residents' conditions change.The Interdisciplinary Team must review and update the care plan: At least quarterly, in conjunction with the required quarterly MDS assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure and provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 for 54 of 54 residents in that: Facility failed to ensure Emergency Narcotic Kit kept in the facility medication room was permanently affixed. This failure could place residents at risk for misappropriation of property, and exploitation related to drug diversion. Findings: Observation and interview with ADON on [DATE] at 10:19 am of facility's only medication room that was key locked and secured, located behind the nursing station desk of B hall/unit. There was a small approximately 10X10X10 bright red metal box with a keypad coded front, which was closed and sealed, located on an upper cabinet shelf. The box had 2 small holes on the back side of the box and a red sticker tag labeled Brazos. Another side of the box had a sticker labeled with Pharmacy A's contact information. The top of the box had a white sticker tag with the number 53 written on it and another white sticker that read Exp 8/25. There was still another laminated white sticker that had a list of 24 narcotic medication names listed as being contained inside the box and a number amount of each. The ADON said she never noticed the 2 small holes on the back side of the box and that the sticker that read Exp 8/25 referred to when the medications inside the box expired. The ADON said the box was changed weekly by Pharmacy A usually on Wednesday's and the number 53 was most likely how the pharmacy numbered the boxes they delivered. The ADON said the list of medications on the top of the box were what was located inside the box and that only licensed nursing staff had keys and access to the medication room. She said in the event emergency-controlled medications were ordered; the charge nurse would have to contact Pharmacy A for a code to access the ordered medication inside the box and sign a narcotic reconciliation sheet which Pharmacy A kept and was included in the facility pharmacy review when used. The ADON said the box would then be replaced by Pharmacy A after any narcotic medication withdrawal on the next medication delivery from Pharmacy A which occurred daily. When asked how she could tell the list of medications on the top of the box were what was actually contained in the box, she said the box can not be opened without a code from Pharmacy A and a triplicate prescription order from a physician and since Pharmacy A has to provide reconciliation count sheet for licensed staff to sign, there had been no reconciliation sheets, the box was sealed closed. The box was removable from the shelf and could be picked up easily and held by hand. The ADON was able to demonstrate holding the box freely in both hands and replaced the box back on the upper shelf. She said to her knowledge there had never been any issue with the box being removed or missing from the medication room and only licensed nursing staff had access to the medication room which automatically locked once entered or exited. The ADON said since she worked at the facility over the last 2 years, there were no drug diversions. She said she would speak with the DON and Corporate Nurse immediately to get the issue resolved because if someone did take the box it was potentially full of a lot of drugs that could have high street resale value. Interview with DON on [DATE] at 10:33 am who said she had only been working at the facility for a brief time and was not aware that the emergency kit narcotic/controlled medication box in the medication room was removable and not permanently affixed. The DON said Pharmacy A replaced the box weekly and prn once used or accessed, and each box had a new number. The DON said the box should be permanently affixed and could see the potential for concern regarding removal of controlled medication E-kit box from the medication room despite at least a double lock system of the lock on medication room door with limited, only authorized staff access, required physician triplicate order and pharmacy provided code to access any medication inside the box. The DON said she would work to fix the issue promptly so nothing like theft of the box could happen. Interview with Administrator on [DATE] at 10:36 am he said he was not aware of the narcotic E-kit medication box in the medication room was not permanently affixed or anchored to the shelving inside the locked medication room or that the box could potentially be picked up and removed. He said he was fixing the issue already and to his knowledge there had been no issues with missing or unreconciled medications or any drug diversions at the facility. Attempted telephone interview with Pharmacy A on [DATE] at 10:44am, 11:18 am, and 2:23pm. Did not receive a return call prior to facility exit. Record review on [DATE] at 10:48 am of white laminated sticker on top of narcotic E-kit box revealed the following: Drug.1. Acetaminophen-Cod #3 Tab.Alternate Name.Tylenol #3.QTY.102. Acetaminophen-Cod #4 Tab. Alternate Name.Tylenol #4.QTY.103. Alprazolam 0.25 MG. Alternate Name.Xanax QTY.104. Clonazepam 0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: - The facility failed to ensure the tabletop can opener blade and base were free of grime and debris.- The facility failed to ensure that the 3-compartment sink with wash-water and sanitizing solution was not used for food preparation.- The facility failed to label, and date left over food items in the refrigerator\freezer.- The facility failed to ensure that dented can goods were stored away from undented can goods. These failures could place residents at risk for food contamination and foodborne illness. Findings included: Observation and interview on 06/30/25 beginning at 8:30 AM revealed the following:-One of one can opener in the kitchen had dark brownish looking substance around the cutting blade and the blade holder. The Dietary Manager took it out for wash.-Observation of one of one Deep fryer revealed it was 3\4 filled dark looking grease and whitish floating substances on top of the grease. The Dietary Manager said the grease was changed last week Thursday /06/26/25 and the facility had fish fry. She said she it was due to be changed.-Observation of the 3-compartment sink in the kitchen revealed the first sink from the right had 3\4 filled with soapy water, the last sink had chemical sanitizing water about 3\4 filled, and the middle sink had 3-5lbs packs of frozen diced chicken in a standing water (this was identified by the dietary Manager) She said the night shift was supposed to defrost the meat overnight ready for the morning but did not and the chicken was being defrost. She said the chicken was supposed to be defrost in a running water. Next to the chicken was a second container of water in it was 32oz of lactose free milk. -Observation the walk-in freezer revealed an unlabeled plastic container of bell as bell papers. A container of assorted cold cuts meat all together in a container unlabeled and undated the Dietary Manager said that the meat was for sandwiches. -Observation of the dry good storage revealed a dented can of 48 oz of chicken and dumpling and a dented can of 14oz can of beans. During an interview with the Dietary Manager on 06/30/25 at 9:15AM, she said there used to be a separate sink for food preparation but was taken out and the only place the had to prepare food was the 3 compartment sinks. She acknowledged that the 3-compartment sink was not safe for food preparation due to cross contamination and all frozen meat product should be defrosted in running water to prevent bacteria growth.She said preparing food in an unsanitary condition may lead food born illness. She said she would have an in-service with all dietary staff. During an interview with the Facility Administrator on 07/01/25 at 9:00AM, he said he expect the kitchen to always be clean. He said there was a food preparation area before his time and for some reason the sink and area was broken down to create more space in the kitchen and the new owner had a plan to build a food preparation area in the near future. He said preparing food in an unclean environment may lead to contamination and food born illness Record review of Facility's policy dated October 2022 reveal in part- Policy Interpretation and ImplementationFood Receiving and Storage. Policy StatementFoods shall be received and stored in a manner that complies with safe food handling practices. 1. Food Services, or other designated staff, will maintain clean food storage areas at all times.8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).All food items to be kept below 41 F must be placed in the refrigerator located at the nurses' station and labeled with a use by date.3 weeks in as the Dietary Manager. The DM said it was the responsibility of all staff to keep the kitchen clean.