

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: 455490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER The Lakes at Texas City		STREET ADDRESS, CITY, STATE, ZIP CODE 424 N Tarpey Rd Texas City, TX 77591	
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level 1 assessment accurately reflected the resident's status for 2 (Residents #2 & #48) of 6 residents reviewed for PASRR Level 1 screenings. Findings included: Review of Resident #2's face sheet, dated 12 /02/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Cerebral infraction- (Lack of blood to certain parts of the brain) Schizoaffective disorder, Essential hypertension (High blood Pressure), depression, generalized anxiety disorder, restlessness and agitation. Record review of Resident #2's PASRR Level 1 Screening completed on 07/03/24 revealed the section on mental illness was checked as 0 which indicated Resident #2 did not have any mental illness. Record review of Resident #2's annual MDS assessment dated [DATE] indicated her BIMS score was 11 out of 15 which indicated she was moderate on cognition. Record review of Resident #2's clinical record revealed no evidence of a PASRR level 2 evaluation. Resident #48 Record review of Resident #48's face sheet dated 12/03/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses of Undifferentiated Schizophrenia (hallucinations, delusions, disorganized thinking), bipolar disorder (extreme shifts in mood, hopelessness and manic highs), Major Depression, Hemiplegia (complete paralysis of one side of the body) and Hemiparesis (weakness on one side of the body) following Cerebral Infraction (stroke), Bradycardia (slow heart rate), and Cognitive Communication(mental processes- like attention, memory etc). Record review of Resident #48's annual MDS assessment, dated 9/23/25, revealed the BIMS score was six out of fifteen, indicating she had significant cognitive impairment. Record review of Resident #48's PASRR Level 1 screening completed on 11/05/2024 revealed the section on mental illness was checked 0 (zero) which indicated Resident #48 did not have any mental illness. Record review of Resident #48's clinical record revealed no evidence of a PASRR Level 2 evaluation. During an interview with the DON on 12/03/25 at 2:40PM she said the MDS staff was responsible for completing all PASRR related evaluations. In an interview on 12/04/25 at 10:00AM The MDS Coordinator said she was not present at the facility during the time of Resident #2's admission and assessment. She said she would go over the resident's diagnoses and would review all admitting paperwork to ensure that her assessment accurately reflected the resident's condition. She said if the PASRR was inaccurately coded she would complete a new 1012 form which was the Mental illness\Dementia Resident Review and upload that form into a program called SIMPLE which would alert the PASRR program to schedule an evaluation. She said she would complete a 1012 form for all identified residents Review of the Texas Health and Human Services Detailed Item by Item Guide for Local Authorities and Nursing Facilities to Complete the PASRR Level 1 Screening Form, revised June 2023, and accessed at PASRR Forms and Instructions Texas Health and Human Services reflected in part, The PASRR Level I (PL1) Screening Form is designed to identify individuals who are suspected of having mental illness (MI), intellectual disability (ID) or a developmental disability (DD). Developmental disabilities are also referred to as related conditions.If documentation entered on the PL1 Screening Form indicates a suspicion of MI, ID, or DD, a PASRR Evaluation (PE) must be completed to confirm PASRR eligibility. The PE is (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	designed to confirm the suspicion of MI, ID or DD and ensure an individual is placed in the most integrated residential setting receiving the specialized services needed to improve and maintain an individual's level of functioning.Examples of MI diagnoses are: Schizophrenia Mood Disorder (Bipolar Disorder, Major Depressive Disorder, or other mood disorder) Paranoid Disorder, Severe Anxiety Disorder, Schizoaffective Disorder, Post-Traumatic Stress Syndrome, What is not considered an MI: Neurocognitive Disorders, such as Alzheimer's disease, other types of dementia, Parkinson's disease, and Huntington's. (DSM-5*), Depression, unless diagnosed as Major Depression; and Anxiety, unless diagnosed as severe anxiety disorder.Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure services provided by the facility as outlined in the comprehensive care plan met professional standards of quality for one resident (Resident # 10) observed for hand rolls for contracture management. --facility failed to ensure handrolls were placed for Resident #10 for contracture management by following physician orders. This failure could place residents at risk of not receiving care according to physician orders. Record review of Resident #10's face sheet revealed admission date 12/8/23 with diagnoses including Hypoxic Ischemic Encephalopathy (brain injury caused by interruption in blood flow to the brain), tracheostomy (opening into the windpipe to establish an airway), hypertension (high blood pressure), respiratory failure (not enough oxygen or too much carbon dioxide in the body), tachycardia (fast heart rate), stiffness of joint, anoxic brain damage (brain is completely deprived of oxygen and blood flow), cardiac arrest (heart stops beating, cutting off blood flow to brain and body), dysphagia (difficulty swallowing). Record review of Resident #10's care plan, initiated 12/12/23, revised 9/11/24, revealed ADL self-care performance deficit in all ADLs; therapy to screen, evaluate, and treat as needed. Record review of Resident #10s Annual MDS revealed dependent on staff for all ADLs, impairment on both sides, always incontinent, feeding tube while a resident, oxygen therapy, suctioning, tracheostomy care while a resident, respiratory therapy 7 days, splint/brace assistance 0 days. Record review of Resident #10s baseline care plan dated 12/8/23 revealed total dependence on staff for ADLs, incontinent, tracheostomy, oxygen, and enteral feedings. Record review of physicians' orders dated 11/4/25 revealed OT to address BUE hand rolls for contracture management 6 hours or as tolerated 5 days a week. Record review of Occupational Therapy evaluation and plan of treatment, certification period 10/13/25 - 11/12/25 revealed: patient will tolerate BUE hand roll splints for 3 - 5 hours for contracture management. Recommendation was for splint/orthotic: hand rolls BUE. Observations of Resident #10 on 12/1/25 at 11:55am, 12/2/25 at 9:45am and 12/3/25 at 9:30am revealed she was in bed, sleeping, with tracheostomy, feeding tube infusing Jevity 1.5 at 55ml/hr., oxygen concentrator at bedside and suction machine on bedside table. Resident #10s hands were contracted, and there were no hand rolls present for contracture management. Interview with LVN A on 12/3/25 at 9:30am revealed the Restorative aide puts the hand rolls in Resident #10s hands and removes them. Interview with Occupational Therapist on 12/3/25 at 9:40 am revealed she would put the handrolls in Resident #10's hands when she came in to work around 8am in the morning and removed them when she left for the day around 3pm. Interview with Rehab Director A on 12/3/25 at 9:45am revealed resident #10 was on therapy services until 11/12/25, and OT placed the hand rolls in her hands when they came to work and removed them when they left for the day. She said when her therapy service was discontinued 11/12/25, the nurses were supposed to put the hand rolls in her hands for at least 6 hours daily. Interview with ADON on 12/3/25 at 9:50am revealed she said she would write an order for the nurses to place the hand rolls for Resident #10. She looked in all the drawers and cabinets in resident #10s room and did not find any hand rolls but obtained 2 washcloths from the Laundry to use as hand rolls and would have therapy roll them for use with Resident #10. Interview with DON on 12/4/25 at 8:40am revealed she was aware of the issue with hand rolls for Resident #10. She said when Resident #10 was on therapy service, hand rolls were placed by therapy, but when therapy was discontinued, the order went away. She further said, as of yesterday, she now has an order for hand rolls up to 12 hours daily, placed by the nurses, and nurses remove them and assess her hands for any skin breakdown. She said the previous order was for 6 hours a day because therapy placed them on and removed them, since therapy staff were not here all day. Since the nurses are here 24 hours a day, they can place them and remove them. Record review of facility policy Following Physician Orders, dated 9/28/2001, revealed, in part, .carry out and implement physician orders.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one (Resident #10) of 5 residents reviewed for range of motion. The facility failed to ensure handrolls were placed for Resident #10 for contracture management. This failure placed resident at risk of impaired skin integrity, further decline and decrease in quality of life and quality of care. Record review of Resident #10's face sheet revealed admission date 12/8/23 with diagnoses including Hypoxic Ischemic Encephalopathy (brain injury caused by interruption in blood flow to the brain), tracheostomy (opening into the windpipe to establish an airway), hypertension (high blood pressure), respiratory failure (not enough oxygen or too much carbon dioxide in the body), tachycardia (fast heart rate), stiffness of joint, anoxic brain damage (brain is completely deprived of oxygen and blood flow), cardiac arrest (heart stops beating, cutting off blood flow to brain and body), dysphagia (difficulty swallowing). Record review of Resident #10's Annual MDS dated [DATE] revealed dependent on staff for all ADLs, had impairment on both sides and had splint/brace assistance 0 days. Record review of Resident #10's baseline care plan dated 12/8/23 revealed total dependence on staff for all ADLs. Record review of Resident #10's care plan, initiated 12/12/23, revised 9/11/24, revealed ADL self-care performance deficit in all ADLs; therapy to screen, evaluate, and treat as needed. Record review of the physician's orders dated 11/4/25 revealed OT to address BUE hand rolls for contracture management 6 hours or as tolerated 5 days a week. Record review of the Occupational Therapy evaluation and plan of treatment, certification period 10/13/25 - 11/12/25 revealed: patient will tolerate BUE hand roll splints for 3 - 5 hours for contracture management. Recommendation was for splint/orthotic: hand rolls BUE. Observations of Resident #10 on 12/1/25 at 11:15am, 12/2/25 at 9:45am and 12/3/25 at 9:30am revealed she was in bed, sleeping. Resident #10's hands were contracted, and there were no hand rolls present. Interview with LVN A on 12/3/25 at 9:30am revealed restorative aides would put the hand rolls in Resident #10's hands and removed them. Interview with the Occupational Therapist on 12/3/25 at 9:40 am revealed she would put the handrolls in Resident #10's hands when she came in to work in the morning around 8am and removed them when she left for the day around 4pm. Interview with Rehab Director A on 12/3/25 at 9:45am revealed Resident #10 was on therapy services until 11/12/25, and OT placed the hand rolls in her hands when they came to work and removed them when they left for the day. She said when her therapy service was discontinued on 11/12/25, the nurses were supposed to put the hand rolls in her hands for at least 6 hours daily. Interview and observation with the ADON on 12/3/25 at 9:50am revealed she said she would write an order for the nurses to place the hand rolls for Resident #10. She looked in all the drawers and cabinets in Resident #10's room and did not find any hand rolls but obtained 2 washcloths from the laundry to use as hand rolls and would have therapy roll them for use with Resident #10. Interview with the DON on 12/4/25 at 8:40am revealed she was told of the issue with the hand rolls for Resident #10. She said when Resident #10 was on therapy services, hand rolls were placed by therapy, but when therapy was discontinued, the order went away. She further said as of yesterday, she now had an order for hand rolls up to 12 hours, placed by the nurses, and nurses removed them and assessed Resident #10's hands for any skin breakdown. She said the previous order was for 6 hours a day because therapy placed them on and removed them since therapy staff were not at the facility all day. The DON stated since the nurses were here 24 hours, they could place them and remove them. Record review of facility policy Following Physician Orders, dated 9/28/2001, revealed, in part, .carry out and implement physician orders.		

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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 observation, interview 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 1 of 1 medication rooms. The facility failed to ensure expired medications were removed from all medication fridges. This failure could place residents at risk of receiving medications that are not at their intended potency and potential adverse reactions or side effects. Findings included: Record review of Resident #46's face sheet dated 12/2/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Muscular Dystrophy, Unspecified (disease that causes progressive weakness and degeneration of the skeletal muscles). Record review of Resident #46's quarterly MDS dated [DATE], section C revealed a BIMS score of 15 that indicated cognition was intact. Record review of Resident #46's Order Summary Report with active orders as of 12/2/25 revealed no current active orders for Acetylcysteine. Record review of Resident #46's April 2025 MAR revealed the last Acetylcysteine administration documentation for shortness of breath as needed was on 4/21/2025 at 6 p.m. Record Review of In-Service Program Attendance Record dated 12/2/2025 revealed topics including checking for expired drugs on cart and fridge daily, insulin syringes and bottles must be dated at the time they are taken out of the fridge, nurses must discard medication as directed on the bottle or syringe not by the expiration date, and a resident's name must be written on insulin pen and dated if taken from the E-KIT. Observation on 12/2/25 at 10:23 a.m. of the Station 1 Medication Room revealed one Acetylcysteine 20% Solution 30 ml bottle for Resident #46 that had an open date of 1/31/25 written on the label. There was a note on the Acetylcysteine label that said, Good for 96 hours. During interview on 12/2/25 at 10:23 a.m., the ADON said Resident #46 was not taking the Acetylcysteine anymore and he always refused to take the Acetylcysteine and took it only as needed. The ADON said she would dispose of the Acetylcysteine. The ADON said an effect it could have on residents regarding expired medications in the medication refrigerator was that it could be a medication error. The ADON said the nurses were supposed to check the medication refrigerator every day and the ADON said she also checked the medication fridge. During interview on 12/3/25 at 11:40 a.m., the DON said expired medication would not give the full effect of the medication because it may not have been as potent. The DON said the charge nurse and medication aides, whoever administered the medication checked the medication fridges for the medications they were giving. The DON said once a month the pharmacist checked the medication carts and medication fridges for expired medications. The DON said the ADON oversaw that the nurses and medication aides had checked the medication fridges for expired medications. During interview on 12/4/2025 at 8:40 a.m., the Consultant Pharmacist said she had been going to the facility for about three years and came to the facility once a month. The Consultant Pharmacist said she did not notice the Acetylcysteine in the medication refrigerator, or she would have notified the facility. The Consultant Pharmacist said Acetylcysteine was only good for 96 hours once it is opened. The Consultant Pharmacist said the efficacy of the Acetylcysteine would decrease but would not hurt the resident if administered. The Consultant Pharmacist said she checked one medication room, and she did spot checks when she checked the refrigerator. The Consultant Pharmacist said she did teachings based on what she saw when she was at the facility. Record review of the facility's policy Medication Storage with date implemented 1/20/2021 revealed medications rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication carts observed. The facility failed to ensure all insulins were labeled with a resident name and an open date. This failure could place residents at risk of receiving medications that were not ordered for them, receiving medications that are not at their intended potency, and potential adverse reactions or side effects. Findings included: Resident #22 Record review of Resident #22's face sheet dated 12/2/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (high blood sugar) without Complications. Record review of Resident #22's quarterly MDS dated [DATE], section C revealed a BIMS score of 15 that indicated cognition was intact. Section N revealed insulin injections were received four of the last 7 days prior the MDS completion. Record review of Resident #22's Order Summary Report with active orders as of 12/2/25 revealed orders for Tresiba FlexTouch Subcutaneous Solution Pen injector (Insulin Degludec) with instructions to inject 20 units subcutaneously (under the skin) in the morning with start date of 3/1/24. Resident #43 Record review of Resident #43's face sheet dated 12/2/25, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (stroke), Unspecified and Type 2 Diabetes Mellitus (high blood sugar) without Complications. Record review of Resident #43's quarterly MDS dated [DATE], section C revealed a BIMS score of 3 that indicated severe cognitive impairment. Section N revealed insulin injections were received 7 of the last 7 days prior the MDS completion. Record review of Resident #43's Order Summary Report with active orders as of 12/2/25 revealed orders for Insulin Aspart and Protamine and Aspart Flex Pen 70/30 with sliding scale orders with start date of 2/1/25. Resident #50 Record review of Resident #50's face sheet dated 12/2/25, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Unspecified Asthma (chronic lung disease that causes difficulty breathing) with Status Asthmaticus (severe and potentially life-threatening asthma attack) and Type 2 Diabetes Mellitus (high blood sugar) without Complications. Record review of Resident #50's admission MDS dated [DATE], section C revealed a BIMS score of 15 that indicated cognition was intact. Record review of Resident #43's Order Summary Report with active orders as of 12/2/25 revealed orders for Insulin Glargine Solostar Subcutaneous Solution Pen injector with instructions to inject 6 units subcutaneously (under the skin) every 12 hours with start date of 11/24/25. Resident #43 also had order for Insulin Lispro Pen injector with instructions per sliding scale with start date of 11/24/25. Resident #66 Record review of Resident #66's face sheet dated 12/2/25, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia (high blood sugar). Record review of Resident #66's quarterly MDS dated [DATE], section C revealed a BIMS score of 13 that indicated cognition was intact (13-15). Record review of Resident #66's Order Summary Report with active orders as of 12/2/25 revealed Insulin Glargine Solution with instructions to inject 10 units subcutaneously (under the skin) at bedtime with start date of 10/24/25. Resident #43 also had orders for Novolog Solution (Insulin Aspart) with instructions to inject 5 unit subcutaneously (under the skin) with meals for diabetes and to hold for blood sugar less than 200 with start date of 9/4/25. Record Review of In-Service Program Attendance Record dated 12/2/2025 revealed topics including checking for expired drugs on cart and fridge daily, insulin syringes and bottles must be dated at the time they are taken out of the fridge, nurses must discard medication as directed on the bottle or syringe not by the expiration date, and a resident's name must be written on (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin pen and dated if taken from the E-KIT. Observation of Station 2 nurse medication cart on 12/2/25 at 10:44 a.m. revealed one Insulin Aspart Flex Pen had an open date of 10/30/25 and no resident name. The following insulins were found with no open date documented: one vial of Lantus 100 u/ml and two Humalog KwikPens for Resident #50; one vial of Insulin Glargine 100 u/ml and two Insulin Aspart FlexPens for Resident #66; one Insulin Degludec Flex Touch pen for Resident #22; and one Insulin Aspart Protamine and insulin Aspart 70/30 mix Flex Touch pen for Resident #43. During interview on 12/2/25 at 11:04 a.m., LVN A said insulins were supposed to be documented with an open date as soon as they were opened. LVN A said the insulins from the Station 2 Nurse medication cart that did not have an open date documented were administered by the night nurse, but she should have checked them as well. LVN A said Resident #66's blood sugars had been running low, so she had not been getting insulin. LVN A said an effect it could have on the residents if the insulins did not have an open date was that it could be bad because the insulins could be old if they had been out too long. LVN A said she would have to get new insulins and would throw out of all the unlabeled and undated insulins. LVN A said they had in-services on everything but could not remember the last time there was an in-service on insulin. During interview on 12/3/25 at 11:40 a.m., the DON said expired medication would not give the full effect of the medication because it may not have been as potent. The DON said the charge nurse and medication aides, whoever administered the medication checked their carts for expired medications for the medications they were giving. The DON said once a month the pharmacist checked the medication carts for expired medications. The DON said the ADON oversaw that the nurses and medication aides had checked the medication carts for expired medications. The DON said if no name was on the medication, then it could be given to the wrong person and if the medication was expired then the medication could be less effect for treating their diabetes. The DON said the nurses were responsible for checking that insulins were labeled with resident names and open dates and the ADON was responsible for overseeing this was done. During interview on 12/3/25 at 2:12 p.m., the ADON said the nurse who pulled the insulin out of the fridge was responsible for making sure the insulin was labeled with the resident's name and with the open date. The ADON said the insulin was good for 28 days when it came out of the fridge. The ADON said if insulin was not labeled with a resident name or open date it could make a medication error as it could cause harm. The ADON said she checked the medication carts for expired medications, discontinued medications, and dates for medications when they were opened. The ADON said she checked the medication carts once a week or biweekly. The ADON said when she had seen insulins on the medication carts that did not have resident labels or open dates she educated the nurse. The ADON said the pharmacist also checked the medication carts and they come every month. During interview on 12/4/2025 at 8:40 a.m., the Consultant Pharmacist said she had been going to the facility for about three years and came to the facility once a month. The Consultant Pharmacist said insulin should be stored in the refrigerator until it is opened. The Consultant Pharmacist said the insulins should be dated when they were pulled out of the refrigerator. The Consultant Pharmacist said if insulin was not labeled with the resident name, then the wrong resident could get the wrong insulin or the resident could not be getting what they were supposed to be getting. The Consultant Pharmacist said insulin could be out of the refrigerator for 90 days and be fine but if the insulin is out long enough then the insulin might not be as effective. The Consultant Pharmacist said all insulins should have a resident's name. The Consultant Pharmacist said she picked two medication carts random to check during her visits. The Consultant Pharmacist said when she checked the medication carts she checked for expired medications, that medications have open dates and that medications were labeled. The Consultant Pharmacist said she did teachings based on what she saw when she was at the facility. Record review of the facility's policy Insulin Pen Administration reviewed 2/10/2020 revealed insulin pens should be assigned to one patient and labeled appropriately. Record review of the facility's policy Medication Storage with date implemented 1/20/2021 revealed medication carts are routine inspected for discontinued, outdated, defective, or deteriorated medications.		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observations and interviews, the facility failed to ensure each bed had ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains for 4 rooms (Room D1, D5, D6, & D9) of 7 rooms reviewed for privacy. The facility failed to provide full privacy for residents in rooms (D1, D5, D6, & D9) These failures could place residents in these room at risk of being expose, embarrassed and loss of dignity. Findings included: Room D1 Observation and interview on 12/01/25 at 11:40AM, revealed Room D1 occupied by 2 residents and had no full visual privacy curtains. Observation revealed both residents were not interview able the privacy curtain was on the rail between A & B bed. An attempt was made to ensure that the privacy around the bed but would extend to cover residents on both residents Observation indicated the resident in A bed was sleeping and did not answer any question. The resident in B bed asked if this was an investigation. He said he would not answer questions. Room D5 Observation and attempted interview on 12/01/25 at 11:50AM, revealed Room D5 was occupied by 2 residents and had no full visual privacy curtain. Observation revealed the privacy visual cotton was by the A bed. AN attempt to pull the privacy curtain ended halfway at A bed exposing A bed. An attempt was made to have an interview with both residents. The resident in B bed was not interview able. He answered questions by moving his head up and down. The resident in A bed looked and smiled without speaking. Room D6 Observation on 12/01/2024 and attempted interview on 12/01/25 at 11:50AM, revealed Room D6 was occupied by 2 residents and had no full visual privacy curtain. Observation revealed the privacy visual curtain was by A bed. An attempt to pull the privacy curtain across the bed failed. The privacy curtain was half and would only go halfway on the rail and was at the foot of the bed. Observation indicated both residents were out of the room. Room D 9 Observation on 12/01/25 at 1:140PM, revealed Room D9 was occupied by 2 residents and had no full visual privacy curtain. Observation revealed the visual privacy curtain was between the A & B beds, was half and could only cover part of the B bed. Both residents were out of their room. During an interview and observation on 12/02/25 at 10:00PM revealed CNA S and CNA T pulled the privacy curtain in room D9. CNA T said she did not notice the curtain. She said she usually closed the door during patient care and did not pay any attention to the curtains because people always knocked on the door and would not come in. CNA S did not answer if residents in B Bed open the door. Interview on 12/02/25 at 11:30 AM with LVN H revealed residents needed their privacy for dignity reasons. The curtain provided them with a sense of having their own space. She said she had not paid any attention to the privacy curtains. Interview on 12/02/25 at 1:43 AM with CNA I revealed she had not noticed the privacy curtains, She said she usually closed the door. Interview on 12/0225 at 3:00Pm, the Administrator said all residents should have their privacy curtains for their dignity. She stated she would have asked the Maintenance Director to ensure that all rooms were inspected for full visual privacy curtains. She said all staff need education on residents' privacy and ensuring that all privacy curtains go round the bed to provide privacy and dignity. A policy on residents' privacy and dignity was requested on 12/02/25 from the facility. Interview on 12/03/25 at 10:00am, the facility Administrator said the facility did not have policy specific to privacy curtains.		

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NAME OF PROVIDER OR SUPPLIER The Lakes at Texas City		STREET ADDRESS, CITY, STATE, ZIP CODE 424 N Tarpey Rd Texas City, TX 77591	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for 3 of 18 residents (Resident #7, Resident #20 and Resident #22) reviewed for accurate assessments. Residents #7, #20 #22 were inaccurately coded on their MDS assessment. These failures could place residents at risk of not receiving care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Resident #7 Record review of Resident #7's face sheet dated 12/03/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), heart disease, essential (primary) hypertension (High blood), type 2 diabetes mellitus with diabetic neuropath (nerve damage that can happen with diabetes) arthritis (inflammation of the joints), pain, anxiety and major depressive disorder, bipolar disorder and major depressive disorder. Record review of Resident #7's Annual MDS assessment dated [DATE] revealed he had a BIMS score of 15 which indicated intact cognition. The section on nutritional approaches was coded as receiving a mechanically altered diet. The section on oral/dental status, revealed he was coded as 0 which indicated no problem (all natural teeth intact). Record review of Resident #7's care plan dated 09/01/2019 revised 12/03/25 indicated Resident #7 was care planned on his oral cavity as edentulous which indicated no natural teeth. Observation and interview on 12/01/2025 at 2:00PM, revealed Resident #7 was in bed alert and oriented. Observation indicated had no teeth in his oral cavity. During an interview he said he had full dentures and they were somewhere in his nightstand. He said he did not use the dentures because they didn't fit and he did not care too much about his dentures. He said he ate what he could and left what he could not eat. Resident #20 Record review of Resident #20's face sheet dated 12/02/25 revealed [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included chronic obstructive pulmonary disease, heart disease, essential (primary) hypertension (High blood), type 2 diabetes mellitus with diabetic neuropath (nerve damage that can happen with diabetes) arthritis (inflammation of the joints), anxiety and major depressive disorder, cognitive communication deficit (difficulty in communication), and abnormalities of gait and mobility. Record review of Resident #20's Annual MDS assessment dated [DATE] indicated she had a BIMS score of 15 which indicated that she was cognitively intact. The section on nutritional approaches, revealed she was coded as receiving a mechanically altered diet. The section on oral/dental status, revealed she was coded as 0 which indicated no problem (all natural teeth intact). Record review of Resident #20's care plan dated 01/14/19 with revision date of 09/10/2024 and target date of 10/10/25 revealed Resident #20 had likely carious, and missing teeth which placed her at risk for pain and infection. Date Initiated: 01/14/2019 Revision on: 11/15/2019. Observation and interview on 12/03/25 at 2:10PM, revealed she was served mechanical altered diet. During an interview, Resident #20 said she had no natural teeth and no dentures. She said she was alright with her oral cavity. She said she could eat what she wanted and left what she did not want. Resident #22 Record review of Resident #22's face sheet dated 12/2/25, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (high blood sugar) without Complications, Heart diseases, generalized anxiety disorder, hepatitis C and chronic pain. Record review of Resident #22's Annual MDS assessment dated [DATE] indicated he had a BIMS score of 14 which indicated that he was cognitively intact. The section on nutritional approaches, revealed he was coded as receiving a mechanically altered diet. The section on oral/dental status, revealed she was coded as 0 which indicated no problem with her oral cavity (all natural teeth intact). Record review of Resident #22's care plan dated 04/01/22 revised 09/25/24 with a target date of 10/20/25 revealed Resident #22 was care planned for weight gain - Resident #22 has unplanned/unexpected weight gain. Date Initiated: 04/01/2022, Revision on: 04/01/2022. Goal-Resident #22 will not develop complications (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from weight gain such as skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through the next review date. Date Initiated: 04/01/2022, Revision on: 09/25/2024, Target Date: 10/20/2025. During an interview with the MDS Coordinator on 12/03/25 at 3:00PM, she said she started working at the facility about 3 weeks ago. She said all MDS assessments should reflect the resident's condition and status. She said inaccurate assessment may prevent a resident from receiving needed services and care to manage their health. During an interview with the DON and ADON on 12/04/25 at 2:50PM, the DON said residents' assessment should reflect the resident's condition and an inaccurate assessment may delay services. She said her expectation was to ensure that residents were assessed accurately. Record review of Policy on MDS assessment dated [DATE] updated 01/10/21 revealed -Anticipated Outcome -Residents are assessed, using a comprehensive process, in order to identify care needs and to develop an interdisciplinary [NAME] plan		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one of (Resident #22) 18 residents reviewed for comprehensive care plan. The facility failed to review and revise Resident #22's comprehensive person-centered care plan to accurately reflect his weight loss. This failure could affect residents and place them at risk of not receiving appropriate interventions to meet their current needs. Findings Included Record review of Resident #22's face sheet dated 12/2/25, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (high blood sugar) without Complications, Heart diseases, generalized anxiety disorder, hepatitis C and chronic pain. Record review of Resident #22's Annual MDS assessment dated [DATE] indicated he had a BIMS score of 14 which indicated that he was cognitively intact. The section on nutritional approaches, he was coded as receiving a mechanically altered diet. The section on oral/dental status, she was coded as 0 which indicated no problem (all natural teeth intact). Record review of Resident #22's care plan dated 04/01/22 revised 09/25/24 with a target date of 10/20/25 revealed he was planned for weight gain [Resident #22] has unplanned/unexpected weight gain. Date Initiated: 04/01/2022, Revision on: 04/01/2022. Goal-Resident #22 will not develop complications from weight gain such as skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through the next review date. Date Initiated: 04/01/2022, Revision on: 09/25/2024, Target Date: 10/20/2025. Intervention: RD to evaluate and make diet/supplement change recommendations PRN. Provide diet counseling. Date Initiated: 04/01/2022 Monitor and record food intake at each meal. Date Initiated: 04/01/2022 Revision on: 11/12/2024 Monitor report to MD PRN situations leading to increased food consumption, reasons for weight gain, significant wt. changes. Date Initiated: 04/01/2022 Notify MD if: Increasing shortness of breath; escalating edema; increased anxiety; inability to lie flat; change in baseline level of orientation/alertness. Record review of Resident #22's RD assessment dated [DATE] Revealed Hx inadequate oral intake that has improved r/t effects of cancer/cancer chemo tx as evidenced by inconsistent intake. some meals, hx altered taste/taste changes, hx significant wt loss x90-180 days w/ stabilized wt. x30-45 days. Risk for malnutrition, further unplanned wt loss &/or hydration deficit due to effects of cancer & chemo tx. Observation on 12/01/25 at 8:50AM revealed Resident #22 was in bed; he was alert and oriented. In an interview, he said he was not doing well. He said he felt weak and just wanted to sleep. Observation and interview on 12/01/25 at 1:40PM, was observed sitting up in bed. He said he did not eat lunch. He said he was not hungry. He pointed to his snacks and said he would drink his liquid protein and some snacks. Observation and interview on 12/02/25 at 8:30AM revealed Resident #22 had his breakfast and eat 80% of served meal. Observation indicated he had two teeth in his oral cavity. He said he used to have partial dentures, but he no longer had them for a while, and he are what he could when he was hungry. He said he was aware of his weight loss. He said his weight loss was due to his chemotherapy treatment for his cancer. He explained that he took chemo treatment once a month. He said the chemo usually took away his appetite till it was time for the next treatment. He said he had nutritional supplements. During an interview with the MDS Coordinator on 12/03/25 at 3:00PM, she said she started working at the facility about 3 weeks ago. She said she would start reviewing the residents' care plans and make changes as needed. During an interview with the DON and ADON on 12/04/25 at 2:50PM, the DON said care plan revisions and updates were the responsibility of the interdisciplinary team and the acute care plan could be updated by any nurse. She said the care plan should be updated to reflect the resident's condition for better quality of care (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and services. She said not updating the care plan may prevent residents from receiving necessary care and services needed to improve their quality of life. Record review of Facility's provided policy dated 2021 with a revision date of revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.1. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:a. The attending physician.b. A nurse with knowledge of the resident.c. A member of the food and nutrition services staff.d. The resident and the resident's representative, to the extent practicable.e. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: 1. The RAI Coordinator.11. Activities Director/Staff.111. Social Services Director/Social Worker. 1v. Licensed therapists. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.7.The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.		