

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Lake Forest Village by Purehealth		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 Montecito Dr Denton, TX 76210	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility failed to accommodate Resident #1's needs when they did not ensure her call light was within reach for her to call for assistance. This failure could place residents at risk of not having access to receive necessary assistance, which could affect their dignity and well-being. Findings include: Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (partial weakness and paralysis on left side due to stroke), aphasia (a communication disorder affecting speech due to brain injury), dysphasia (swallowing disorder), anoxic brain damage (brain damage due to lack of oxygen), chronic pain (long-standing pain), anxiety disorder (excessive fear or worry), and major depressive disorder (mood disorder characterized by intense sadness). Record review of Resident 1's significant change MDS assessment, dated [DATE], reflected the resident's BIMS score was 14, which indicated intact cognition. Section GG-Functional Abilities reflected Resident #1 required maximal assistance with most ADLs. Section I-Active Diagnoses reflected Resident #1 had hemiplegia or hemiparesis (weakness or paralysis). Record review of Resident 1's care plan, dated [DATE], reflected the resident had an ADL self-care performance deficit r/t paraplegic (impairment of motor or sensory function in lower extremities), post CVA affecting left side. Regarding bed mobility, interventions reflected Resident #1 was able to move up in bed, turn side to side, and sit on the side of the bed with cueing and x 1-2 assist from staff. In an observation and interview on [DATE] at 10:45 AM, Resident #1 was observed lying in bed using her electronic tablet. Resident #1 was dressed and well-groomed. Resident #1 was lying on her back with her head at a 45-degree angle, and she was unable to move her left arm. Resident #1 was able to use her right arm to reach for things within close proximity. Resident #1 used her tablet to express herself as she was unable to communicate verbally due to aphasia. Resident #1 used her tablet by typing out words to express to the state surveyor that she could not get help when needed, because her call light usually was not within reach, and when the door was closed staff could not see her waving for help if they happened to pass by. Resident #1 stated she would have to call her RP or wait for someone to come into the room. Resident #1 stated staff came in approximately every 2 hours, but sometimes she needed help before then, especially if they forgot to leave her essential items within reach on her bedside table. Resident #1 stated she was often frustrated and uncomfortable because of this. Observation of the room revealed Resident #1's call light was coming from the wall on the left side and was tucked behind the frame of the bed. Resident #1 did not have access to the call light, which directly notified the nurses. In an interview on [DATE] at 2:02 PM, CNA A revealed she worked at the</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 455685	If continuation sheet Page 1 of 2

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility for 2 months. She stated she worked with Resident #1, and the resident was able to use her right arm but could not turn completely without assistance. CNA A stated Resident #1 used the call light to get assistance and used her tablet to communicate with staff. CNA A stated it was important for Resident #1's call light to be clipped near her chest or on the bed sheet for easy access because the resident had limited mobility. CNA A stated she generally completed rounds every 2 hours to check on all residents, and she rounded more frequently on Resident #1 due to her condition. CNA A stated when she passed Resident #1's breakfast tray she recalled seeing her call light clipped to the sheet and within reach. She stated after breakfast, she repositioned Resident #1 and had to move the call light away from the resident, so it was possible she forgot to clip it back within reach of the resident. In an interview on [DATE] at 2:29 PM, RN B revealed she worked at the facility for 8 years. She stated she worked with Resident #1 and described the resident as being able to express her needs clearly. RN B stated Resident #1 used her tablet to type out what she needed, and she would bang on the table, wave at staff, or use the call light for assistance. RN B stated call lights should always be within the residents' reach and never tucked behind the bed. RN B stated she was not aware Resident #1's call light was behind her bed. She stated re-education would be completed with staff regarding call lights. In an interview on [DATE] at 2:35 PM, the DON stated Resident #1 was very expressive of her needs and was able to direct her care. The DON stated Resident #1 was unable to move one side of her body and was physically dependent on staff; however, she could move one of her arms and was able-bodied enough to reach and turn herself to a certain degree. The DON stated Resident #1 communicated her needs primarily through typing words or using sounds on her tablet, and she would bang, tap, wave, or use the call light to get staff's attention. She stated Resident #1 would also send a message to her RP through the tablet to communicate any needs, and the RP would then call the facility. The DON stated Resident #1 had multiple ways of getting help; however, the call light was still expected to be within the resident's reach when she was in bed. The DON stated the CNAs did rounds at least every two hours and as needed, and it was protocol for them to ensure the call lights were within reach before leaving the rooms. The DON stated the risk of not ensuring residents were able to reach their call lights could place them at risk of not receiving help when needed. In an interview on [DATE] at 2:51 PM, Resident #1's RP stated she had concerns staff sometimes forgot about the resident. The RP stated Resident #1 used the call light to get assistance and if she could not reach the call light, she would tap on the table or use sound on her tablet. The RP stated Resident #1's room was at the end of the hall, so staff did not always hear the tapping or sounds from the tablet if they were at the nurses' station, and she worried they would forget to check on her. The RP stated she visited Resident #1 often and would find the call light out of the resident's reach. She stated there was also a monitor in Resident #1's room and she could see when the resident needed help and was unable to reach her call light, so she would call the facility. The RP stated this concern had been addressed with the facility several times and it would only get better for a little while. Record review of the facility's Resident Rights policy, revised [DATE], reflected in part the following: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to communication with and access to people and services, both inside and outside the facility.</p>		