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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455871 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/05/2025 |
| NAME OF PROVIDER OR SUPPLIER Lynwood Nursing and Rehabilitation LP | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 S Alamo Levelland, TX 79336 | |

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) |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279</p> <p>Based on interviews and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promoted the maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of the resident for 1 of 7 (Resident #1) residents reviewed for resident rights.</p> <p>CNA B failed to allow Resident #1 to call her Family Member when Resident #1 requested to make that call at approximately 2:30 AM on 01/24/25.</p> <p>This failure could place residents at risk for diminished quality of life and loss of dignity and self-worth.</p> <p>Findings included:</p> <p>Record review of Resident #1's undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of type 2 Diabetes Mellitus (inability of the body to use insulin properly), altered mental status (change in a person's awareness and alertness), major depressive disorder (feelings of sadness), urinary tract infection (bacteria in the urinary tract), anxiety disorder (intense, excessive, persistent worry and fear), restlessness and agitation (feeling uneasy, anxious), insomnia (problems falling or staying asleep), cognitive communication deficit (communication difficultly caused by cognitive impairment)</p> <p>Record review of Resident #1's MDS dated [DATE] revealed Section C- Cognitive patterns a BIMS score of 13 which indicated Resident #1 was cognitively intact. Section D - Mood: B. Feeling down, depressed, or hopeless - yes, 7-11 days.</p> <p>D. Feeling tired or little energy - yes, 7-11 days.</p> <p>Section F - daily preferences -</p> <p>F. how important is it to you to have your family or a close friend involved in discussions about your care? 1-Very important</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #1's comprehensive care plan dated 12/05/25 revised on 01/24/25, revealed the resident has history of verbal outbursts and physical aggression when getting care done. Goal: Resident #1 will demonstrate a reduction in aggressive behaviors during care. Approach: Staff will maintain a calm, non-threatening presence. Talk the resident through the whole care process. Psychosocial well-being, Goal: Resident #1 will express/exhibit satisfaction. Approach: Allow to express feelings, keep topics of conversation light and cheerful, listen carefully and be non-judgmental. Mood state: Resident #1 has history of depression and anxiety. Goal: Resident #1 will express/exhibit satisfaction. Approach: Be reassuring and listen to concerns.</p> <p>Record review of Resident #1's psychological evaluation visit note dated 01/03/25, revealed Resident #1 was seen for adjustment difficulty, anxiety, depression/sadness, long-term memory problems, short-term memory problems and sleep disturbance. Resident #1 reported she was very nervous and anxious all the time, and nothing helped to calm her nervous. Resident #1 reported she felt on edge, and highly irritable, she only slept about three hours a night. Resident #1 contributed her uncontrolled anxiety with separation from her son and home.</p> <p>Record review of written statement dated 01/24/25 from CNA B, revealed Resident #1 was screaming and asking for her Family Member. I stated that it was 2:30 AM and that Family Member was sleeping. I reassured Resident #1 that Family Member would be back as soon as Family Member woke up.</p> <p>During an interview on 2/4/2025 at 3:15 PM with Resident #1, she was unable to answer any questions regarding the events from the night of 01/24/25.</p> <p>During an interview on 02/05/25 at 12:26 PM with the ADM, she stated Resident #1 had the right to call Family Member at 2:00 AM and CNA B should have let Resident #1 call her Family Member.</p> <p>During an interview on 02/05/25 at 2:50 PM with Family Member, he stated if Resident #1 wanted to call him at 2:00 AM, 3:00 AM, 4:00 AM, he would be fine with that, he wanted the facility to let her call him at any time. He stated Resident #1 could not recall the incident however thought if she could, it would have bothered her that CNA B did not let her call him. He stated that Resident #1 usually wanted to call him because she was afraid when away from him and needed reassurance from him.</p> <p>During an interview on 02/05/25 at 3:50 PM with CNA B, she stated on 01/24/25 around 2:00 AM she was doing her rounds and heard Resident # 1 yelling out. She stated she entered Resident #1 room and Resident #1 yelled she wanted to call (Family Member) . She stated she told Resident #1 no because (Family Member) is at home and asleep. CNA B stated Family Member had never told her not to call in the night, and in the past, they had called Family Member when Resident #1 was upset or refusing care.</p> <p>During an interview on 02/05/25 at 5:24 PM with NP, she stated Resident #1 should have been allowed to call Family Member. Family Member was awake and there for Resident #1. She stated the situation could have been handled differently, and not allowing Resident #1 to call her Family Member could have increased her anxiety.</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 02/05/25 at 6:21 PM with LVN E, she stated she was in the room, providing care for Resident #1 with CNA D . She stated Resident #1 yells out during care because she is afraid, she will fall. She stated CNA B entered the room and started to talk to Resident #1. She stated Resident #1 wanted to call her Family Member, and CNA B stated not at this hour it's 2:00 in the morning.</p> <p>Record review of a progress notes dated 01/24/25 revealed LSBW observed Resident #1 in her room. She was resting peacefully with no signs of distress. Family Member was also in room. Family Member advised that Resident #1 reported that she had no recollection of any problems or concerns during the previous night. Family Member reported that Resident #1 had been refusing medication and that she resists care and at times becomes combative during care, especially in the mornings. Family Member stated Resident #1 is hard of hearing and tonal adjustment is required in order for Resident #1 to hear.</p> <p>Record review of the facility's policy titled; Resident Rights dated 2001 revised date February 2021</p> <p>Policy Statement</p> <p>Employees shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to</p> <p>b. be treated with respect, kindness, and dignity</p> <p>e. self-determination</p> <p>f. communication with and access to people and services, both inside and outside the facility.</p> <p>aa. visit and be visited by others from outside the facility.</p> <p>cc. access to a telephone, mail, email.</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279</p> <p>Based on interview and record review, the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 1 of 7 residents (Resident #1) reviewed for hygiene, in that.</p> <p>1. The facility failed to provide incontinence care on three separate opportunities for Resident #1 on 1/26/2025.</p> <p>These failures could place residents at risk for skin breakdown and infections.</p> <p>Findings include:</p> <p>Record Review of Resident #1's undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of nondisplaced fracture of third cervical vertebra (fracture of bones in the neck), anxiety disorder, major depressive disorder, restlessness and agitation, type 2 diabetes, hypertension (high blood pressure) and chronic pain.</p> <p>Record Review of Resident #1's MDS dated [DATE] revealed Section C- Cognitive patterns a BIMS score of 13 which indicated</p> <p>Resident #1 was cognitively intact. Section GG- Functional Abilities revealed resident was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity, for personal hygiene, toileting hygiene and toilet transfer. Section GG- Functional Abilities revealed Resident #1 required Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for rolling left to right, sit to lying and lying to sitting on side of bed.</p> <p>Record Review of Resident #1's care plan revealed a problem of Functional urinary incontinence R/T Dementia created on 1/28/2025. Resident #1's care plan revealed an approach of apply moisture barrier to skin and Provide incontinence care after each incontinent episode.</p> <p>Record Review of Resident #1's grievance form dated 01/27/2025 revealed:</p> <p>Person making complaint and relationship to resident: Resident #1's family member.</p> <p>Detail of Complaint/Grievance: Stated Resident #1 sat in poop for about two hours.</p> <p>Date Complaint/Grievance occurred: 01/26/2025.</p> <p>What shift did the complaint/grievance occur? 3-11pm .</p> <p>.Summary statement of grievance: Resident #1's family member was disappointed in call light response time and stated Resident #1 needed to go to the restroom and had BM (bowel movement) on her for about 2 hours .</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Summary of pertinent findings or conclusions:</p> <p>Resident #1 pushed the call light three times before Resident #1's needs were met .</p> <p>.Decision: Grievance was confirmed: In service conducted with staff by ADM and DON over call light response time, not turning off call light until service is completed.</p> <p>During an interview with Resident #1's family member on 2/4/2025 at 11:21 AM, he stated the other day, he had called to have Resident# 1 go to the bathroom and the CNA stated she would be right back and turned off the call light. He stated about 15 minutes later he called again, and the CNA stated they were pretty busy, but she would try to find somebody to help her. He stated she did eventually come back but he was not sure how long it had been. He stated the first time he called Resident #1 was not wet and did not have a bowel movement. He stated after that, she was wet and did have a bowel movement and at that point she needed to be changed. During a second interview with Resident #1's family member on 2/5/2025 at 2:50pm he stated he remembers calling the first time around 7pm, it may have been 6:45pm, and the CNA did not come back. He stated she came into the room said, I'll be right back and turned off the call light. He stated he hit the call light again, and she came back and said, I'm going to turn off the call light and be back in a minute. He stated it took her longer to come back after the second time he pushed the call light button. He stated he rang it a third time and she was already on her way back with a second person and the CNA had stated they were pretty busy. He stated they changed her around 8:45pm- 8:50pm. He stated that day Resident #1 was telling him she needed to use the bathroom. Resident #1's family member stated Resident #1 does not remember how she felt but he believes she would have been upset because she does not like to sit in a dirty brief. He stated he felt that this was neglect. He stated he did not remember the CNA's name and did not recall the exact date.</p> <p>During an interview with Resident #1 on 2/4/2025 at 3:15pm, Resident #1 was unable to answer any questions regarding the events from night 1/26/2025.</p> <p>During an interview with the ADM on 2/5/2025 at 12:28pm, she stated Resident #1's call light was pushed by the son. The ADM stated, CNA A had stated she was getting her rounds together and she would try to find a second person. The ADM stated she was told that he called again and at that time, the CNA's were under the impression that she had not gone yet, and CNA A was trying to find someone. CNA A was then pulled by the smoking residents to be taken outside to smoke. She stated, then CNA C told CNA A that Resident #1 had a bowel movement and when CNA A came back from smoking, they went to change her. The ADM stated staff were not trained to prioritize resident smoke breaks over providing resident care. She stated she expected the CNA's to find assistance in a timely manner. She stated when she spoke to CNA A, she said she was doing the best she could, and CNA A apologized several times and stated every resident was just as important. The ADM stated there had been three opportunities for Resident #1's needs to be met. The ADM stated they did in-services on call lights and abuse and neglect on 1/27/2025.</p> <p>During an interview with FNP on 2/5/2025 at 5:24pm, she stated she expected the staff at the facility to provide resident care immediately. She stated she was aware it was not always possible to attend to residents immediately but being left in a dirty brief was unacceptable. She stated residents being left in a dirty brief could increase the risk of infection or skin breakdown.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview with CNA C on 2/5/2025 at 7:49 pm, she stated she was working on 1/26/2025. She stated she was working with three other CNA's including CNA A. CNA C stated she had been working 100 hall that night and saw the call light going off in 200 hall. She stated CNA A asked if CNA C could assist her in changing Resident #1. CNA C stated she was unable to at that moment because she had another resident, she was providing care for. She stated she did see the call light go off again for hall 200 and about 30 minutes later she saw it go off again. She stated she went to answer the call light and Resident #1's family member stated, she needs to be changed. CNA C stated she told him they would come change Resident #1, but they were very busy. She stated CNA A was assigned to do the 8:30pm smoke break, and CNA A did take the residents out to smoke. She stated around the time of the smoke break, she became available to assist CNA A with her residents. CNA C stated her, and CNA A went into the room to change Resident #1 and Resident #1 was happy and Resident #1's family member was okay. CNA C stated they did apologize and Resident #1's brief was barely dirty and wet. CNA C stated CNA A's Hall is very heavy, and the other CNAs don't always offer to help. CNA C stated everyone was busy that night with call lights and resident care. CNA C stated she does not believe Resident #1 can tell when she has to go to the bathroom. She sated stated there have been times when Resident #1's family member will state Resident #1 needs to go to the bathroom and when they go in, Resident #1 will ask What are you doing? I don't need to go to the bathroom. CNA C stated Resident #1 does not use the bedpan or the bedside commode because she does not always know when she has to go. CNA C stated resident was incontinent and wears briefs. CNA C stated she has been trained on abuse and neglect and did not feel that CNA A's actions were neglectful.</p> <p>Record Review of document titled Provider Investigation Report dated 1/31/2025 revealed the following statement by CNA A, CNA C and LVN F:</p> <p>Interviewee's Name: CNA A .</p> <p>.2. Please explain fully what you know of the incident: Resident #1's family member stated that Resident #1 needed to go to the restroom. I informed him I had to wait for a 2nd person. Call light went off again and Resident #1 was saying she needed to go to restroom. CNA A stated the smokers then wanted to be taken out. When CNA A came inside, CNA C stated Resident #1 had a BM. We then changed her.</p> <p>3.About what time did it happen? Around 7ish</p> <p>.5. Do you have any knowledge about possible causes of the incident? It was a cluster of events.</p> <p>Interviewee's Name: CNA C .</p> <p>.2. Please explain fully what you know of the incident: I was working my hall when I answered Resident #1's call light since CNA A was with the smokers. Resident #1's family member stated Resident #1 had a BM. When CNA A came back inside and I saw her, I asked her if she needed help with Resident #1. We then change her. The BM was fresh.</p> <p>3.About what time did it happen? during 1st rounds.</p> <p>.5. Do you have any knowledge about possible causes of the incident? We are all busy during shift changes and getting residents ready for bed and changed. We did the best we could.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interviewee's Name: LVN F .</p> <p>.2. Please explain fully what you know of the incident: When I was doing my PM med pass, I went into Resident #1's room and did my assessment with her. She didn't voice any concerns. Call light was not on . Resident #1's family member stated Resident #1 had BM and needed to be changed .LVN F stated the aid is in the next room and if Resident #1's family member would like the door left open or closed he stated closed, and I told CNA A.</p> <p>3.About what time did it happen? Around 8 pm</p> <p>Record review of facility document titled Topic: Call Light response time/Grievances/Abuse</p> <p>Instructor: ADM/DON, Date Inservice initiated: 1/27/2025 revealed:</p> <p>Call light response time. Anyone is able to answer a call light, no one should walk past a call light going off. If you go into a room and are unable to provide the service, you need to make sure the leave the call light on. Do not turn off the call light if the resident still needs help.</p> <p>Record review of facility policy titled Answering the Call Light last revised on March 2021, revealed:</p> <p>Purpose</p> <p>The purpose of this procedure is to ensure timely responses to the resident's requests and needs.</p> <p>.Steps in the Procedure .</p> <p>2. a. If the resident needs assistance, indicate the approximate time it will take for you to respond.</p> <p>b. If the resident's request requires another staff member, notify the individual.</p> <p>c. If the resident's request is something you can fulfill, complete the task within five minutes if possible.</p> <p>d. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance.</p> |