STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455871	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Nursing and Rehabilitation	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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 observations, interviews, and record review, the facility failed to treat residents with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 2 of 8 residents (Resident #2 and #3) reviewed for respect. CNA D failed to treat residents with respect and dignity when she told Resident #2 and Resident #3, she did not have to take them out to smoke, on an unknown date in July 2025. These failures could place the residents at risk of feeling disrespected.Findings included: Record review of Resident #2's undated face sheet revealed a [AGE] year-old male admitted on [DATE]. Resident #2 had a medical history of COPD (a group of lung diseases that cause airflow obstruction and breathing difficulties), alcohol induce dementia (a type of alcohol-related brain damage), and muscle weakness. Record review of Resident #2's quarterly MDS dated [DATE], Section C-Cognitive Patterns revealed a BIMS score of 06, which indicated Resident #2 had severe cognitive deficit. Record review of Resident #3's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #3 had a medical history of schizophrenia (a serious mental health condition that affects how people think, feel and behave), HIV (a virus that attacks the body's immune system), insomnia (persistent problems falling and staying asleep), and alcoholic cirrhosis of liver (a chronic liver disease caused by excessive alcohol consumption over many years). Record review of Resident #3's admission MDS dated [DATE], Section C-Cognitive Patterns revealed a BIMS score of 09, which indicated Resident #3 had moderate cognitive deficit. Record review of facility document titled Grievance Decision Report, dated 7/30/2025 revealed: .Detail of Complaint/Grievance: Resident showed [ADM] + [and] DON video of employee having an interaction with another resident and threatened to take away his smoking privilege. Date complaint/grievance occurred: unknown.Summary statement of grievance: Resident [Resident #3] reported concerns of how an employee spoke to him and another resident. Steps taken to investigate the grievance: other resident [Resident #2] interviewed that had the interaction with the employee, resident [Resident #2] didn't report concerns. Summary of pertinent findings of conclusions: prior to employee [CNA D] working another shift, employee will have one on one conversation on expectations. During an interview on 9/2/2025 at 12:23pm with Resident #3, he stated CNA D had been telling another resident that she was not going to take him to smoke. He stated he did not remember what resident it was but that she did not have the right to refuse to take anyone out to smoke. He stated he did record her because he felt that she was violating their rights to smoke. Resident #3 stated CNA D did take them to smoke a few moments later but that he felt she did not treat them with respect and was rude. Resident #3 was unable to recall the date of the incident but stated he did do a grievance report a few days later.During an interview on 9/2/2025 at 2:23pm with LVN B, he stated he does not remember there being any incidents between CNA D, Resident #3 or Resident #2. He stated there was only one night when CNA D told him Resident #2 was cussing and yelling at her because they were running behind on their smoke break and CNA D had told Resident #2 to give her a minute and she would take them out. LVN B stated CNA D did not mention denying the residents their smoke break. He stated there were no reports made to him by any residents. LVN B stated if he had to guess which resident was cussing at CNA D, he would guess [Resident #2] because he can be aggressive if staff are late with smoke breaks. During an interview on 9/2/2025 at 5:02pm with CNA D, she stated she did not recall the date but that she remembers the night shift being busy and running behind. She stated they were running a little behind on going to smoke and had told the smoking residents they would be late taking them to smoke. She stated Resident #2 was mumbling something, and she told him she would not take him to smoke and that they are not always going to be able to take them at the same time. CNA D stated she did ask Resident #3 if he was recording her, and he stated yes. She stated she did take the residents out to smoke within a few seconds of saying she would not. CNA D stated her behavior was inappropriate and she had just been irritated from being behind on schedule. She stated she understood how she spoke to the residents was not how they were trained and that she had been in serviced on resident rights and customer service. She stated she does have a strong voice, and it is often mistaken for yelling, even when she is not. She stated all residents had a right to be treated with respect and she felt she did not treat the residents with respect when she spoke to them in that manner. She stated she will not do that again and will treat all residents with respect. During an interview on 9/3/2025 at 9:30AM with Resident #2, he stated he did not remember the time or date of that incident. He stated he does not remember what started it or why she was

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure adequate supervision of Resident #1 who was newly admitted to the facility on [DATE] and was exhibiting signs of confusion and exit-seeking behavior. Resident #1 then eloped from the facility approximately 27 (twenty-seven) hours later on 07/20/25 between 7:45 PM and 8:00 PM. Staff were unaware of Resident #1's elopement when the facility was notified by a citizen of the community via telephone on 07/20/25 at approximately 8:15 PM that the resident had wandered to a nearby apartment complex and appeared confused. The noncompliance was identified as PNC. The IJ began on 07/20/25 and ended on 07/21/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of harm, serious injury or death.Record review of Resident #1's face sheet, dated 09/02/25 revealed Resident #1 was admitted to the facility on [DATE] with the following diagnoses: dementia (progressive decline in cognitive functions), and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear and nervousness). Record review of the Assessment for Risk of Elopement, created by LVN C and dated 07/19/25 at 5:09 PM, revealed Resident #1 was not at risk for elopement. Record review of Resident #1's Baseline Care Plan, dated 07/20/25 revealed elopement risk factors would be evaluated to minimize risk of elopement. Record review of Resident #1's Resident Progress Report, created by LVN B on 07/20/25 at 5:47 AM revealed: Resident restless continues to wander in and out of rooms with exit seeking behavior, gave 1 ml lorazepam. Increased supervision and had resident sit with me at the nurse's station. Gave resident a memory board to help keep her busy. Record review of Resident #1's Resident Progress Report, created by LVN B on 07/20/25 at 8:54 PM revealed LVN B received a phone call that the resident was outside at a nearby apartment complex. Resident #1 was observed by LVN B at the apartments next door to the facility sitting down talking to the people. The resident was redirected back to the facility and assessed without noted injury. The hospice agency, Medical Director, and the resident's family member were contacted. No new orders were received. The resident was placed on one-to-one monitoring. Record review of the facility's Form 3613-A (Provider Investigation Report), dated 7/20/25, revealed LVN B was notified via telephone on 07/20/25 at 8:15 PM, of Resident #1's elopement from the facility. A community member called the facility and reported that Resident #1 had been found at the neighboring apartment complex and was confused. LVN B and CNA F went to the apartment complex and assisted Resident #1 back to the facility. The resident was assessed and found to have no injuries and did not require medical treatment. Resident #1 stated she was trying to go home. Resident #1 was placed on one-to-one supervision upon return to the facility and remained on one-to-one supervision until being discharged on 07/21/25 with family. A head count was conducted to account for all residents. Door alarms were checked and found to be functioning properly. Staff in-services were initiated for ANE, elopement, and responding to door alarms. Following the elopement, proper functioning of door alarms continued to be monitored, and elopement assessments and care plans were updated for all residents who were deemed at-risk for elopement. Additionally, a sign was placed at the lobby door directing visitors to notify staff if the door alarm was sounding upon approach. An elopement binder was updated for current at-risk residents and placement at the nurse's station was verified. Record review of Resident #1's Discharge MDS, dated [DATE], revealed:Section C - Cognitive Patterns - BIMS was blank and did not contain a score for Resident #1.Section E - Behavior - revealed the resident exhibited wandering behavior 1 to 3 days. Section GG - Functional Abilities revealed the resident was able to stand from a sitting position with supervision or touching assistance and was able to walk 150 feet independently.Section I - Active Diagnosis - revealed the resident had an anxiety disorder. During an interview on 09/02/25 at 9:15 AM, the DON stated Resident #1 was admitted to the facility on [DATE] around 5:00 PM for a 5-day respite stay. She stated the resident was independently ambulatory upon admission and had a diagnosis of dementia. She stated LVN C admitted Resident #1 then passed care on to LVN B approximately one hour later, due to shift change. The DON stated Resident #1 did not immediately show signs of exit-seeking behavior on the day of admission, but she began to show signs of increased confusion and wandering behavior in the evening shortly after shift change. She stated LVN B implemented interventions for Resident #1's wandering behavior and anxiousness by allowing her to sit at the station with him, provide games for redirection and administer