

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  12/08/2025
NAME OF PROVIDER OR SUPPLIER  Lynwood Nursing and Rehabilitation		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)
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on 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 6 (Resident # 1) residents reviewed for pharmaceutical services. The facility failed to ensure MA A completed the medication administration for Resident #1 according to standard of practice when she placed the medications in Resident #1's mouth during the breakfast meal and left prior to observing that Resident #1 had swallowed the medications. Resident #1's medications were found in a cup beside the resident's breakfast tray by the resident's family member who assisted Resident #1 to finish taking the medications. This failure could place residents at risk of not receiving the full medication dosage or intended therapeutic benefit of ordered medications. Record review of Resident #1's undated face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Disease (a progressive brain disorder that causes memory loss), coronary artery disease (a condition where the arteries that supply blood to the heart muscle become narrow or blocked), hypertension (high blood pressure), and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness and loss of interest or pleasure in activities). Record review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Resident #1 had a BIMS score of 02, indicating the resident had severe cognitive impairment. Further review revealed Resident #1 received the following classes of medications: antidepressant (given for depression), anticoagulant (given to prevent blood clots), diuretic (given to treat or prevent fluid buildup in the body), antiplatelet (given to prevent blood clots), and anticonvulsant (given to prevent seizures; may also be given as a treatment for behavioral disturbances in patients with dementia). Record review of Resident #1's comprehensive care plan, date initiated 07/28/2022, revealed Resident #1 had cognitive loss/dementia. Record review of Resident #1's physician's orders dated 10/22/25, the following orders for morning medications: 7:00 AM - 10:00 AM - Aspirin [OTC] 81 mg tablet, delayed release; 1 po QD; start date 09/20/20227:00 AM - 10:00 AM - Clopidogrel 75 mg tablet; 1 tablet po QD; start date 07/27/20227:00 AM - 10:00 AM - Divalproex 125 mg delayed release; 1 tablet; oral; start date 07/14/20257:00 AM - 10:00 AM - Guaifenesin [OTC] 400 mg tablet, 1 tablet; oral; start date 10/04/20227:00 AM - 10:00 AM - Lasix (furosemide) 40 mg tablet, 1 tablet; oral; start date 06/17/20247:00 AM - 10:00 AM - Metoprolol succinate tablet extended release 25 mg tablet, 1 tablet po QD; start date 07/08/20247:00 AM - 10:00 AM - Pantoprazole 20 mg delayed release tablet, 1 tablet po Q AM; start date 11/25/20237:00 AM - 10:00 AM - Potassium chloride 20 mEq extended-release tablet, 1 tab; oral; start date 08/12/20237:00 AM - 10:00 AM - Rosuvastatin 5 mg tablet, 1 tablet by mouth; start date 07/27/20227:00 AM - 10:00 AM - Sodium chloride 1 gram tablet, 1 tab po QD; start date 07/27/20227:00 AM - 10:00 AM - Zolof 50 mg tablet, 1 tablet; oral; start date 07/14/2025 Record review of Resident #1's MAR dated 10/18/25, revealed MA A administered the following morning medications: Aspirin 81 mg tablet, 1 tablet by mouth Clopidogrel 75 mg tablet, 1 tablet by mouth Divalproex 125 mg delayed release tablet, 1 tablet by mouth Guaifenesin 400 mg tablet, 1 tablet by mouth Lasix 40 mg tablet, 1 tablet by mouth Metoprolol succinate 25 mg extended-release tablet, 1 tablet by mouth Pantoprazole 20 mg delayed release tablet, 1 tablet by mouth Potassium chloride 20 mEq extended-release tablet, 1 tablet by mouth Rosuvastatin 5 mg tablet, 1 tablet by mouth Sodium chloride 1 gram tablet, 1 tablet by mouth Zolof 50 mg tablet, 1 tablet by mouth During an interview on 10/22/25 at 9:53 AM, Family Member stated Resident #1's morning medications were observed in a plastic cup next to Resident #1's tray during breakfast. Family Member stated a couple of the medications appeared to be wet like they had been in [Resident #1's] mouth. Family Member stated Resident #1 took the medications that were in the cup and MA A was made aware that the resident had taken the medications. Family Member stated Resident #1 had a history of refusing medications at times and holding medications in her mouth or spitting them out. Family Member stated they called the facility to report to a nurse that Resident #1's medications were not properly administered. During an interview on 10/22/25 at 2:45 PM, MA A stated she routinely gave scheduled medications to Resident #1. She stated Resident #1 would occasionally refuse to take her medications. MA A stated she had also observed Resident #1 pocket her medications in her mouth on one occasion, meaning she would hold the pills in her cheek rather than swallowing them. MA A stated she recalled giving Resident #1 her medications in the dining room during breakfast. She stated she prepared the medications in an administration cup and wrote Resident #1's initials on the outside of the cup</p>		