STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455903	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER: Lake Lodge Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3800 Marina Dr Lake Worth, TX 76135	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observations, interviews, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 6 residents (Residents #1) reviewed for abuse. The facility failed to protect Residents #1 from neglect when they failed to provide the necessary care devices to prevent injury from a fall. Resident #1 had a history of subdural hemorrhage with brain injury and a previous order for a fall mat. The CNA was aware the fall mat was missing and Resident #1 experienced convulsions/seizures resulting in a fall. Resident #1 sustained a skin tear from the fall. These failures could place residents at risk of abuse and neglect, serious injury, serious harm, serious impairment, pain, mental anguish, or death. On 02/28/24 at 3:38 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/29/24 at 3:52 PM, the facility remained in compliance at a severity level of no harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. Findings included: Record review of Resident #1's face sheet dated 02/27/24 reflected he was a [AGE] year-old male admitted initially on 06/23/23 and again on 02/23/24 DX included: Traumatic Subdural Hemorrhage with loss of consciousness (brain injury) of unspecified duration, HX of Subsequent Encounter Conversion Disorder with seizures or convulsions (conversion disorder is a condition in which you have physical symptoms but no injury or illness to explain seizures). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 0 indicating severely impaired cognition- nonverbal, Section K feeding Tube, Section M stage 4 wound documented and being treated with ointments and medication, including diet, Section N Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin), Section O no treatments. Pain unable to answer. Record Review of Resident #1's Care plan dated 12/01/23 reflected he has a resident is at risk for falls r/t traumatic subdural hemorrhage neuromuscular dysfunction and chronic respiratory failure. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455903	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Lodge Nursing & Rehabilitation	3800 Marina Dr Lake Worth, TX 76135

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of PN dated 2/25/2024 at 7:07 AM by LVN A reflected '[company name]'was notified '[Resident #1's fall and injuries]' and will send a nurse down to assess pt . Record review of Resident #1's PN dated 02/26/24 at 08:47 AM by the DON reflected X ray to the forehead and facial bones shows no obvious fracture. Nursing will continue to treat skin per standing orders. Record review of Resident #1's PN/MD BY MD O note dated 02/26/24 12:55 AM, reflected Date of Service: 02/26/2024 Visit Type: Follow Up Transition of Care: No transition occurred. Details: This is a copy of a signed encounter note documented in Chief Complaint / Nature of Presenting Problem: Review x-ray result . Neurology discussed MRI and EEG results with FM that since patient has not shown improvement clinically from a neurological standpoint. Patient will have to continue with current supportive care treatment . Reviewed. Nursing Staff: Reviewed x-ray result Patient: Limited by cognition. Patient had a fall over the weekend. X-ray reviewed and no fracture. Patient had a small skin tear. Wound care is already following. Observation of Resident #1 on 02/27/24 at 11:00 AM and 02/28/24 at 8:15 AM revealed resident to be lying in bed, head of bed raised, feeding tube operating, both bags were dated, eyes closed, and a fall mat on the floor. Resident was observed to have two healing stage skin injuries to the forehead. Resident was not interviewable. In an interview on 02/27/24 at 3:09 PM, with CNA J revealed on 02/25/24 at 6 PM she arrived to work and conducted rounds every 2 hours or less. CNA J stated that she sat adjacent to Resident #1's room due to his history of falls and seizures. CNA J stated she was familiar with Resident #1's care and knew he required bed in low position, call light near, and fall mat next to bed. CNA J stated she did not notify the head nurse that the fall mat was missing. CNA J had conducted rounds on resident 15 minutes prior him falling at 4:40 AM on 02/25/24. CNA J said at 5:00 AM she heard him hit the floor and entered immediately, called for nurse, and remained until nurse arrived. CNA J stated Resident #1 was bleeding from skin tears located on his bed. CNA J said Neglect of a Resident was failing to provide the Resident with care and identified and scheduled by MD. CNA J said the fall mat would have prevented the injuries that Resident #1 sustained from the fall. In an interview with the DON on 02/27/24 3:38 PM she stated that she was contacted by LVN A on 02/25/24 at 6:40 AM via video call to assess the resident. Reporting that Resident#1 fell out of the bed on the floor and had skin tears with blood on his forehead. The DON stated Resident #1 has fall prevention precautions in place to prevent falls, related to convulsing like seizures. The DON stated the cause of the fall was possibly due to him coughing and convulsing, like a seizure, resulting in falling on the floor and gaining injuries. She said the fall mat was not in place on the day of the incident. The DON said on 02/23/24 the day of re-entry, LVN I was working the 6 PM-6 AM shift and was not familiar with the resident's care and orders, and failed to ensure the fall mat was in place. The DON stated the rounding nurses and aides did not ensure the resident's fall mat was in place during shifts on 02/23/24, 02/24/24, and 02/25/24. The DON stated that the mat should have been in place, and she expects nursing to review MD orders, care plans, and assessments to ensure the residents are receiving care consistent with their needs and orders . DON said failing to provide Resident #1' fall mat per MD orders was neglect, and the staff working on that day confirmed observation of the missing fall mat, however, it was not implemented for his safety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 02/28/24 at 9:33 AM RN J stated upon arriving and completing shift change reports on 02/25/24 at 6 AM she was notified by LVN E that Resident #1 had fallen and had injuries to the forehead. RN J said there were no other details provided. RN J proceeded to Resident #1's room and she observed injuries to his forehead. She then cleaned the blood off of his forehead, applied Tiple Antibiotic Ointment to his forehead, and took Resident #1's vital signs. RN J said the fall mat was not on the floor next to the bed. RN J called the MD, the DON, and his family to report the incident. RN J does not know the details of the fall, as it was not provided, and she did not ask additional questions. RN J said the DON arrived at the facility on 02/25/24 at 4:30 PM and the '[company name]'nurse arrived at 5:00 PM. Both assessed the resident and the DON ordered X-rays . RN J stated that she did not review Resident #1's orders the day of the incident. The DON and '[company name]' nurse placed a fall mat on the floor upon arrival. RN J said X-rays were negative for fractures. In an interview on 02/28/24 at 10:28 AM with LVN W revealed the readmission process included taking patient vital signs, skin assessment, review medications and orders to see if orders changed. Nurses should notify the MD and confirm resident orders upon readmission to assure notification of orders and to determine if there was a need to change or follow up on returned orders. In an interview with RN HN nurse on 02/28/24 at 10:55 AM revealed Resident #1 was admitted to '[company name]' at the hospital prior to discharge on 02/24/24. RN HN stated that the facility nurse called '[company name]' on call line to report the incident, and the on-call nurse reported she would be out to assess. RN HN said the on-call report stated Resident #1's fall on 02/25/234 at 6:26 AM. LVN A called and stated he had fallen on the floor from his bed, sustaining injuries to his forehead, no discomfort or distress. RN HN said Resident # 1's first care encounter at the facility was on Monday (02/27/24). She ordered Bolster's (a long thick pillow that is placed under the pillow for support.) for his bed (when sitting up he aspirates/coughs during tube feeding and he moves forward.) She placed the fall mat on 02/25/24 after the fall. She was not aware of the fall mat orders prior to intake to '[company name]'. In an interview on 02/28/24 at 1:04 PM with LVN S, she stated that she arrived on 02/23/24 at 7:00 PM and Resident #1 had been readmitted . She conducted vital signs and completed a skin assessment. She was not familiar with his care. She reviewed his orders. However, she did not recall an order for a fall mat. LVN S stated the mat was present when she arrived, and Resident #1 had no injuries. LVN S said it was important to review orders and ensure the mat was down to prevent injuries from falls or lessen the injuries. LVN S was trained after the incident by the DON on admission assessment, orders, fall precautions, and reviewing of the MD orders. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of policy titled Abuse/Neglect dated 03/29/18 reflected The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation This includes but is not limited situations that may constitute abuse or neglect to any resident in the facility. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will train through orientation and on-going in-services on issues related to abuse/neglect prohibition practices regularly . Investigations will be reviewed by the facility administrator and/or Abuse Preventions within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. The facility will designate an Abuse Preventions to monitor tracking and trending data and completion of investigations as needed. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse will be investigated by the Abuse Preventions and/or designee and a comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventions All allegations of abuse, will be investigated. This was determined to be an Immediate Jeopardy (IJ) on 02/28/24 at 3:38 PM The ADM, DON, and CRN were notified. The ADM was provided with the IJ template on 02/28/24 at 3:43 PM. The following Plan of Removal submitted by the facility was accepted on 02/29/24 at 9:10 AM . Plan of Removal was accepted on 02/29/24 at 11:23 AM. Free from Neglect Statement: The facility failed to ensure Resident #1 was free from abuse and neglect in that: Resident #1 was found on the floor in his room on 2/25/24 at 6:47 am by CNA J. Interventions: 1. Resident # 1 was transferred to the hospital as of 2/28/24 for evaluation. 2. The Charge Nurse and CNA that cared for resident #1 on the shift he sustained the fall was in-serviced 1:1 by the DON and Regional Compliance Nurse on: a. Fall Prevention Strategies (ensuring fall mats are in use) b. Abuse and Neglect Policy to include ensuring safety devices are in place. c. Kardex: how to use to determine if a fall mat is required for a resident. 3. An audit was performed by the Regional Compliance Nurse and the DON for all residents who require a fall mat on 2/28/24 to ensure that they are in place. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The medical director was notified of the immediate jeopardy citation on 2/28/24 by the Director of Nursing. 5. An ADHOC QAPI meeting was held on 2/28/24 with the IDT Team to include the medical director to discuss the immediate jeopardy and plan of removal. In-services: The following in-services were initiated by the Administrator, the DON, and Regional Compliance Nurse on 2/28/24 for all Charge Nurses. All Charge Nurses, not present on 2/28/24, will be in-serviced prior to the start of next shift. All new hires will be in-serviced during orientation. All agency staff will be in-serviced prior to the start of their shift. o Fall Prevention Strategies (ensuring fall mats are in use) o Abuse and Neglect Policy to include ensuring safety devices are in place. o Kardex: how to use to determine if a fall mat is required for a resident. o Following MD orders (including the use of fall mats and ensuring bed in low in position). o Inservice provided on a list of residents that require a fall mat. Monitoring: The DON/ADON/Designee will review 3 residents per day x 5 days a week to ensure fall mats are in place x 4 weeks. Monitoring of the POR included the following: Record review of in-service titled Abuse and Neglect, by DON, CRN, and ADM dated 02/26/24, 02/27/24, 02/28/24, 02/29/24 reflected curriculum covered the facility's policy on abuse and neglect, fall precautions, interventions, Kardex referencing, MD orders, and reporting abuse and neglect immediately to the Abuse Coordinator (the Administrator). Interviews were conducted on 02/29/24 starting at 1:01 PM and continued through 4:03 PM with the following staff from various shifts: CNA G (6 AM-6 PM), CNA J (6 PM-6 AM), CNA S (6 AM-6 PM), CNA D (6 AM-6 PM), CNA T (6 AM-6 PM), CNA P (6 AM-6 PM), CNA L (6 AM-6 AM), RN J (6 AM-6 PM)), the CRN , the DM, the MD, the SW, the HKS, the DOR, the ADM, the DON, and the ADON were all able to communicate education attendance and knowledge of the in-service curriculum responding timely, reporting immediately, fall mats, Kardex for care list, types of abuse, abuse coordinator, timing of reporting abuse and neglect, and identifying abuse and neglect. Observations and interviews on 02/29/24 from 1:00 PM to 3:30 PM with Residents#1, #3, #5, #21, #26, and #30 reflected all fall mats were in place, and their current care plans and assessments reflected that interventions were in place for effective and person-centered care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator and the DON were notified the IJ was removed on 02/29/24 at 4:30 PM. The facility remained out of compliance at a scope of isolated and at the severity level of no harm, due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place. In an interview with the Administrator on 02/29/24 at 3:47 PM revealed his expectations of staff were to comply with facility policies and procedures, follow up with patients requiring specialized care, monitor and report to leadership (ADON, DON, and CRN) any inconsistencies, and compliance nursing services. He stated the DON will assign an overnight staff to follow through on the process in place such as following physician orders, accessing and reviewing Kardex overnight system with aides to ensure familiarity with resident care. The ADM, the DON, and the ADON will monitor documentation of task off site electronically to ensure compliance. All staff will ensure the residents receive the best care possible. Expectation for nursing and aides to complete end of shift reports best practice expectations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interviews and record review, the facility failed to implement their written policies and procedures regarding allegations of neglect for 1 of 4 resident reviewed for abuse. (Resident #1) The facility failed to implement their policy on reporting neglect when Resident #1 fell out of bed and sustained 2 injuries to his forehead on 02/25/24. These deficient practices could place residents at risk for abuse, neglect, and not having their needs met. Findings included: Resident #1 Record review of Resident #1's face sheet dated 02/27/24 reflected he was a [AGE] year-old male admitted initially on 06/23/23 and again on 02/23/24. DX included: Traumatic Subdural Hemorrhage with loss of consciousness (brain injury) of unspecified duration, and Subsequent Encounter Conversion Disorder with seizures or convulsions (conversion disorder is a condition in which you have physical symptoms but no injury or illness to explain Seizures). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected 0 BIMS score indicating severely impaired cognition-nonverbal, Section K feeding Tube, Section M stage 4 wound documented and being treated with ointments and medication, including diet, Section N Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin), and Section O no treatments. Pain unable to answer. Record Review of Resident #1's Care plan dated 12/01/23 reflected resident is at risk for falls r/t traumatic subdural hemorrhage neuromuscular dysfunction and chronic respiratory failure and date initiated 09/05/23. No additional information listed. Record review of Resident #1's PN/MD BY MD O note dated 02/26/24 12:55 PM, reflected Date of Service: 02/26/2024 Visit Type: Follow Up Transition of Care: No transition occurred. Details: This is a copy of a signed encounter note documented in Chief Complaint / Nature of Presenting Problem: Review x-ray result . Neurology discussed MRI and EEG results with FM that since patient has not shown improvement clinically from a neurological standpoint. Patient will have to continue with current supportive care treatment . Reviewed. Nursing Staff: Reviewed x-ray result Patient: Limited by cognition. Patient had a fall over the weekend. X-ray reviewed and no fracture. Patient had a small skin tear. Wound care is already following. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's MD orders dated 02/26/24 at 2:45 PM reflected Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0.25 milliliter via NG-Tube (Nasogastric intubation NG Tube Management. A nasogastric (NG) tube is a thin, soft tube made of plastic or rubber that is passed through the nose) every 3 hours as needed for Pain or shortness of breath MD orders dated 10/06/23 at 6:00 PM by DON reflected Apply floor mat when resident is in bed every shift for Fall precaution .MD orders dated 02/27/24 at 6:00 PM by DON reflected Apply floor mat when resident is in bed every shift for Fall precaution Record review of Resident #1's fall nursing note dated 02/27/24 at 12:24 AM by LVN DO reflect injury: skin tear forehead .size 8.8 cm X 0.1, 1.2 cm X 0.1, no S/S of infection, no decline since fall no appearance of pain, no changes that required MD notification, all interventions fall mat, low bed. Record review of TMAR reflected May have floor mat when in bed on time a day for safety precautions may be off the floor during ADL's. Documentation revealed nurse initials for 02/24/24 and 02/25/24 by RN J, 6 AM to 6 PM, indicating this was check. In an interview on 02/27/24 at 9:20 AM, the Administrator reviewed the policy for the facility nursing staff failed to implement the protocol of following MD orders, fall precautions, and reporting reports of abuse and neglect. Administrator sated that nursing staff should have assured that MD orders and fall precautions were followed for Resident #1. The DON and ADON were responsible for monitoring TAR, treatment task, and MD orders to assure nursing practices for followed. DON and ADM reported that the incident was reported on 02/27/24 at 6:00 PM after entrance. Administrator stated that the resident did not sustains severe injuries, however failing to follow procedures led to Resident injuries and pain. Observation of Resident #1 on 02/27/24 at 11:00 AM and 02/28/24 at 8:15 AM revealed resident to be lying in bed, head of bed raised, feeding tube operating, both bags were dated, eyes closed, and a fall mat on the floor. Resident was observed to have two healing stage skin injuries to the forehead. Resident was not interviewable. In an interview on 02/27/24 at 3:09 PM, with CNA J revealed on 02/25/24 at 6 PM she arrived to work and conducted rounds every 2 hours or less. CNA J stated that she sat adjacent to Resident #1s room as h has a history of falls and seizures. CNA J stated she was familiar with Resident #1's care and knew he required bed in low position, call light near, and fall mat next to bed. CNA J stated she did not notify the head nurse that the fall mat was missing. CNA J had conducted rounds on resident 15 minutes prior him falling at 4:40 AM on 02/25/24. CNA J said at 5:00 AM she heard him hit the floor and entered immediately, called for nurse, and remained until nurse arrived. CNA J stated Resident #1 was bleeding from skin tears located on his bed. CNA J said Neglect of a Resident was failing to provide the Resident with care and identified and scheduled by MD. CNA J said the fall mat would have prevented the injuries that Resident #1 sustained from the fall. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 02/27/24 3:38 PM she stated that she was contacted by LVN A on 02/25/24 at 6:40 AM via video call to assess the resident. Reporting that Resident#1fell out of the bed on the floor and had skin tears with blood on his forehead. The DON stated Resident #1 has fall prevention precautions in place to prevent falls, related to convulsing like seizures. The DON stated the cause of the fall was possibly due to him coughing and convulsing, like a seizure, resulting in falling on the floor and gaining injuries. She said the fall mat was not in place on the day of the incident no when she arrived on 02/25/24 at 4:30 PM. The DON stated the rounding nurses and aides did not ensure the resident's fall mat was in place during shifts on 02/23/24, 02/24/24, and 02/25/24. The DON stated that the mat should have been in place, and she expects nursing to review MD orders, care plans, and assessments to ensure the residents are receiving care consistent with their needs and care. DON said failing to provide Resident #1' fall mat per MD orders was neglect, and the staff working on that day confirmed observation of the missing fall mat, however, it was not implemented for his safety. In an interview on 02/28/24 at 9:33 AM RN J stated LVN E reported that Resident #1 had fallen and had injuries to the forehead. RN J said there were no other details provided. RN J proceeded to Resident #1's room and she observed injuries to his forehead. She then cleaned the blood off of his forehead, applied Tiple Antibiotic Ointment to his forehead, and took Resident #1's vital signs. RN J said the fall mat was not on the floor next to the bed. RN J does not know the details of the fall, as it was not provided, and she did not ask additional questions. RN J said the DON and hospice nurse were contacted at prior shift and arrived at the facility on 02/25/24 at 4:30 PM and the hospice nurse arrived at 5:00 PM. Resident was further assessed by both RN J stated that she did not review Resident #1's orders the day of the incident, nor place the fall mat down after the injury. She stated that the DON and hospice nurse put the mat in placed upon their arrival that evening. RN J said the facility policy was to review orders and other care documents for implementing and monitoring resident care. RN J said Resident #1 she conducted rounds every two hours from 6 AM to 6 PM. RN J said failing to placed fall mat on the floor and following other procedures and precautions could lead to resident sustaining injuries. A record review of the facility's policy titled Abuse/Neglect dated 03/29/18 reflected, After receipt of the allegation the Abuse Preventions and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines found in Provider letter 19-17. A report to the appropriate agency will include the following: The name and address of the suspected victim. The name and address of the suspected victim's care giver, if known. The nature and extent of any injuries resulting from the suspected abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injury of unknown source The nursing facility will make an addendum to any reportable incident in its report to HHSC if the resident subsequently experiences a negative outcome. g. Other pertinent information as available. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form. 4. With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee(s) will immediately be suspended pending an investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observations, interview, and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 4 residents (Resident #1) reviewed for neglect. The facility failed to implement their policy on reporting neglect when Resident #1 fell out of bed and sustained 2 injuries to his forehead on 02/25/24. These deficient practices could place residents at risk for abuse, neglect, and not having their needs met. Findings included: Resident #1 Record review of Resident #1's face sheet dated 02/27/24 reflected he was [AGE] year-old male admitted initially on 06/23/23 and again on 02/23/24 DX included: Traumatic Subdural Hemorrhage With Loss Of Consciousness (brain injury) Of Unspecified Duration, Subsequent Encounter Conversion Disorder With Seizures Or Convulsions, Conversion disorder is a condition in which you have physical symptoms but no injury or illness to explain Seizures, Chronic Respiratory Failure With Hypoxia (ineffective exchange of oxygen and gases by the respiratory system), Dysphagia (difficulty swallowing), Unspecified. Record review of Resident #1's quarterly MDS dated [DATE] reflected 0 BIMS severely impaired cognitively nonverbal, Section K feeding Tube, Section M stage 4 wound documented and being treated with ointments and medication, including diet, Section N Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin), Section O no treatments. Pain unable to answer. Record Review of Resident #1's Care plan dated 12/01/23 reflected has an ADL Self Care Performance Deficit . is at risk for nutritional problems r/t G-Tube (tube used for feeding that's inserted directly in the stomach) Status he has a skin tear, laceration, or abrasion. Assess reason for skin injury occurrence. Notify staff of cause; determine measures to prevent further skin injuries . requires tube feeding r/t Dysphagia .is risk for falls r/t traumatic subdural hemorrhage, neuromuscular dysfunction and chronic respiratory failure . subdural hemorrhage, neuromuscular dysfunction and chronic respiratory failure .has Seizure Disorder. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455903	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER Lake Lodge Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 Marina Dr Lake Worth, TX 76135	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's MD orders dated 02/26/24 at 2:45 PM reflected Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0.25 milliliter via NG-Tube (Nasogastric intubation NG Tube Management. A nasogastric (NG) tube is a thin, soft tube made of plastic or rubber that is passed through the nose) every 3 hours as needed for Pain or shortness of breath MD orders dated 10/06/23 at 6:00 PM by DON reflected Apply floor mat when resident is in bed every shift for Fall precaution .MD orders dated 02/27/24 at 6:00 PM by DON reflected Apply floor mat when resident is in bed every shift for Fall precaution In an interview on 02/27/24 at 9:20 AM, the Administrator stated the DON reported the incident to him on 02/25/24 immediately. However, the resident did not sustain any life-threatening injuries, so the Adm did not initially complete a report to the state. The Administrator stated he did investigate the situation by talking to all the staff who worked on shift and everyone she spoke to stated they did not witness anything physical. She stated she did not have any documentation of the investigation. On 02/27/24, the Adm reported the incident to HHS around 6:00 PM. In an interview on 02/27/24 at 9:25 AM with the DON revealed RN EC and LVN A reported the fall to her after all assessments were completed. The DON assessed Resident #1 with both nurses present a second time at 6:50 AM via video call. The DON notified ADM and CRN of the incident on 02/25/24 immediately. The DON stated that she nor the Administrator investigated the fall and injuries. In a phone interview on 02/27/24 at 1:54 PM, CNA J upon hearing the resident fall, she remained with the resident and reported the fall immediately to charge nurse RN EC. CNA J said she observed 2 bleeding injuries to Resident #1's forehead. RN EC was accompanied by LVN A, who reported to Resident #1's room, called for further assistance from LVN A, and assessed the resident and completed vital signs. RN EC and LVN A then transferred him back to the bed. She remained and communicated the fall at shift change with on coming CNA A. In an interview on 02/27/24 at 2:00 PM with RN J she stated upon arrival and completion of shift change reports on 02/25/24 at 6 AM, she was notified by RN EC that Resident #1 had fallen and had injuries to his forehead. RN J proceeded to Resident #1's room and she observed injuries to his forehead. RN J does not know the details of the fall, as it was not provided, and she did not ask additional questions. RN J notified the DON after completing his vital signs and assessment. In a phone interview with RN EC on 02/27/24 at 2:15 PM she reported that she was notified by the aide of the fall on 02/25/24. She notified the charge nurse on duty, LVN A. They both assessed the residents' vital signs and communicated to the oncoming shift about the fall. Resident #1 was observed to have two injuries to his forehead. LVN A notified the DON. Interviews were attempted on 02/27/24, 02/29/24, and 03/06 24 with LVN A, and she did not return the call. In an interview on 02/28/24 at 8:45 AM with the ADM he stated he reported the incident on 02/27/24 to HHS around 6:00 PM. The ADM said he was the abuse coordinator and expected staff to report incidents of abuse and neglect to him, so he could report it to the state. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's policy titled Abuse/Neglect dated 03/29/18 reflected, After receipt of the allegation the Abuse Preventions and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines found in Provider letter 19-17. A report to the appropriate agency will include the following: The name and address of the suspected victim. The name and address of the suspected victim's care giver, if known. The nature and extent of any injuries resulting from the suspected abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injury of unknown source The nursing facility will make an addendum to any reportable incident in its report to HHSC if the resident subsequently experiences a negative outcome. g. Other pertinent information as available. The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form. 4. With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee(s) will immediately be suspended pending an investigation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview and record review the facility failed to ensure the resident environment remained free of accidents hazards and each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 8 residents reviewed for accidents hazards. The facility failed to protect Residents #1 from accidents when they failed to provide the necessary care devices to prevent injury from a fall. Resident #1 had a history of subdural hemorrhage with brain injury and a previous order for a fall mat. The CNA was aware the fall mat was missing and Resident #1 experienced convulsions/seizures resulting in a fall. Resident #1 sustained a skin tear from the fall. This failure could affect 8 Residents at the facility that received fall precautions and interventions resulting in serious harm and injuries. On 02/28/24 at 3:38 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/29/24 at 3:52 PM, the facility remained in compliance at a severity level of no harm and a scope of' 'isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. Findings included: Record review of Resident #1's face sheet dated 02/27/24 reflected he was a [AGE] year-old male admitted initially on 06/23/23 and again on 02/23/24 DX included: Traumatic Subdural Hemorrhage with loss of consciousness (brain injury) of unspecified duration, HX of Subsequent Encounter Conversion Disorder with seizures or convulsions (conversion disorder is a condition in which you have physical symptoms but no injury or illness to explain seizures). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 0 indicating severely impaired cognition- nonverbal, Section K feeding Tube, Section M stage 4 wound documented and being treated with ointments and medication, including diet, Section N Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin), Section O no treatments. Pain unable to answer. Record Review of Resident #1's Care plan dated 12/01/23 reflected he has a resident is at risk for falls r/t traumatic subdural hemorrhage neuromuscular dysfunction and chronic respiratory failure. Record review of PN dated 2/25/24 at 06:47 AM reflected Progress Note: Resident was found on the floor face down. Has a skin tear on the forehead. No neurological deficits noted at this time. wife called no response, unable to leave a voicemail because the mailbox was full. neuro check in progress. DON and Dr. Notified.To continue with the plan of care. BP 120/71 P 78 T 98.7 02 96. Record review of Resident #1's incident report dated 02/25/24 at 6:55 AM by LVN A reflected resident was found on the floor face down. Has a skin tear on the forehead. No neurological deficits noted at this time. Unable to speak. MD notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's fall nurse note dated 02/25/24 at 7:05 AM by RN J reflected no injury, no decline, no appearance of pain, and fall interventions; fall mat, low bed, bed assist handle, 1/4 rail. Record Review of PN dated 2/25/2024 at 7:07 AM by LVN A reflected '[company name]' was notified '[Resident #1s fall and injuries]' and will send a nurse down to assess pt . Record review of PN dated 02/25/24 at 7:10 AM by RN-EC reflected, Resident admitted to [company name] '[company name]' with the diagnosis of Traumatic Subdural Hemorrhage (a type of bleeding in the brain from a blow to the head) with loss of consciousness (awareness). No directions specified for order. Record review of Resident #1's X-ray dated 02/25/24 (time unknown) reflected order given by MD NK, conducted by technician LO .reviewed by MD PS . procedures (facial bones, less than 3 views .findings no obvious fractures or other significant abnormality seen in visualized facial bones .Impression: normal study electronically signed by MD S 02/26/24 at 5:10 PM Record review of Resident #1's PN dated 02/26/24 at 08:47 AM by the DON reflected X ray to the forehead and facial bones shows no obvious fracture. Nursing will continue to treat skin per standing orders. Record review of Resident #1's PN dated 02/26/24 08:47 AM by the DON reflected X ray to the forehead and facial bones shows no obvious fracture. Nursing will continue to treat skin per standing orders. Record review of Resident #1's PN/MD BY MD O note dated 02/26/24 12:55 PM, reflected Date of Service: 02/26/2024 Visit Type: Follow Up Transition of Care: No transition occurred. Details: This is a copy of a signed encounter note documented in Chief Complaint / Nature of Presenting Problem: Review x-ray result . Neurology discussed MRI and EEG results with FM that since patient has not shown improvement clinically from a neurological standpoint. Patient will have to continue with current supportive care treatment . Reviewed. Nursing Staff: Reviewed x-ray result Patient: Limited by cognition. Patient had a fall over the weekend. X-ray reviewed and no fracture. Patient had a small skin tear. Wound care is already following. Record review of Resident #1's PN dated 02/26/24 at 2:47 PM by the DON reflected Resident admitted to '[company name]' with diagnosis of Traumatic Subdural Hemorrhage with loss of Consciousness .'[company name]' nurse in house to assess resident and new orders received for pain, anxiety, increased secretions and nausea and vomiting, scoop mattress, morphine sulfate Q 3 h for pain or SOB, Lorazepam for anxiety Q 6 h. Record review of Resident #1's PN dated 02/26/24 3:55 AM BY RN AR reflected bump noted on forehead. neuro checks continue to be done; no S/S of infection noted. nurses will continue with ordered wound treatment and monitor for any S/S of infection. LVN I. Record review of Resident #1's fall nursing note dated 02/27/24 at 12:24 AM by LVN DO reflect injury: skin tear forehead .size 8.8 cm X 0.1, 1.2 cm X 0.1, no S/S of infection, no decline since fall no appearance of pain, no changes that required MD notification, all interventions fall mat, low bed. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record review of Resident #1's fall nurse note dated 02/27/24 at 7:04 AM by LVN DO indicate no injury, fall mat and low bed. Fall note assessment dated [DATE] indicated skin tear or laceration on forehead 0.8cm x o. 1, 1.2cm x

o.1.

Record review of neuro assessment dated [DATE] at 07:04 AM and 02/28/24 at 10:10 AM by RN J reflected Eyes were spontaneously opening, sounds only-moans/groans .abnormal flexion-stimulus causes abnormal flection of limbs (adduction of arm, internal rotation of shoulder, pronation of forearm, with flexion-decorticate posture no new observations.

Observation of Resident #1 on 02/27/24 at 11:00 AM and 02/28/24 at 8:15 AM revealed resident to be lying in bed, head of bed raised, feeding tube operating, both bags were dated, eyes closed, and a fall mat on the floor. Resident was observed to have two healing stage skin injuries to the forehead. Resident was not interviewable.

In an interview on 02/27/24 at 3:09 PM, with CNA J revealed on 02/25/24 at 6PM she arrived at her shift, and conducted rounds every 2 hours or less. CNA J stated she was familiar with Resident #1's care. CNA J stated Resident #1 was a fall risk and required his bed in low position and fall mat next to bed. CNA J heard Resident #1 fall on the floor, and she immediately responded and observed Resident #1 lying fac down on the floor, and bleeding skin tears to his forehead. CNA J, called for the nurse, and remained with Resident #1. CNA J said it was important to ensure fall prevention devices were applied for residents to prevent injurie. CNA J said Resident #1's fall mat was not applied next his bed, and he sustained injures. CNA J said the fall mat could have decreased impact and prevented Resident #1's injures from occurring.

In an interview with the DON on 02/27/24 3:38 PM she stated that she was contacted by LVN A on 02/25/24 at 6:40 AM via video call to assess the resident. Reporting that Resident#1 fell out of the bed on the floor and had skin tears with blood on his forehead. The DON stated Resident #1 has fall prevention precautions were ordered to prevent resident injuries from accidents and falls. DON said she was notified immediately. DON stated resident was immediately assessed by nurses per facility protocol and notification to '[company name]', MD, and FM. DON stated the rounding nurses and aides did not ensure the resident's fall mat was in place during shifts on the day of the fall, 02/25/24. DON stated that she expects all nursing staff to ensure resident orders, preventions, and care needs are followed. She further expects the nursing staff to review residents' orders, implement as written, and monitor during rounds to prevent accidents from occurring. DON said she initiated in service with her nursing staff on MD orders, resident monitoring, and care needs, including but limited to fall mats, low beds, new and re-admission orders and precautions to prevent accidents.

In an interview on 02/28/24 at 9:33 AM RN J stated upon arriving and completing shift change reports on 02/25/24 at 6AM she was notified by LVN E that Resident #1 had fallen and had injuries to the forehead. RN J notified the MD, the DON, and his family to report Resident #1's fall. RN J was not provided the details of the fall, nor did she did not ask additional questions. RN J said the DON and '[company name]' on call nursed arrived to assess Resident #1's incident, applied fall mat, and additional prevention devices for safety. RN J said failing to follow MD orders could result in resident's receiving injuries when falling. or prevention could prevent accidents from occurring.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 02/28/24 at 10:28 AM with LVN W revealed nurses are expected to review and follow MD orders, ensure fall prevention devices are implemented and monitored every shift to prevent injuries. Additional tasks include, monitoring devices, following up on orders, and reporting immediately any changes with the orders. LVN W stated that fall mats are a prevention device that can prevent accident injuries if a resident fall. In an interview with RN HN nurse on 02/28/24 at 10:55 AM revealed Resident #1 was admitted to '[company name]' at the hospital prior to discharge on 02/24/24. RN HN stated that the facility nurse called '[company name]' on call line to report the incident, and the on-call nurse reported she would be out to assess. RN HN said the on-call report stated Resident #1's fall on 02/25/234 at 6:26 AM. LVN A called and stated he had fallen on the floor from his bed, sustaining injuries to his forehead, no discomfort or distress. RN HN said Resident # 1's first care encounter at the facility was on Monday (02/27/24). She ordered Bolster's (a long thick pillow that is placed under the pillow for support.) for his bed (when sitting up he aspirates/coughs during tube feeding and he moves forward.) She placed the fall mat on 02/25/24 after the fall. She was not aware of the fall mat orders prior to intake to '[company name]'. In an interview on 02/28/24 at 1:04 PM with LVN S, Resident #1 had been readmitted on [DATE], and she observed his fall mat positioned next to his bed during rounds. LVNS stated Resident #1 had no falls during her shift on 02/23/24 from 7P-6A. LVN S said it was important to review MD orders and ensure they are being followed so the resident does sustain injuries. Record review of the facility policy dated October 5, 2016, titled Preventive Strategies to Reduce Fall Risk reflected Policy: The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility. Procedure: After risk is assessed, individualized nursing care plans will be implemented to prevent falls. Incident Reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the resident(s). Environment: Keep bed in low position. This was determined to be an Immediate Jeopardy (IJ) on 02/28/24 at 3:38 PM]. The ADM, CRN and DON were notified. The ADM was provided with the IJ template on 02/28/24 at 3:52 AM The following Plan of Removal submitted by the facility was accepted on 02/29/24 at 11:23 AM Plan of Removal Free of Accidents Hazards/Supervision/Devices Statement: The facility failed to supervise Resident #1 and abuse and neglect in that: Resident #1 was found on the floor in his room on 2/25/24 at 6:47a by CNA. Interventions: 1. Resident # 1 was transferred to the hospital as of 2/28/24 for evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The Charge Nurse and CNA that cared for resident #1 on the shift he sustained the fall was in-serviced 1:1 by the DON and Regional Compliance Nurse on: a. Fall Prevention Strategies (ensuring fall mats are in use) b. Abuse and Neglect Policy to include ensuring safety devices are in place. c. Kardex: how to use to determine if a fall mat is required for a resident. 3. An audit was performed by the Regional Compliance Nurse and DON for all residents who require a fall mat on 2/28/24 to ensure that they are in place. 4. The medical director was notified of the immediate jeopardy citation on 2/28/24 by the Director of Nursing. 5 An ADHOC QAPI meeting was held on 2/28/24 with the IDT Team to include the medical director to discuss the immediate eopardy and plan of removal. In-services: The following in-services were initiated by the Administrator, DON, and Regional Compliance Nurse on 2/28/24 for all direct care staff. All direct care staff not present on 2/28/24 will be in-serviced prior to the start of next shift. All new hires will in-serviced during orientation. All agency staff will in-serviced prior to the start of their shift.Fall Prevention Strategies (ensuring fall mats are in use); Abuse and Neglect Policy to include ensuring safety devices are in place; Kardex: how to use to determine if a fall mat is required for a resident . Inservice provided on a list of residents that require Monitoring: The DON/ADON/Designee will review 3 residents per day x 5 days a week to ensure fall mats are in place x 4 weeks. Monitoring of the POR included the following: Record review of in-service titled Abuse and Neglect, by DON, CRN, and ADM dated 02/26/24, 02/27/24, 02/28/24, 02/29/24 reflected curriculum covered the facility's policy on abuse and neglect, fall precautions, interventions, Kardex referencing, MD orders, intervention and reporting abuse neglect immediately to the Abuse Coordinator (Administrator). Interviews were conducted on 02/29/24 starting at 1:30 PM and continued through 4:30 PM with the following staff from various shifts: CNA A, CNA D, CNA L, CNA J, CNA S, CNA T, CNA P, LVN A, LVN C, LVN D, LVN P, LVN S, RN E, RN J, RN R, AD, DM, MAD, SW, HKS, DOR were interviewed and confirmed in-service trainings: Fall Prevention Strategies (ensuring fall mats are in use), Abuse and Neglect Policy to include ensuring safety devices are in place. Kardex: how to use to determine if a fall mat is required for a resident. Following MD orders (including the use of fall mats and ensuring bed in low in position. Inservice provided on a list of residents that require a fall mat. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews with the following licensed nurses on 02/29/24 at 2:30 PM LVN A, LVN C, LVN D, LVN P, LVN S, RN E, RN J, RN R, were interviewed and confirmed attendance at in-services training on the types of abuse, Fall Prevention Strategies (ensuring fall mats are in use), Abuse and Neglect Policy to include ensuring safety devices are in place. Kardex: how to use to determine if a fall mat is required for a resident. Following MD orders (including the use of fall mats and ensuring bed in low in position). Interviews with completed on 02/29/24 at 3:20 PM with ADON, DON, and CRN confirming additional in-service training and information for nurse managers to audit and monitor The Don/ADON/Designee will review 3 residents per day x 5 days a week to ensure fall mats are in place x 4 weeks. In an interview with the Administrator on 02/29/24 at 3:47 PM revealed his expectations of staff were to comply with facility policies and procedures, follow up with patients requiring specialized care, monitor and report to leadership (ADON, DON, and CRN) any inconsistencies, and compliance nursing services. He stated the DON will assign an overnight staff to follow through on the process in place such as following physician orders, accessing and reviewing Kardex overnight system with aides to ensure familiarity with resident care. The ADM, the DON, and the ADON will monitor documentation of task off site electronically to ensure compliance. All staff will ensure the residents receive the best care possible. Expectation for nursing and aides to complete end of shift reports best practice expectations. The Administrator and the DON were notified the IJ was removed on 02/29/24 at 4:30 PM. The facility remained out of compliance at a scope of isolated and at the severity level of no harm, due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.