STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455903	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Lodge Nursing & Rehabilitation	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #1) of seven residents reviewed for call lights. The facility failed to ensure Resident #1's call button was placed within reach. This failure could place dependent residents at risk of injuries and unmet needs. The findings included: Record review of Resident #1's face sheet, dated 05/23/2024, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included, anoxic brain damage (lack of blood flow to brain tissue, results from poisoning such as drug overdose), disruption of traumatic injury wound repair, subsequent encounter (injury, poisoning and certain other consequences of external cause), hyperlipidemia (elevated level of lipids, like cholesterol in the blood), Tracheostomy status (the presence of a tracheostomy), and Type 2 diabetes (a problem in the way the body regulates and uses sugar as fuel). Record review of resident #1's quarterly MDS Assessment, dated 04/12/2024 reflected no record of Resident #1's BIMS. Cognitive patterns included memory problems and severely impaired cognitive skills for daily decision making. He was always incontinent of bowel and bladder and dependent for toileting, showers, and transfers. He had a feeding tube. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, dated 02/05/2021, reflected the following: Focus: [Resident #1] has a Tracheostomy and is at for altered respiratory status/Difficulty Breathing/Shortness of Breath. Intervention: Monitor/document level of consciousness, mental status, and lethargy PRN. Provide means of communication and procedural information. Reassure that help is available immediately. Focus: [Resident #1] requires supplemental oxygen via Tracheostomy r/t Ineffective gas exchange. Intervention: Provide reassurance and allay anxiety: Have an agreed-on method for the resident to call for assistance (e.g., call light, bell). Stay with the resident during episodes of respiratory distress. Focus: [Resident #1] is risk for falls. Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs a safe environment with: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach) Focus: [Resident #1] has a communication problem r/t anoxic brain damage. Intervention: Ensure/provide a safe environment: Call light in reach . An observation and attempted interview on 05/23/2024 at 9:30 AM revealed Resident #1 in bed. Resident #1 had a tracheostomy, feeding tube, and oxygen. Resident #1's call button (pad) was on the dresser beside the bed and not accessible to him. Resident #1 did not answer questions this surveyor asked about the call button. In an interview on 05/23/2024 at 9:56 AM, LVN A stated Resident #1 did not speak but could move his hands. She said he did not use the call button, but it should be placed on the bed beside him, so he had access to it. She said he did not have access to the call button when it was on the dresser beside his bed. She said it was all staff's responsibility to ensure call lights were within reach for all residents. She said it was resident's right to be able to call for assistance when they required it. An interview on 05/23/2024 at 10:00 AM, with the DON and Administrator, the DON stated all residents should have access to their call light. She said although Resident #1 never used his call light, it should be placed where he had access to it. She said all staff were responsible to ensure resident's call lights were placed in their reach to ensure they could call for assistance if they needed to. The Administrator stated he expected staff to check for call light placement throughout the day to ensure residents could call for assistance. In an interview on 05/23/2024 at 10:57 AM, CNA B said she placed Resident #1's call pad on the dresser when she was providing care to him earlier in the morning. She said she forgot to place it beside him in bed when she left the room. She stated Resident #1 had a call pad and it should be placed beside him in bed because he could roll onto it to call for assistance as needed. She stated he rarely used the call pad but it was his right to have it accessible to him. She said all staff were responsible to ensure call lights were placed for all residents. In an interview on 05/23/2024 at 12:05 PM, the Corporate Compliance Nurse stated she expected call light to be accessible to all residents no matter their ability to use them. She said residents had a right to call for assistance if they felt they need it. She said all staff were responsible to ensure call lights were placed and accessible to residents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy, titled, Resident Rights, reflected, The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. Respect and Dignity: 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.