

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 06/06/2024
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)
<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507</p> <p>Based on observations, interviews, and record review the facility failed to provide radiology or other diagnostic services to meet the needs of its residents in a timely manner for 1 (Resident #1) of 3 residents reviewed for radiology services.</p> <p>The facility failed to follow up on Resident #1's x-ray results in a timely manner.</p> <p>The facility failed to follow up on x-ray results that revealed a fracture of the right tibial plateau. Resident #1 was sent to hospital on 05/13/2024 at 10:10 am.</p> <p>The noncompliance was identified at PNC. The Immediate Jeopardy (IJ) began on 05/12/2024 and ended on 05/15/2024. The facility had corrected the noncompliance before the survey began.</p> <p>These failures resulted in delayed diagnosis, medical treatment, and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #1's admission record, dated 06/05/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease.</p> <p>Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 3, indicating severe cognitive impairment.</p> <p>Review of Resident #1's care plan, dated 05/13/2024, revealed the resident was at risk for falls - aimlessly wandering. Interventions included anticipate and meet the resident's needs, ensure the resident was wearing appropriate footwear when ambulating or mobilizing in w/c, and keep needed items, water, etc. within reach.</p> <p>Review of Resident #1's nurse note dated 05/12/2024 at 1:15 pm, written by LVN A, reflected Resident c/o pain on right knee, upon assessment noted right knee slightly swollen and tender to touch, Clinician on call notified via phone call, assessment done via video call, new order received for right knee xray and ultrasound and both ordered. Awaiting on the xray and ultrasound.</p> <p>Review of Resident #1's nurse noted, dated 05/12/2024 at 4:55 pm, written by LVN A, reflected Xray of right knee done, RP notified via phone call.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's nurse note dated 05/13/2024 at 10:42 am, written by the DON, reflected In the course of reviewing nursing documentation, the DON saw that the resident complained of right knee pain which was assessed and seen to be slightly swollen, MD notified, x-ray and ultrasound ordered. The xray results came in 5/13/24 indicating resident has a suspicious metadisphyseal longitudinal fracture of the medial tibial condyle extending into the intercondylar notch. This nurse notified the MD with the result and order received to sent the resident out to the hospital. Nurse administered Tylenol 650, notified RP, and Administrator of the fracture. Resident sent to the ER for evaluation and treatment related to suspicious fracture.</p> <p>Review of Resident #1's nurse note dated 05/13/2024 at 2:55 pm, written by LVN B, reflected Resident returned from Hospital with the Dx: of a closed fracture of the right tibial plateau. The Resident was transferred back into bed. The resident has a brace noted on the right leg. New Order to follow-up with an orthopedic MD given. The PCP aware of the resident's return. No medication changes at this time. Will continue with the plan of care.</p> <p>Review of facility's Provider Investigation report for Resident #1, dated 05/13/2024, revealed the following:</p> <p>Resident complained of pain to her right knee. Right knee swollen and slightly inflamed, no bruising. Physician notified, order for x-ray obtained. Nurse gave resident 2 tablets of Tylenol 325 mg for pain. No bruising around knee, slightly inflamed with some redness. X-ray showed fracture of the medial tibial condyle with extension into the intercondylar notch.</p> <p>When x-ray report was received resident sent to hospital. Hospital sent resident back with an immobilizer on her knee and an order to see orthopedic doctor. Nursing staff obtained orders from physician for pain medication, no weight bearing to right leg, pain assessment every shift, right leg to be in immobilizer at all times, and to keep leg elevated when in wheelchair. Physician, family, DON and Administrator notified of injury. Quality of Life Rounds done by Social Worker in the secure unit.</p> <p>[Resident #1] could not say how she received her fracture. Interviews with staff and residents on the secure unit did not reveal how resident obtained injury. Camera footage of the unit was reviewed for the unit and did not show how resident obtained her injury. Resident does not have a history of falls.</p> <p>In an interview on 06/05/2024 at 9:19 am, the DON stated Resident #1 complained of leg pain. They did an x-ray, the results were delayed, and when the results came in, she realized Resident #1 had a fracture. The DON stated the results were delayed probably 8 hours and she saw the results the next day around 9 am. When asked why the results were delayed, the DON stated communication with the x-ray company. She said they always fax results but did not this time. She said staff have access to the results (through a portal) but if they were critical, the x-ray company was supposed to fax, call, and if no answer from the facility they were supposed to call the DON's cell phone.</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/05/2024 at 10:30 am, the DON stated she was in the process of getting a new imaging company after the incident with Resident #1. She stated in-services with the staff were completed on stat x-rays. She stated if the x-ray was not completed within 4-5 hours, the nurse was to notify the doctor who may send the resident out to the hospital. The DON stated the night nurse, RN F, did not call the x-ray company to follow up and communicated to follow up in the morning to the nurse. The DON stated she in-serviced RN F that she was supposed to call the x-ray company about the result or call the doctor to say she did not get any report.</p> <p>Observation on 06/05/2024 at 11:31 am in the secure unit revealed Resident #1 well groomed and dressed sitting up in her wheelchair in the hallway outside of her room. Resident #1's right leg had an immobilizer and was elevated. Resident #1 stated she was not in any pain and did not know how her knee was injured.</p> <p>In an interview on 06/05/2024 at 2:16 pm, the DON stated they did not have a written policy on x-ray services. She stated they follow the change of condition policy, and depending on what it was, if x-rays were needed, they followed the procedures based on the change of condition.</p> <p>Attempted interview on 06/05/2024 at 2:24 pm with RN F was unsuccessful, a voicemail was left.</p> <p>In an interview on 06/05/2024 at 2:53 pm, LVN B stated she was in-serviced on change of condition. She stated if a stat lab/x-ray was ordered, the time frame to check, and call them to follow up. She stated if a stat x-ray was ordered the company would usually come out in 1-4 hours and the results would be available within 1-2 hours. LVN B stated she was in-serviced because a resident on the secure unit had a fractured leg, and they did not know why the injury occurred. LVN B stated if x-rays were ordered on her shift and the x-ray company had not come out, or the x-ray was completed but no results were faxed or called in to the facility, she stated she would call the x-ray company to follow up and notify the MD and the DON. She stated especially if a resident continued to have a change of condition, they would be sent out. LVN B stated she had come in on Monday (05/13/2024) and was told that Resident #1's x-rays were done but results were not posted. She said the ADON had come back to the unit with the results around 9 am. LVN B said when she came in on Monday, Resident #1 just was not moving as much. She stated Resident #1 was normally very mobile, walked, bends over, and tried to clean things everywhere so it was weird for her to not move. She said Resident #1 was not able to verbalize her needs and was pretty depressed the first week or two [after the injury] but was perking back up now.</p> <p>In a telephone interview on 06/05/2024 at 3:34 pm, LVN C stated she was in-serviced on stat x-rays. She stated if they were not completed timely, she would call the x-ray company, let the next nurse know, and inform the doctor. LVN C stated if a resident's x-ray was completed on her shift she would check the fax, or the portal. She stated if results were not received timely, she would call the x-ray company to see what was going on, inform the DON, and let the doctor be aware. She stated the nurse on shift was responsible and the DON or anyone could follow up for the results. She stated the risk was the patient could have an injury.</p> <p>In an interview on 06/05/2024 at 3:49 pm, RN E stated if x-rays or labs were ordered on her shift and they were not done or no results were received she would contact her supervisor, and handover to the next shift. She stated if stat x-ray was done on a resident during her shift and no result was received, she would contact the doctor. RN E stated they could be in pain, or injury if not treated.</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/05/2024 at 3:59 pm, LVN D stated she had been in-serviced on x-rays because someone that fell on the [secure] unit. LVN D stated she was in serviced on stat orders and said if it was an emergency like a suspected fracture, she would put in the order stat, and contact the x-ray company if they were not there timely. She stated she was supposed to contact the doctor if the stat x-ray was not done within 4 hours. LVN D stated the nurse checked the fax for results and notify the doctor if the x-ray was done on their shift. LVN D stated if the results were not received timely the resident could be in pain and it could delay treatment.</p> <p>In a telephone interview on 06/05/2024 at 4:49 pm, the Regional Director of Operations for the x-ray company stated the order came in for Resident #1 on 05/12/2024 at 1:08 pm as a routine study. She stated images were uploaded at 4:39 pm and results were read [by the radiologist] at 6:46 pm. She stated they did not get an answer when they called the facility that evening on 05/12/2024. She stated there was a timestamp on 05/13/2024 at 9:54 am where an agent spoke with a nurse (the ADON). She stated the results were faxed usually right when it was read by the radiologist. She stated the facility also had access to their database (where results can be retrieved).</p> <p>In an interview on 06/06/2024 at 9:43 am, LVN A stated she was in-serviced on stat x-rays and the timeframe to follow up. She stated if a stat x-ray was ordered, and the x-ray had not been done then contact the doctor and the DON. She said if the x-ray had been done and results were not received, she would call the x-ray company, and check the portal. LVN A stated if the resident had a broken bone, they would need to go to the hospital. She stated the nurse was responsible to check the results and all nurses have access to the portal. LVN A stated it there was an abnormal lab or x-ray, the company was supposed to call with a critical lab or critical anything.</p> <p>In an interview on 06/06/2024 at 10:08 am, when asked what the risk to the resident was, the DON stated Resident #1 was monitored and pain medicine was given. The DON stated pain was not severe like crying. When Resident #1 went to the hospital, she was not prescribed pain medicine, so they contacted the doctor after she returned, and Resident #1 was prescribed Tylenol 3 to manage pain for the injury. The DON stated nurses and herself were responsible but not one person it was the team. She said they had conversations of changing the x-ray company, and they already had a new lab company as of 06/03/2024.</p> <p>In an interview on 06/06/2024 at 10:08 am, the Regional Compliance Nurse stated they had put a plan in place and an issue could arise if not addressed. She stated they could have continued to have a timeliness issue and pain was not an issue since Resident #1's pain was addressed. She said they had to give a 30-day notice for the new x-ray company.</p> <p>Attempted interview on 06/06/2024 at 10:48 am with RN F was unsuccessful, a voicemail and text message were left.</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 06/06/2024 at 1:07 pm, RN F stated on her shift Resident #1's x-ray was already done, the result was pending, and she handed off to the oncoming nurse. She stated the x-ray company did not call her, and she was not informed of any results. She said the x-ray company was supposed to call if any problem. RN F stated LVN A already documented in [EHR name] and there was nothing new, so she did not document about the pending result, she just informed the oncoming nurse (LVN B). RN F stated she was in-serviced on 05/15/2024 on following up on x-ray and lab results. She stated if any abnormality the x-ray company was supposed to call her. She stated if she got the report that indicated a fracture, she was supposed to notify the MD, the DON, the RP and if any orders, to send to the hospital. RN F stated she knows to check the portal for any results and document the status in [EHR name].</p> <p>Record review of in-services dated 05/13/2024, on the topic of Injuries of unknown origin imaging request reflected the following: All falls and injury related imaging request must be entered as STAT orders. Notify the MD if the stat orders have not been performed after 4 hrs and request if there can be a change of plan for example sending the resident to the hospital.</p> <p>Record review of in-services dated 05/13/2024, on the topic of Reviewing imaging and laboratory results reflected the following: Review imaging and laboratory results obtained during your shift and notify the MD, the DON, and the RP with the results. Follow up on labs and imaging ordered prior to your shift and during your shift for results and communicate with the next shift on all new orders received.</p> <p>Record review of in-services dated 05/13/2024, on the topic of Injuries of unknown origin and change of condition reflected the following: Notify the Administrator immediately if a resident is found with an injury of unknown origin. Notify the MD, the DON and the RPs of all injuries to a patient and any change of condition.</p> <p>Record review of in-service dated 05/13/2024, signed by RN F, on the topic of Following up and checking on imaging and labs results ordered reflected the following: Following up on imaging and labs results ordered during your shift and on the prior shift and notified the MD, the RP, and the DON of all abnormal results and document in [EHR Name].</p> <p>Follow up on all new and prior laboratory imaging and medication orders and document in [EHR Name] the result status. Check the laboratory and imaging portal results that were performed prior to your shift and within your shift and notify the MD, the RP and the DON of the results and status documented in [EHR Name].</p> <p>Notify the MD immediately and document recommendations in [EHR Name] of all abnormal results, during shift change always give report on the results or pending results, pending collection and those performed of all imaging laboratory orders to the oncoming nurse. Check the result tab in [EHR Name] for all residents within your shift and report abnormal results to the MD. Check the imaging portal for all outstanding results.</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of policy titled Notifying the Physician of Change in Status revised March 11, 2023, reflected in part: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. This facility utilizes the INTERACT tool, Change in Condition - When to Notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires immediate notification of the physician or non-immediate/Report on Next Workday notification of the physician. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record .9. Faxes should be following up by the end of the business day .11. Abnormal lab, x-ray and other diagnostic reports require physician notification.</p>		