

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 04/07/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on observation, interview, and record review the facility failed to establish and maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 Residents (Resident #1) reviewed for infection control.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure CNA B used the required PPE for Resident #1, who was on enhanced barrier precautions due to her wound, and indwelling foley catheter, while assisting LVN A with Resident #1's wound care and getting Resident#1 dressed on 04/07/25. 2. The facility failed to ensure LVN A used the required PPE for Resident #1, who was on enhanced barrier precautions due to her wound, and indwelling foley catheter, while performing wound care for Resident #1 on 04/07/25. 3. The facility failed to ensure LVN A performed hand hygiene between glove changes when she went from dirty to clean during incontinence care for Resident #1. 4. The facility failed to ensure LVN C used the required PPE for Resident #1, who was on enhanced barrier precautions due to her wound, and indwelling foley catheter, while assisting the resident with getting dressed and ready for the mechanical lift on 04/07/25. <p>These failures could place residents at risk of cross-contamination and development of infection.</p> <p>Finding Include:</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 03/14/25, reflected a [AGE] year-old female who was initially admitted to facility on 08/23/24 and readmitted on [DATE]. Resident #1 had a BIMS score of 08, which indicated she was moderately cognitively impaired. Resident #1 had diagnoses which included hypertension (elevated blood pressure), end stage renal disease (kidney failure) and cerebral vascular accident (type of ischemic stroke resulting from a blockage in the blood vessels supplying blood to the brain).</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's comprehensive care plan, dated 01/13/25, reflected Focus. [Resident #1] is on Enhanced Barrier Precautions. Goal. There will not be any transmission of infection from or to the resident. Intervention. Gloves and gown should be donned if any of the following activities are to occur . transfer, dressing .incontinent care, bed mobility, wound care . other high contact activity.</p> <p>Record review of Resident#1's Physician Orders Report, dated 11/05/24, reflected Enhanced Barrier Precaution related to foley Catheter and wounds. Wear gloves and gown for all catheter care and wound care.</p> <p>In an observation on 04/07/25 at 9:05 AM, Resident #1's room was noted with a sign on her door which indicated she was on Enhanced Barrier Precautions, no PPE cart in front of the room. LVN A entered Resident #1's room to do wound care. Resident #1's wound was in the sacral area. LVN A washed her hands and put on gloves, but no gown. CNA B entered Resident #1's room to help LVN A with wound care. CNA B washed her hands and put on gloves, but no gown. LVN A uncovered Resident #1 and unfastened Resident #1's brief. Both staff helped Resident #1 turn to her left side. LVN A opened Resident #1's brief, the resident had a bowel movement. LVN A removed the old dressing, and cleaned Resident #1's buttocks area, folded the brief, and pushed it under the resident. LVN A changed gloves without performing any kind of hand hygiene. LVN A cleaned Resident #1's wound, applied Santyl ointment, alginate calcium and border dressing on the wound. CNA B got a clean brief from the drawer and put it under the resident. Both staff turned Resident #1 on to her back, CNA B cleaned Resident #1's front area. Both staff turned Resident #1 to her right side. CNA B removed the dirty brief and finished putting the clean brief on the resident. LVN A washed hands and exited the room. LVN C entered Resident #1's room to help CNA B dress Resident #1 and get her ready for the mechanical lift, in anticipation of a dialysis appointment. LVN C washed hands, put on gloves, and no gown. Both staff got Resident #1 dressed in a T-Shirt and pants and put a sling under her. Both staff covered Resident #1, removed gloves, and washed hands before exiting the room .</p> <p>Interview with LVN A on 04/07/25 at 09:26 AM revealed she knew she was supposed to wear a gown for the resident's wound care, but she forgot. She stated she was nervous. LVN A stated she was trained to wear a gown for high contact with residents in Enhanced Barrier precautions. LVN A stated she was required to change gloves and perform hand hygiene whenever she was going from dirty to clean task. She stated she realized she had not done hands hygiene She stated the risk of not following the proper infection control policy, like not wearing proper PPE in EBP room, and performing hand hygiene was the spread of germs and infections.</p> <p>In an interview with CNA B on 04/07/25 at 09:28 AM, she stated she did not put on a gown, because there was no PPE supplies cart in front of the room, as the other rooms for EBP in the Hall. She stated she would put a PPE supply cart in front of the room. She stated the risk to residents was cross contamination.</p> <p>Interview with LVN C on 04/07/25 at 09:32 AM revealed she knew she supposed to wear a gown for any high contact with the residents on EBP, but she forgot. She stated she was in serviced on EBP, but she could not recall how long ago. She stated the risk to residents was cross contamination and development of infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 04/07/25 at 11:59 AM, she stated staff were taught any resident who was on Enhanced Barrier Precautions required gloves and a gown when providing any contact with the resident. The DON stated the staff were trained on when to change their gloves and sanitize their hands. She stated staff needed to change their gloves when they went from dirty to clean. She stated the risk was an increased risk of infections.</p> <p>Record review of the facility's policy, dated 04/01/2024 and titled Enhanced Barrier Precaution, revealed Enhanced Barrier Precaution (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistance organisms that employ targeted gown and glove use during high contact resident care activities.</p> <p>Record review of the facility's policy, updated 03/2024 and titled Infection Control Policy & Procedure Manual 2019, , reflected 1. Hands hygiene. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . After removing gloves . Gloves. Wearing gloves does not replace the need for hand washing.</p>		