

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 03/11/2026
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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 infection for 08 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8,) of 12 residents reviewed for infection control. The facility failed on 03/11/26 to ensure infection control procedures were followed when the MA failed to sanitize the wrist blood pressure cuff between each resident when she obtained blood pressure readings. This failure could place residents at risk of infection. Findings included: Record review of Resident #1's face sheet, dated 03/11/26 reflected he was a [AGE] year-old male who was admitted on [DATE] and diagnosed with Parkinson (progressive neurological disorder causing movement problems), unspecified, tremor (an involuntary, rhythmic shaking movement of body parts) unspecified, personal history of traumatic brain injury and essential primary Hypertension (high blood pressure). Record review of Resident #1's MDS, dated [DATE] reflected, his BIMS score was 14 which indicated no cognition impairment. Record review of Resident #2's face sheet, dated 03/11/26 reflected she was a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE] and diagnosed with Type 2 Diabetes Mellitus without complications and essential primary hypertension (high blood pressure). Record review of Resident #2's MDS, dated [DATE] reflected, his BIMS score was 14 which indicated no cognition impairment. Record review of Resident #3's face sheet, dated 03/11/26 reflected he was a [AGE] year-old male who was admitted on [DATE] and diagnosed with chronic kidney disease stage 4 (severe) and essential (primary) hypertension (high blood pressure). Record review of Resident #3's MDS, dated [DATE] reflected, his BIMS score was 09 which indicated moderate cognition impairment. Record review of Resident #4's face sheet, dated 03/11/26 reflected she was a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE] and diagnosed with essential (primary) hypertension (high blood pressure). Record review of Resident #4's MDS, dated [DATE] reflected, her BIMS score was 15 which indicated no cognition impairment. Record review of Resident #5's face sheet, dated 03/11/26 reflected she was a [AGE] year-old female who was admitted on [DATE] and diagnosed with essential (primary) hypertension (high blood pressure). Record review of Resident #5's MDS, dated [DATE] reflected, her BIMS score was 01 which indicated severe cognition impairment. Record review of Resident #6's face sheet, dated 03/11/26 reflected she was an [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE] and diagnosed with essential (primary) hypertension (high blood pressure). Record review of Resident #6's MDS, dated [DATE] reflected, her BIMS score was 99 which indicated resident was unable to complete interview. Record review of Resident #7's face sheet, dated 03/11/26 reflected he was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE] and diagnosed with essential (primary) hypertension (high blood pressure). Record review of Resident #7's MDS, dated [DATE] reflected, his BIMS was not documented. Record review of Resident #8's face sheet, dated 03/11/26 reflected she was a [AGE] year-old female who was admitted on [DATE] and diagnosed with essential (primary) hypertension (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 - Some</p>	<p>(high blood pressure).Record review of Resident #8's MDS, dated [DATE] reflected, his BIMS score was 15 which indicated no cognition impairment. During an observation on 03/11/26 at 7:53 AM, the MA attempted to obtain Resident #1's BP with BPM #1. The MA was not able to obtain a read from Resident #1's wrist. The MA used BPM #1 on Resident #2's wrist without sanitizing between each resident. The MA washed and dried her hands before she exited out of the room. During an observation on 03/11/26 at 8:05 AM, the MA used BPM #1 and used BPM #2 on Resident #3's wrist. The MA did not sanitize the wrist cuff to both machines after she obtained the BP measurements. The MA washed and dried her hands before she exited Resident #3's room. During an observation on 03/11/26 at 8:20 AM, the MA used BPM #2 on Resident #4's wrist. The MA did not sanitize the wrist cuff after she obtained Resident # 4's BP measurement. The MA washed and dried her hands before she exited Resident #4's room. During an observation on 03/11/26 at 8:34 AM, the MA used BPM #2 on Resident #5's wrist. The MA did not sanitize the wrist cuff after she obtained Resident #5's BP measurement. The MA washed and dried her hands before she exited Resident #5's room. During an observation on 03/11/26 at 8:40 AM, the MA used BPM #2 on Resident #6's wrist. The MA did not sanitize the wrist cuff after she obtained Resident #6's BP measurement. The MA washed and dried her hands before she exited Resident #6's room. During an observation on 03/11/26 at 8:48 AM, the MA used BPM #2 on Resident #7's wrist. The MA did not sanitize the wrist cuff after she obtained Resident #7's BP measurement. The MA washed and dried her hands before she exited Resident #7's room. During an observation on 03/11/26 at 8:56 AM, the MA used BPM #2 on Resident #8's wrist. The MA did not sanitize the wrist cuff after she obtained Resident #8 BP measurement. The MA washed and dried her hands before she exited Resident #8's room. During an interview and observation on 03/11/26 at 9:02 AM, The MA stated the cuff was sanitized between each resident when the residents had covid to prevent cross contamination. The MA showed the surveyor the sanitizer wipes on the medication cart and stated those were the wipes that are used to clean the cuff and cart. During an interview on 03/11/26 at 9:40 AM, LVN B stated BP cuffs must be sanitized between residents because residents could have something contagious on their skin and could pass it to other residents. During an interview on 03/11/26 at 10:12 AM, LVN C stated BP cuffs are sanitized between each resident to avoid cross contamination. During an interview on 03/11/26 at 2:30 PM, the DON stated BP cuffs are sanitized between each resident to prevent cross contamination. The DON stated she started an in-service with nursing staff. Record review of facility policy titled Infection Control Plan Overview, revised 03/2024 reflected, Process surveillance reviews practices directly related to resident care in order to identify whether the practices comply with established prevention and control procedures and policies based on recognized guidelines. Examples of this type of surveillance include monitoring of compliance with transmission based precautions, proper hand hygiene, and the use and disposal of gloves. Process surveillance determines, for example, whether the facility: Minimizes exposure to a potential source of infection Uses appropriate hand hygiene prior to and after all procedures Ensures that appropriate sterile techniques are followed, for example, that staff: Use sterile gloves, fluids, and materials, when indicated, depending on the site and the procedure, Avoid contaminating sterile procedures; and Ensure that contaminated/non-sterile items are not placed in a sterile field. Uses Personal Protective Equipment (PPE) when indicated. Ensures that reusable equipment is appropriately cleaned, disinfected, or reprocessed.</p>		