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	03/31/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to ensure staff reported potential use of medication not provided by the facility to the ADM and DON for 1 of 5 (Resident #1) reviewed for quality of care.CNA B failed to report Resident #1 told her he had been taking medication for weight loss provided by family.This failure could place residents at risk of adverse effects to medications or medication interactions, that can lead to residents not meeting their highest practicable physical, mental, and psychosocial needs.Findings included:Record review of Resident #1's face sheet revealed an [AGE] year-old male admitted with a primary diagnosis of acute respiratory failure (lungs cannot get enough oxygen in blood). Other pertinent diagnoses included anxiety disorder (excessive fear or worry), acute on chronic systolic congestive heart failure (body cannot pump enough blood to heart), acute pulmonary edema (fluid buildup in lungs), type 2 diabetes mellitus (body cannot produce enough insulin to maintain blood sugar levels), and obesity (excessive fat accumulation, can lead to serious health conditions). Record review of Resident #1's progress notes, dated 03/07/2026, reflected: Entered resident's room for routine check. Witnessed resident's [family member], handing a syringe to the resident. Observed resident self-inject into lower abdomen. [family member] stated he takes this for anxietyResident remained conscious, alert and oriented.Immediately asked to see the syringe but she refused stating everybody in this facility knows about this Notified DON and Physician- left message. No immediate adverse reactions noted. Will continue to monitor.Record review of Resident #1's orders, dated 03/09/2026, revealed Resident #1 did not have an order for weight loss medication. Record review of Resident #1's care plan, dated 03/13/2026, revealed Resident #1 did not have a care plan for weight loss mediation or self-administering medications. Care plan interventions included for medications to be given as ordered by physician. During an interview on 03/30/2026 on 11:27 a.m. with Resident #1's family member, she said she had not provided Resident #1 with any anti-anxiety medications from outside the facility. The family member said she did provide Resident #1 with the over-the-counter medication, Mucinex (loosens chest congestion, treats cold, flu, and coughs), from outside the facility. There was no mention of weight loss medication at this time. During an interview on 03/31/2026 at 9:30 a.m. with the DON, she said LVN A reported to her that she had seen Resident #1 self-administering medication on 03/07/2026 and that the family member was the one who provided the medication. LVN A reported to the DON that the family member said it was for anxiety and all the nurses knew about it. The DON said she told LVN A she did not know about it and requested LVN A to get the medications from the family member. The DON said LVN A told her the family member then said it was water used as a placebo and she would not give her the medication. The DON said she contacted the family member to educate her she could not provide medications to Resident #1 and requested to meet on 03/09/2026 and to bring the medication to her. The DON said Resident #1 was monitored for changes after the alleged incident of the self-administered medications and did not show adverse side effects on 03/07/2026 and 03/08/2026. She said on 03/09/2026 she went to educate Resident #1 that he could not take medications not provided by the facility. The DON said at that time, he had just eaten breakfast and did not look normal. She said a nurse had taken his vitals and his oxygen saturation level was low, and they discharged him to the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital. The DON said Resident #1 had a history of respiratory issues before that day. The DON said she had called the family member about the discharge, and the family member did not ever bring the medication to the DON. She indicated the family member was not seen again in the facility after the alleged incident on 03/07/2026 through when Resident #1 was discharged to the hospital on [DATE], due to complications related to his diagnosis of acute respiratory failure. The DON said the over-the-counter medication, Mucinex, was in Resident #1's room. The DON said the facility felt it was not safe for Resident #1 to reside at the facility due to the family member not following the facility's policy of not providing medications from outside of the facility. She indicated it was a risk to Resident #1 due to possible negative side effects. During an interview on 03/31/2026 at 11:41 a.m. with LVN A, she said she saw Resident #1 injecting himself with a medication and the family member standing by Resident #1. She said the family member said it was for anxiety and everyone (nursing staff) knew about it. LVN A said she asked the family member to look at it and the family member told her she had a prescription for it. LVN A said the family member then said it was just water used as a placebo to make him calm down and she walked away. LVN A said she called the DON and documented the alleged incident. LVN A said she monitored Resident #1 every 30 minutes to check for change of conditions, and she did not see any change during the remainder of her shift. She indicated the next shift monitored Resident #1 too. LVN A said it was important to report the alleged incident because the facility administers medications to the resident and anything coming from outside could end his life and the facility would not know what the medication was. During an interview on 03/31/2026 at 1:47 p.m. with CNA B, she said she provided care for Resident # when he was a resident at the facility. She said she had not heard about the incident regarding a family member giving Resident #1 medication that was not provided by the facility. CNA B said Resident #1 did say something to her about the family member giving him medication for weight loss. She said she never saw the family member give him medication; she said she had not heard from other staff members that Resident #1 said he took weight loss medication. CNA B said she did not report to her supervisor what Resident #1 had told her because she did not think it needed to be but maybe should have because if he received medication that was not provided by the facility, it could have been a risk to Resident #1. During an interview on 03/31/2026 at 2:47 p.m., RN C said they provided care for Resident #1. RN C said they had not heard from Resident #1 about him taking medication that was not provided by the facility. RN C said they would report it to the DON if they had heard that because the facility and doctor needed to know what medication Resident #1 was taking due to medication interactions, and for the best interest of the resident. During an interview on 03/31/2026 at 3:10 p.m. with LVN D, she said she provided care for Resident #1, and he had never told her about taking medications provided by family members. LVN D said she worked on 03/07/2026 during the alleged incident. She said the family member came to the nurse's station and told LVN A the medication was for weight loss. She said she never heard the family member say it was for anxiety. LVN D said if she had heard about or seen Resident #1 receiving medication from outside of the facility, she would report it to the DON, ADM, and MD. She said it was a risk for residents to take medications not given by the facility because residents may not administer them the right way and something could happen. During an interview on 03/31/2026 at 3:40 p.m., the DON said she had asked other nurses about Resident #1 receiving medication provided by family members and they indicated they did not know about the medication. The DON said nurses were expected to report if they had heard a resident was receiving medications not provided by the facility. The DON said she had not heard from the CNAs if they had heard about residents receiving medications not provided by the facility, but CNAs were educated to report to her and the ADM if they heard something. The DON said they know to report to her but would do further education. She said the risk of not reporting could be harmful to the resident due to medication interactions or if a resident was allergic to the medication. During an interview on 03/31/2026 at 4:25 p.m. with the ADM, he said he expected staff to communicate because he and the DON were supposed to be aware of everything, so they can care plan and document. The ADM said if (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was receiving medication without the facility knowing there was a risk of medication interactions.Record review of the facility's Abuse/Neglect policy, undated, reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.Definitions1. Abuse: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.2. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.7. 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.E. Reporting1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.