

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Lakeview Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 502 East Coke Rd Winnsboro, TX 75494	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 5 of 9 residents (Resident #7, Resident #13, Resident #25, Resident #34, and Resident #45) reviewed for abuse. 1. The facility failed to implement their policy when they did not complete incident reports after a resident-to-resident incident between Resident #34, Resident #13, and Resident #25 on 05/01/2025, and on 07/19/2025 for Resident #7. 2. The facility failed to implement their policy when they did not complete incident report after injury of unknown origin for Resident #45 on 07/31/25 and failed to document the training related to this incident. These failures could place the residents in the facility at risk for physical, mental, and/or psychosocial harm and lack of complete documentation of the incidents. Findings included: Record review of the facility's policy titled, Abuse Prohibition Policy, revised 06/02/2025 indicated, This protocol was intended to assist in the prevention of abuse, neglect and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse. Physical abuse includes hitting, slapping, kicking, shoving, pinching and controlling behavior through corporal punishment. Verbal abuse is defined as the use of, oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal/mental abuse include, but are not limited to, cursing, yelling, saying things to frighten a resident. Resident to Resident Incidents: The following guidelines will be implemented when resident to resident incidences occur: 4. An incident report will be completed for the perpetrator and the victim. Reporting/ Response. 2. The Abuse Coordinator will report . injuries of unknown origin will be reported withing 24 hours of the allegations. Investigation reporting i. and indicate any corrective actions taken. 1. Record review of Resident #34's face sheet dated 02/09/2026 indicated he was an [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke), spastic hemiplegia affecting right dominant side (muscle stiffness and weakness on the right side of the body), and intermittent explosive disorder (repeated, sudden bouts of impulsive, aggressive, violent behavior or angry verbal outbursts). Record review of Resident #34's Quarterly MDS assessment dated [DATE] indicated he was sometimes understood by others and sometimes he understood others. The MDS assessment indicated Resident #34 had a BIMS score of 6, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #34 did not have behaviors. The MDS assessment indicated Resident #34 required substantial/maximal assistance with personal hygiene, toileting hygiene, and partial/moderate assistance with showering bathing and setup or clean-up assistance for eating. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #34's care plan with a target date of 03/30/2026 indicated he had the potential to be physically aggressive. Resident #34's care plan indicated to analyze times of day, places, circumstances, triggers, and what de-escalated his behavior and to document it, to assess and anticipate his needs, to monitor/document/report as needed any signs and symptoms of him posing danger to himself and others. Record review of the Provider Investigation Report dated 05/05/2025 indicated, an incident date of 05/01/2025. The investigation summary indicated, Resident #34 was at a table in the front lobby with Resident #13 and Resident #25. Resident #13 and Resident #25 expressed their worries, real or imagined, at length to anyone they saw. Resident #34 was upset, and started telling them to shut up, but they did not respond positively to the negative attitude. Resident #34 started telling them that he was going to kill them if they did not shut up. Record review of a witness statement indicated LVN A was the nurse when the incident occurred. Record review of the Provider Investigation Report dated 07/22/2025 indicated, an incident date of 07/19/2025. The investigation summary indicated, Resident #34 was at a table in the front lobby with Resident #7, they started arguing. Resident #34 told Resident #7 to shut up and then grabbed her right wrist as she reached her hand out towards him and squeezed it. A volunteer of the facility intervened, and they were separated. The nurse assessed Resident #7 for any injury none were found and there were no complaints of pain. Record review of a witness statement indicated RN B was the nurse when the incident occurred. Record review of the Incidents Report with date range of 02/09/2025-02/09/2026 did not indicate an incident dated 05/01/2025 for Resident #34. An incident of physical aggression initiated was indicated on the Incidents Report for Resident #34 on 07/19/2025. Record review of Resident #34's electronic medical record on 02/10/2026 did not indicate documentation of the incidents on 05/01/2025 and 07/19/2025. 2. Record review of Resident #13's face sheet dated 02/09/2026 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included senile degeneration of the brain (deterioration of the brain which leads to cognitive decline, memory impairment, and changes in behavior and personality) and cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination). Record review of Resident #13's Comprehensive MDS assessment dated [DATE] indicated she was sometimes understood by others and sometimes she understood others. The MDS assessment indicated Resident #13's BIMS score was a 0, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #13 did not have behaviors. The MDS assessment indicated Resident #13 was dependent on staff for toileting, personal hygiene, and bathing, and required setup or clean-up assistance for eating. Record review of Resident #13's care plan with a target date of 04/11/2026 indicated she required total assistance from staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Record review of the Incidents Report with date range of 02/09/2025-02/09/2026 did not indicate an incident dated 05/01/2025 for Resident #13. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's electronic medical record on 02/10/2026 did not indicate documentation of the incident on 05/01/2025. 3. Record review of Resident #25's face sheet dated 02/09/2026 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and paralysis of the left side after a stroke) and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #25's Quarterly MDS assessment dated [DATE] indicated she was sometimes understood by others and sometimes she understood others. The MDS assessment indicated Resident #25's BIMS score was a 0, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #25 did not have behaviors. The MDS assessment indicated Resident #25 required substantial/maximal assistance with personal and toileting hygiene, bathing, and setup or clean-up assistance for eating. Record review of Resident #25's care plan with a target date of 04/06/2026 indicated she had a potential to be verbally aggressive related to dementia. The care plan indicated to analyze key times, places, circumstances, triggers and de-escalate behaviors and to intervene before agitation escalated. Record review of the Incidents Report with date range of 02/09/2025-02/09/2026 did not indicate an incident dated 05/01/2025 for Resident #25. Record review of Resident #25's electronic medical record on 02/10/2026 did not indicate documentation of the incident on 05/01/2025. 4. Record review of Resident #7's face sheet dated 02/09/2026 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included vascular dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and essential primary hypertension (high blood pressure). Record review of Resident #7's Quarterly MDS assessment dated [DATE] indicated she was sometimes understood by others and sometimes she understood others. The MDS assessment indicated Resident #7's BIMS score was a 0, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #7 did not have behaviors. The MDS assessment indicated Resident #7 was dependent on staff for all ADLs. Record review of Resident #7's care plan with a target date of 05/11/2026 indicated she had the potential to be physically aggressive to other residents related to cognitive impairment. Resident #7's interventions included to assess and anticipate her needs, monitor seating positions when she was out of bed, and to intervene before agitation escalated, and engage her calmly in a conversation. Record review of the Incidents Report with date range of 02/09/2025-02/09/2026 did not indicate an incident dated 07/19/2025 for Resident #7. Record review of Resident #7's electronic medical record on 02/10/2026 did not indicate documentation of the incident on 07/19/2025. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an attempted phone interview on 02/10/2026 at 10:21 AM, RN B did not answer the phone. During an interview on 02/10/2026 at 10:28 AM, LVN A said if she was the nurse on 05/01/2025, the incident with Resident #34, Resident #13, and Resident #25, was not reported to her. LVN A said she did not remember anything being reported to her. LVN A said when there was a resident-to-resident altercation it should be documented in the progress notes, and an incident report should be completed. LVN A said documentation was important for everyone to know what happened. LVN A said it was important for an incident report to be completed so there was proper follow-up on the incident and the residents involved in the incident. During an interview on 02/10/2026 at 1:36 PM, the DON said when an incident happened, such as a resident-to-resident altercation, the nurses were responsible for completing an incident report, and within the incident report the nurses were able to document a progress note to ensure it was documented in the resident's electronic medical record. The DON said she was responsible for monitoring the nurses to ensure the documentation and incident reports were completed and the ADON provided her assistance with monitoring the nurses. The DON said every morning they looked at the incidents to ensure all incidents were documented properly and an incident report was completed. The DON said she did not know why the incidents on 05/01/2025 and 07/19/2025 were not documented in Resident #34's, Resident #7's, Resident #13's, and Resident #25's electronic medical records. The DON said she did not know why an incident report was not completed for Resident #34 on 05/01/2025. The DON said it was not necessary to complete an incident report for Resident #13 and Resident #25 for the incident with Resident #34 on 05/01/2025. The DON said it was not necessary to complete an incident report for Resident #7 for the incident with Resident #34 on 07/19/2025. The DON said an incident report was only necessary for the perpetrator. The DON said it was important for incidents to be properly documented and incident reports to be completed to ensure they had completed everything, so they knew what was going on with the residents, and for trending the incidents. During an interview on 02/10/2026 at 2:00 PM, the ADON said when there was a resident-to-resident altercation an incident report should be completed for all the residents involved. The ADON said the DON and Administrator reviewed the incidents to ensure they were properly documented, and incident reports were completed. The ADON said she did not know why the incident reports and documentation for the incidents on 05/01/2025 and 07/19/2025 was not completed. The ADON said it was important to complete incident documentation and incident reports to ensure there was proper follow-up, to keep the residents safe, to prevent other accidents/incidents, and to catch trends. During an interview on 02/10/2026 at 2:10 PM, the Administrator said his expectations were if something happened an incident report should be completed, and it should be documented. The Administrator said when an incident occurred, all residents involved should have an incident report completed. The Administrator said the DON was responsible for ensuring incidents were documented an incident report was completed. The Administrator said the incident report let them know if something happened, and without it they would not be able to properly adjust the residents plan of care. The Administrator said the incident reports prevented future issues. The Administrator said documentation should be completed so they would be able to identify the care they needed to provide and address any care practice issues. 5. Record review of a face sheet dated 02/11/2026 indicated Resident #45 was [AGE] years old, admitted to facility on 07/11/2023. Her diagnoses included severe obesity, diabetes (high blood sugar), muscle weakness, major depressive disorder recurrent psychotic symptoms (severe (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reoccurring depressive episodes accompanied by delusions or hallucinations), hypertension (condition in which the blood against the artery walls is too high), and anxiety disorder. Record review of Resident #45's care plan with revision dated 08/22/2025 indicated Resident #45 was high risk for falls related to her cognitive impairment and was dependent on transfers. She had fall on 07/20/2025. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #45 was usually able to make herself understood and usually understand others. She had a BIMS of 03 (severely impaired cognitively). She exhibited no behaviors over the 7 days look back period. She was dependent on staff for most ADLS. She had a fall during the observation period. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #45 was usually able to make herself understood and usually understands others. She had a BIMS of 11 (moderately impaired cognitively). She exhibited no behaviors over the 7 days look back period. She was dependent on staff for most ADLS. She had no falls during the observation period. Record review of the Incidents Report with date range of 07/30/2025 to 08/02/2025 did not indicate an incident dated 07/31/2025 for Resident #45. Record review of the provider investigation report dated 07/31/2025 for Resident #45 indicated she had a bruise on her chest and said the staff had dropped the left bar but did not know which CNAs were getting her up. The provider investigation form indicated the staff would be trained in reporting injuries of unknown origin. During an observation and interview on 02/9/2026 at 8:00 a.m., Resident #45 was in her bed and was watching TV. She said she had tried to stand up a while back and said she had forgotten she could not walk. She said she slid out of the bed, and she said she must had gotten bruised on her chest then but was unsure of the date the fall happened. She denied the staff had hurt her. During an interview on 02/11/2026 at 11:45 a.m., the Administrator said he expected an incident report to be completed for Resident #45. He said the nurse on duty that day does not work here anymore. He said she was terminated but not related to this issue. He said he could not find the documentation for the training that was completed on 7/31/25. He said he had given the training forms to the staff. He said he did not remember if they turned in the training forms with their signatures. During an interview on 02/11/2026 at 12:00 p.m., the DON said the incident report dated 07/20/2025 should have been updated or a new incident report made and that was not done as she pointed to the electronic record for Resident #45. She said the only training was done prior to this incident by her and she was not aware the PIR indicated more training was needed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for 1 of 1 kitchen reviewed for food service safety. 1. The facility failed to seal, label and date a clear plastic bag of frozen chicken wings in freezer #1, and an opened box of egg rolls in Freezer #2. 2. The facility failed to label and date a clear plastic bag of frozen chicken parts in Freezer #1, and a bag of frozen cauliflower in Freezer #2. 3. The facility failed to label and date a clear plastic bag of sliced cheese and an open container of chicken base in Refrigerator #1. 4. The facility failed to keep a container identified as thickener sealed in dry storage room. These failures placed residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings Included: During initial observation and interview on 02/09/2026 at 08:15 a.m. to 9:00 a.m., revealed freezer #1, freezer #2, refrigerator #1 and dry storage room in the kitchen contained the following: Freezer #1: *an open, unlabeled (missing the name of the food item, the open date, the expiration or use by date) clear plastic bag of frozen chicken wings that were not properly labeled, sealed and exposed to the elements. [NAME] D said the plastic bag contained chicken wings. *an unlabeled (missing the name of the food item, the open date, the expiration or use by date), clear plastic bag of frozen chicken parts that were not properly labeled with opened date or identifying the item. [NAME] D said the plastic bag contained chicken parts. Freezer #2: *a sealed bag of unlabeled (missing the name of the food item, the open date, the expiration or use by date) bag of cauliflower. [NAME] D said the plastic bag contained cauliflower and the original bag was damaged during unpackaging last week, so he repackaged it. *an open box unsealed (missing the open date, the expiration or use by date) original cardboard box containing a clear plastic bag of frozen egg rolls that was not properly sealed and exposed to the elements. [NAME] D said the bag contained frozen egg rolls. Refrigerator #1: *a sealed bag of unlabeled (missing the name of the food item, the open date, the expiration or use by date) clear bag of sliced cheese. The Dietary Manager said the bag contained sliced cheese. *an open unlabeled (missing the open date, the expiration or use by date) container of chicken base. The Dietary Manager indicated the chicken base had been opened and partially used. Dry Storage Room: *an open/unsealed/exposed container labeled Thickener. [NAME] D said the container had Thickener in it and closed and sealed the container. During an interview on 02/09/2026 at 8:45 a.m., [NAME] D said he did not know who left the bags of chicken wings and chicken parts unlabeled in the freezer #1 and all foods in the freezer should be labeled with content and date opened. He said that the original cauliflower bag was damaged during delivery and he repackaged the cauliflower and should have labeled and dated the new package when he repackaged it. He said all open boxes or bags of frozen foods being stored should be sealed or they could get freezer burn. He said once the packaging was opened or if food was repackaged it should be labeled with the content, opened date and/or expired or used by date. He said he had been trained to ensure that after opening a food item, it should be labeled with the open date and stored in a sealed container. He said in the dried food storage room all containers should be labeled and resealed after use to prevent air exposure or contamination. During an interview on 02/09/2026 at 10:40 a.m., the Dietary Manager said that he was not aware that frozen items in freezers #1 and #2 and foods and cooking base in refrigerator #1 were not sealed, labeled, and dated appropriately. He said that food packaging should have been resealed and labeled with name of the food item, the open date, the expiration or use by date) once opened. He said moving forward his expectations were all products in the kitchen be stored correctly. He said packages of food and dry storage containers should be sealed so not to expose food to the elements. The Dietary Manager said it was the responsibility of all the dietary staff to ensure products were labeled and stored correctly. He said he did spot checks periodically in kitchen to be sure everything was working in kitchen and completed a walk-through checking for sanitary conditions. He said not storing and preparing food appropriately could cause contamination (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or freezer burn affecting the freshness and quality of resident's food. During an interview on 02/11/2026 at 11:00 a.m., the Administrator said he was the direct supervisor of the Dietary Manager, and he expected kitchen staff to follow policies on food storage and preparation including all open items to be closed/sealed, labeled/dated when open and discarded when expired. He said not storing and preparing food appropriately could cause freezer burns, affecting the freshness and quality of residents' food. Review of a facility policy, revised June 25, 2025, Refrigerator and Freezer indicated Policy Statement: This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Policy interpretations and implementation: .7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from the cases for storage. Used by dates will be completed with expiration dates on all prepared foods in refrigerators. Expiration dates on unopened food will be observed and quotation used by quotation dates indicated once the food is opened. 8. Supervisors will be responsible for insuring food items in pantry, refrigerators, and freezers are not expired or passed parish dates. Review of a facility policy, revised June 25, 2025, Dry Storage indicated 4. If the food is taken out of the original container (what the manufacturer placed the product in) it must be labeled and dated. 9. If the item is open, the food must be tightly sealed. It should be dated with the date that it was opened. If the product was removed from its original container, then the product should also have the name of the product. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 01/21/2026 indicated: .3-305.11 Food Storage. Food shall be protected from contamination by storing the food: (1) In a clean, dry location;(2) Where it is not exposed to slash, dust or other contamination . 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers .(B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement .Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents assessments accurately reflected the resident's status for 2 of 14 residents (Residents #17 and #41) reviewed for accuracy of assessments. 1. The facility failed to accurately complete the MDS assessment to indicate Resident #17's tobacco use. 2. The facility failed to accurately complete the MDS assessment to indicate Resident #41's PASARR positive. These failures could place residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings include: 1. Record review of Resident #17's face sheet, dated 02/09/2026, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #17 had a diagnosis which included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe). Record review of Resident #17's admission MDS assessment, dated 09/22/2025, indicated Resident #17 was not marked for current tobacco use during the assessment period. The assessment indicated Resident #17 had a BIMS score of 15, which indicated intact cognition with a diagnosis of chronic obstructive pulmonary disease. Record review of Resident #17's care plan, with a target date of 04/21/2026, indicated Resident #17 was at risk of injury due to smoking preference with interventions that included evaluating her smoking safety ability and provided appropriate interventions as indicated. Record review of an Admit or Readmit Evaluation, dated 09/15/2025 indicated a smoking screening of Resident #17 currently smoked cigarettes and required monitoring during smoking episodes. Record review of Progress notes dated 09/18/2025 indicated Resident #17 went out to smoke before returning to bed. During an observation and interview on 02/09/2026 at 9:30 a.m., indicated Resident #17 was sitting in her wheelchair she said she smoked daily, the staff kept her smoking supplies and monitored her during smoking times. Resident #17 said she was aware of the smoking times. During an observation on 02/10/2026 at 9:43 a.m., Resident #17 was observed smoking, a staff member was observed lighting the cigarette and provided smoking supplies and monitored the resident during the smoking episode. During an interview on 02/10/2026 at 1:45 p.m., LVN A said she was providing care for Resident #17 today and she smoked cigarettes daily. LVN A said the staff kept Resident #17's smoking supplies, lit her cigarettes and monitored her during smoking episodes. She said the MDS Nurse was responsible for all MDSs in the facility. During an interview and record review on 02/10/2026 at 8:19 a.m., the MDS Nurse said she was responsible for all MDSs completed in the facility and her back up that double checked random MDSs was the Regional Case Mix. She said she was educated on completion of MDSs. The MDS Nurse said Resident #17 was a smoker but did not smoke on admission to the facility. On review of Resident (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#17's nurses note the MDS Nurse said Resident #17 did smoke during the look back period of the MDS and she would modify Resident #17's admission MDS. She said she overlooked the tobacco use on Resident #17's MDS. The MDS Nurse said the resident risk of an MDS not marked for tobacco use and the resident smoked was just an inaccurate MDS. During an interview on 02/11/2026 at 8:05 a.m., the DON said the MDS Nurse was responsible for all MDSs in the facility and was educated on completion of the MDSs. She said she was the backup that double checked random MDSs. She said Resident #17 smoked daily. The DON said she and the MDS Nurse both missed Resident #17's MDS not marked for smoking. The DON said the risk of an MDS not marked for tobacco use when the resident smoked was a resident may not be reevaluated for smoking and her smoking concerns may not be addressed. She said the MDS did not accurately describe the resident. The DON said her expectation was all MDSs completed accurately. During an Interview on 02/11/2026 at 8:19 a.m., the Administrator said the MDS Nurse was responsible for all MDSs in the facility and was educated on completion of MDSs. He said the DON and Regional Case Mix were the backup to double check MDSs for accuracy. The Administrator said Resident #17 was the only resident in the facility that smoked and all staff were aware she smoked. He said smoking was overlooked on Resident #17's MDS. The Administrator said the resident risk of a resident that smoked is not documented on their MDS was an inaccuracy of the MDS. He said his expectation was all MDSs be accurate, complete and individualized to each resident. 2. Record review of Resident #41's face sheet, dated 02/10/2026, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #41 had a diagnosis which included mild intellectual disabilities (a condition that affects a person's ability to learn and function at an expected level) and frontal lobe and executive function deficit (impairments in cognitive processes controlled by the front part of brain, affecting skills such as planning, organization, and impulse control). Record review of Resident #41's annual MDS assessment, dated 01/07/2026, indicated Resident #41 was not marked 1. Yes, for resident currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition and Level II Preadmission Screening and Resident Review (PASARR) conditions and conditions related to ID/DD status were incomplete. The assessment indicated Resident #41 had a BIMS score of 15, which indicated intact cognition with a diagnosis of mild intellectual disabilities. Record review of Resident #41's care plan, with a target date of 04/09/2026, indicated Resident #41 was identified as having PASARR positive status related to ID with diagnosis of Intellectual Disability and required specialized services of habilitation coordination and independent skills training. Record review of a LIDDA Individual profile and habilitation service plan indicated Resident #41 was receiving PASARR services. She had habilitation service plan beginning 08/14/2025 with an end date of 08/13/2026 and individual profile indicating begin date 08/14/2025 with end date of 08/13/2026. During an observation and interview on 02/11/2026 at 9:30 a.m., indicated Resident #41 was sitting up in her bed she said she received habilitation and independent services through PASARR and a representative from LIDDA visited with her routinely. During an interview and record review on 02/11/2026 at 9:35 a.m., the MDS Nurse said Resident #41 was PASRR positive and received habilitation and individualized specialized services. On review of Resident #41's Individual and Habilitation Service Plans the MDS Nurse said Resident #41 was PASRR (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lakeview Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 502 East Coke Rd Winnsboro, TX 75494	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positive and was receiving habilitation and specialized services and her annual MDS should have reflected that in section A. She said she overlooked the PASRR positive on Resident #41's MDS. The MDS Nurse said after surveyor intervention she found that Resident #41's annual MDS did not indicate she was PASRR positive and she modified the annual MDS for accuracy. During an interview on 02/11/2026 at 10:55 a.m., the DON said she and the Regional Case Mix were the backup that double checked random MDSS. She said Resident #41 was PASARR positive and the MDS should have indicated that for accuracy. The DON said Resident #41's annual MDS was modified after the surveyors intervened. The DON said the annual MDS should have indicated Resident #41 was PASARR positive if not she may not have received available services. The DON said her expectation was all MDSs to be completed accurately initially and modified if inaccuracy identified. During an Interview on 02/11/2026 at 11:10 a.m., The Administrator said Resident #41 was PASARR positive and received services. He said PASARR was overlooked on Resident #41's annual MDS. The Administrator said the resident risk of a resident that are PASARR positive not documented on their MDS was an inaccuracy of the MDS. During an interview on 02/11/2026 at 10:45 a.m., the Regional Case Mix said the MDS Nurse was responsible for all MDSS in the facility and was educated on the completion of MDSS. She said nursing and SW were responsible for certain sections of the MDS, but the MDS Nurse was responsible for the smoking section. She said she was the back up and checked skilled MDS (MDSs that captured skills including therapy or medical services requiring professional staff) but not all MDS. She also checked any MDSs the MDS Nurse had a concern with. The Regional Case Mix said she did not check Resident #17's Annual MDS that was not marked for tobacco use. She said the tobacco use on Resident #17's MDS was overlooked and the MDS could be corrected. The Regional Case Mix said the resident risk of an MDS not marked for tobacco use when the resident smoked was that it could affect resident care. She said all smokers must have someone in attendance during smoking episodes. She said that Resident #41 MDS should have indicated she was PASRR positive and receiving rehabilitation and individualized services for her ID. She said the MDS should be accurate to reflect PASRR positive and services they are receiving so that resident care is not affected. Record review of the facility's policy titled, MDS CODING POLICY, reviewed 06/02 /2025, indicated . facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, indicated . A1500: Preadmission Screening and Resident Review (PASRR) Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions Item Rationale To document conditions associated with intellectual or developmental disabilities. Steps for Assessment 1. If resident is [AGE] years of age or older on the ARD, complete only if A0310A = 01 (admission assessment). 2. If resident is [AGE] years of age or younger on the ARD, complete if A0310A = 01, 03, 04, or 05 (admission assessment, Annual assessment, SCSA, Significant Correction to Prior Comprehensive Assessment) . Coding Instructions Check all conditions related to ID/DD status that were present before age [AGE]. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely. Code A: if Down syndrome is present. Code B: if autism is present. Code C: if epilepsy is present. Code D: if other organic conditions related to ID/DD is present. Code E: if an ID/DD condition is present but the (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident does not have any of the specific conditions listed. Code Z: if ID/DD condition is not present.J1300: Current Tobacco Use coding . Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1. Yes. Coding Instructions, Code, no: if there are no indications that the resident used any form of tobacco. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 14 residents (Resident #3) reviewed for comprehensive care plans in that: The facility failed to develop and implement a comprehensive person-centered care plan for Resident #3's EBP (enhance barrier precautions) due to G-tube (gastric-tube for feeding and medications). This failure could place residents at risk of not receiving the appropriate care, services or treatment needed in a timely manner. Findings included: Record review of Resident #3's face sheet dated 02/10/2026 reflected the resident was an 81 -year-old male admitted to the facility on [DATE] with an original admission date of 07/24/2024. Resident #3 had diagnoses including dysphagia (difficulty swallowing), and gastrostomy tube (G-tube) - (a device inserted through the abdominal wall directly into the stomach to provide long-term nutrition, hydration, and medication). Record review of Resident #3's Annual MDS assessment, dated 01/08/2026, reflected that he scored a 09 on his BIMS which reflected moderately cognitively impaired. Resident #3 had a G-tube for nutrition, hydration, and medications. Record review of Resident #3 most recent Care Plan reflected Resident #3 did not have EBP precautions developed on his care plan or interventions. Record review of Resident #3 Physician's Order Summary dated 01/05/2026 reflected clean G-tube site with NS (normal saline), pat dry and cover with dressing daily. There was no EBP precaution order. During an interview on 02/10/2026 at 3:10 p.m., the DON said the MDS nurse was responsible for developing care plan for Resident #3. The DON said that EBP should have been included in the care plan and did not know why it was not completed. She stated that EBP should have been care-planned for Resident #3, and she said it had been overlooked. During an interview on 02/11/2026 at 11:50 a.m., the MDS nurse said that the DON and herself were responsible for developing the care plans. She said the DON was ultimately responsible for signing off on all care plans for accuracy and completion. Review of a facility policy dated 06/202/2025 titled Care Plans, Comprehensive Person-Centered indicated the following: . 8. The comprehensive, person-centered care plan will. b) Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; . g) Incorporate identified problem areas; h) Incorporate risk factors associated with identified problems; and o) Reflect currently recognized standards of practice for problem areas and conditions.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 27 residents (Resident #29) observed for medication storage. 1. The facility failed to ensure Resident #29 did not have a refresh plus eye drop ampule sitting on top of a covered bowl of cereal on top of his dresser. These failures could place residents at risk for not receiving drugs and biologicals as needed and injury. Findings include: Record review of Resident #29's face sheet dated 02/10/26 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses which included dry eye syndrome and need for assistance with personal care. Record review of Resident #29's quarterly MDS assessment dated [DATE] indicate he was usually able to understand others and he could usually make himself understood. The MDS also indicated he had a BIMS score of 3 which meant he had severely impaired cognition. Record review of Resident # 29's care plan revised on 10/15/25 indicated he had impaired visual function related to use of eyeglasses and dry eye syndrome with interventions in place for nurse to administer refresh plus as ordered. Record review of Resident #29's order summary report dated as of 02/10/26 indicated he had an order for: 1. Refresh Plus Ophthalmic Solution (Carboxymethylcellulose Sodium) Instill 1 drop in both eyes at bedtime related to dry eye syndrome of bilateral lacrimal glands with a start date of 12/29/25 and no end date. 2. Refresh Plus Ophthalmic Solution (Carboxymethylcellulose Sodium) Instill 1 drop in both eyes in the morning related to dry eye syndrome of bilateral lacrimal glands with a start date of 12/29/25 and no end date. During an observation and interview on 02/09/26 at 11:15 AM Resident #29 was sitting on the side of his bed. Resident #29 had a Refresh eye drop ampule on his dresser, on top of his covered bowl of cereal. Resident #29 said he guessed the girl left the medication for his eyes for him to take but it was closed so it had not been used and he said he usually did not do it (administer the eye drops) but maybe the nurse was coming back. During an observation on 02/09/26 at 12:43 PM the refresh eye drops were not on Resident #29's dresser. During an interview on 02/10/26 at 1:47 PM LVN C said she did not know where Resident #29 got the refresh plus eye drops. She said it was scheduled early in the morning and LVN C was responsible for administering it to him. LVN C said she removed the refresh eye drop ampule from Resident #29's room. She said the failure placed a risk for other residents getting the medication and ingesting it or using it and having adverse side effects. During an interview on 02/10/26 at 10:41 AM LVN A said she did not know how Resident #29 got the refresh eye drops. LVN A said he did the eye drops himself and then said she saw Resident #29 take the eye drops and LVN A threw the used ampule away. LVN A said she always makes sure to give the refresh eye drops to Resident #29 and removed the empty ampule after use. LVN A said she was responsible for ensuring the eye drops were administered and the failure placed a risk for Resident #29 or other residents to get a hold of the medications when they were not supposed to and ingest or misuse. During an interview on 02/10/26 at 2:21 PM The DON said the charge nurse may have set the refresh eye drop down and forgot to administer it. The DON said all medications should be locked on the medication carts and not at any resident's bedside. The DON said she expected the nurses to give all medications while they were in the room and remove all used and unused medications. The DON said the failure placed risks for residents taking more medications than they should or other residents getting a hold of the medication and misusing it. During an interview on 02/10/26 at 2:52 PM The Administrator said his expectation was for the medications to be on a locked medication cart and not left in any resident's room. The Administrator said the failure placed a risk for residents to use medications for other purposes and demented residents drinking medications, using the medications inappropriately, and missing doses. Record review of the facility policy Storage of Medications, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed 06/24/25 indicated: Policy StatementThe facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy interpretation and Implementation:Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.3.The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.12. Only persons authorized to prepare and administer medications have access to locked medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 infections for 2 of 10 residents (Residents #3 and #31) observed for Infection Control. 1. The facility failed to implement EBP for Resident #3 during a G-tube medication administration on 02/10/2026. 2. The facility failed to implement EBP for Resident #31 during a wound care dressing change on 02/10/2026. These failures could place residents and staff at risk for cross-contamination and development of infections. Findings Included: 1. Record review of Resident #3's face sheet dated 02/10/2026 reflected the resident was an 81-year-old male admitted to the facility on [DATE] with an original admission date of 07/24/2024. Resident #3 had a diagnosis of gastrostomy tube (G-tube) - (a device inserted through the abdominal wall directly into the stomach to provide long-term nutrition, hydration, and medication). Record review of Resident #3's Annual MDS assessment, dated 01/08/2026, reflected that he scored a 09 on his BIMS which reflected moderately cognitively impaired. Resident #3 had a G-tube for nutrition, hydration, and medications. Record review of Resident #3 most recent Care Plan, last revised 01/15/26, failed to reflect Resident #3 had EBP precautions in place. Record review of Resident #3 Physician's Order Summary dated 01/05/2026 reflected clean G-tube site with NS (normal saline), pat dry and cover with dressing daily. There was no physician order indicating Resident #3 should be on EBP precautions. During an observation on 02/10/2026 at 1:30 p.m., outside Resident #3's room there was no EBP signage. There was EBP signage and 3-drawer PPE cart located across the hallway which was indicated for another resident. During a medication administration observation on 02/10/2026 at 1:30 p.m., LVN A prepared medication for Resident #3 to be administered via the G-tube. LVN A donned gloves, raised Resident #3's shirt, held the G-tube while checking for patency and assessed placement. She then administered the medication and water flushes. LVN A did not wear a gown during the medication administration via G-tube/direct contact with Resident #3. During an interview on 02/10/2026 at 1:45 p.m., LVN A said that she failed to follow the EBP because she forgot to wear a gown during Resident #3's G-tube medication administration. She said she had been trained on EBP and should have applied the gown prior to entering the room to perform the medication administration to Resident #3 but she forgot. She said that not wearing a gown during the G-tube medication administration could spread infection or cause cross contamination. During an interview on 02/10/2026 at 3:10 p.m., the DON said she had placed EBP signage on Resident #3's door and that it must have fallen off. She said her expectations were for nursing staff to follow EBP protocols and to wear gown and gloves when administering medications via G-tube. 2. Record review of admission Record dated 02/11/2026, indicated Resident #31 was [AGE] years old male with diagnosis of non-pressure chronic ulcer of abdomen (ulcer or break in skin that fails to heal as it should and typically more chronic in nature. Record review of Resident #31's quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 15 indicating that he was intact cognitively. He made himself understood and understood others. He required ointment/medications application and nonsurgical dressings for ulcer treatment. He required maximum assistance for self-care and mobility tasks. Record review of Resident #31's care plan, revision dated 01/27/2026, indicated Resident #31 required wound care to RUQ of abdomen and right flank and enhance barrier precautions. Interventions included wound care as prescribed by physicians and enhanced barrier precautions used during high-contact resident care activities as applicable such as wound care (any skin opening requiring a dressing). Record review of physician's orders for Resident #31 dated 02/09/2026 indicated wound care to right outer thigh cleanse with normal saline, pat dry, apply hydrofera blue (antibacterial) foam to wound bed, cover with foam dressing every 3 days and as needed if dressing soiled or dislodged and wound care to RUQ cleanse with normal saline (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or wound cleanser, allow to air dry, clean 10 cm border of peri wound with chlorohexidine swab, allow to dry, apply saline moisten mesalt (sodium chloride impregnated) dressing, cover with foam dressing daily and as needed if dressing soiled or dislodged. No physician order indicating Resident #31 should be on EBP because of his open wounds. During an interview on 02/09/2026 at 10:56 a.m., Resident #31 said he has a wound or fistula to his RUQ of abdomen due to his enlarged hernia and wound to his right thigh. He said facility staff performed his wound care daily and he visits a wound care physician weekly for oversight of his wounds. He said the facility staff wore gowns and gloves during his wound care. During an observation on 02/10/2026 at 10:55 a.m., indicated outside Resident #31's room was an EBP signage. There was a 3-drawer PPE cart located at entrance to Resident #31's room. During an observation on 02/10/2026 at 11:00 a.m., indicated LVN A provided wound care and a dressing change. LVN A did not wear a gown during the dressing change/direct contact with Resident #31. During an interview on 02/10/2026 at 11:40 a.m., LVN A said that she failed to follow the EBP because she forgot to wear a gown during Resident #31's wound care and dressing change to his right thigh and abdominal wound. She said she had been trained on EBP and should have applied a gown prior to entering the room to perform wound care and dressing change to Resident #31's wounds but she forgot. She said that not wearing a gown during the wound care and dressing change could spread infection or cause cross contamination. During an interview on 02/11/2026 at 10:40 a.m., the DON said she has provided staff with training regarding infection control and enhance barrier precautions. She said her expectations were for staff and visitors to perform hand hygiene upon entering and when leaving a resident's room, and when hands were soiled. She said EBP should be followed by staff with direct care provided to residents with open wounds, tube feedings, IV's, foley catheters, and tracheostomies. The DON said her expectations are for all staff to be mindful of the residents' status and utilize EBP as required. The DON said the risk of failing to perform EBP could lead to spread of infection to other residents or even staff. During an interview on 02/11/2026 at 11:30 a.m., the Administrator said his expectations were that all staff adhere to the EBP when providing high contact care for residents with wounds, tube feedings, IV's, tracheostomies and indwelling devices. He said all residents requiring EBP should have orders, signage on the doors and care plans indicating the required precautions. He said not following EBP as required could cause spread of infection or cross contamination. Review of a facility policy, reviewed, June 30, 2025, Enhanced Barrier Precautions indicated Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions as expand the use of PPE to donning of gown and glove during high contact resident care activities that provide opportunities for transfer of MDRO's to staff's hands and clothing. A single set PPE cannot be used for more than one patient. EBP are indicated for residents with any of the following: colonization with a CDC targeted MDRO when contact precautions do not otherwise apply or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds. Indwelling medical device examples include central lines, urinary catheters feeding tubes and tracheostomies. Donning PPE for residents on EBP based on activity provided/ assistance while in resident room: Resident activity of performing wound care does require enhance barrier precautions including donning gloves and gown. Resident activity of administering medications enterally does require enhanced barrier precautions including donning gloves and gown.		