STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675438	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Village Nursing and Rehabilitation	2320 Lake Shore Dr Waco, TX 76708

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49048 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological's were stored in locked compartments and inaccessible to unauthorized staff, visitors, and residents for two of five medication carts observed in that: Medication carts #1 and #2 were left unattended and unlocked. This failure could allow residents, staff and visitors unsupervised access to prescription and over-the-counter medications. Findings include: Medication Cart #1: An observation on 09/10/20224 at 5:10 am revealed Medication cart # 1 in Hall-B was against a wall across from the nurses' station, with the drawer's facing outward. The medication cart was unlocked and unsupervised. There were no residents and no staff within sight. Observation of the contents of the drawers revealed they contained prescription and over-the-counter medications. In an interview on 09/10/20224 at 5:12 am, LVN-A stated she had recently gotten something from the cart and forgot to lock it. The cart remained opened as LVN-A began to walk down the hall. In an interview on 09/10/20224 at 6:20 am, LVN-A stated the medication cart should have been locked. When asked about potential negative outcomes for residents she said they could take unprescribed medications and have severe reactions. Medication Cart #2: An observation on 09/10/20224 at 5:15 am revealed Medication cart # 2 in Hall-A was against a wall across from the nurses' station, with the drawer's facing outwards. The medication cart was unlocked and unsupervised. Two residents were sitting in the day room across from the nurses' station and multiple staff members navigating in, out and around the nurses' station. Observation of the contents of the drawer's revealed they contained prescription and over-the-counter medications. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/10/20224 at 5:20 am, LVN-B stated medication carts should be locked, unless they were being used. When asked about potential negative outcomes for residents, she said the residents could have had severe allergic reactions to medications, including death. In an interview on 09/10/2024 at 11:15 am, the DON stated the expectation was that medication carts should have been locked unless it was being used at that time. The drawers should have been faced towards the wall or inward, in the doorway of the resident's room. When asked about potential negative outcomes for residents, she said residents could have had minor allergic reactions to medications or it could have been fatal. In an interview on 09/10/2024 at 11:15 am, the ADM stated the expectation was for the medication and treatment carts to be locked when not in use. When asked about potential negative outcomes for residents, he said, Nothing could have happened, or something could have happened. He clarified that residents could have minor or severe reactions to medications and medications could have been taken from the cart. Record review of the facility's policy titled Security of the Medication Cart, 2001 MED-PASS, Revised April 2007, reflected: Policy Statement: The medication cart shall be secured during medication passes. Policy Interpretation and Implementation: 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should be parked in the doorway of the resident's room during medication pass. The cart doors and drawers should be facing the resident's room. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with the doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurse's station or inside the medication room.