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	05/10/2025

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review the facility failed to immediately notify Resident #1's Responsible Party and practitioners when there was a significant change the resident's physical status (a deterioration in health) for one of five residents (Resident #1) reviewed for resident rights. The facility failed to inform Resident #1's Responsible Party when he refused to eat or drink from dinner on 4/9/2025 to breakfast on 4/11/2025. The resident was sent to theER on [DATE] with altered mental status, high heart rate resulting in a diagnosis of Acute encephalopathy [altered brain function], Acute renal failure [decreased blood flow to the kidneys] and profound dehydration. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 5/8/2025 at 12:25 pm; the facility was notified and given an IJ template. While the IJ was removed on 05/10/2025 at 5:50 pm, the facility remained at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for immediate harm to their health and safety related to lack of self-determination, decreased nutritional status and dehydration. of a lack of a dignified existence, self-determination and quality of life. Findings include: Record review of Resident 1#'s face sheet, dated 4/17/2025, reflected a [AGE] year-old male who was admitted to the NF on 4/9/2025. Resident #1 had diagnoses which included: Cerebral Infarction (stroke - when blood flow to the brain in blocked), Hypertension (high blood pressure), Neoplasm related pain (tumor related pain), Heart Disease, Ataxia (impaired coordination) and Myocardial Infarction (heart attack). Resident #1' s face sheet indicated a FM was his RP and his emergency contact #1. Record review of Resident #1's Care Plan, dated 4/23/2025, reflected the following problem made on 4/11/2025 after the resident was sent to the ER: Potential for alteration in nutrition r/t mechanically altered diet. Resident has been found to pocket food. The following interventions were listed for this problem: document meal intake in the clinical record, notify physician as needed. (continued on next page)

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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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's progress notes, dated 4/9/2025 - 4/11/2025, reflected no entries regarding refusal of nutrition or hydration, no entries that practitioners were notified of refusal of nutrition/hydration and no entries that RP was notified of refusal of nutrition/hydration by Resident #1. Record review of Resident #1's EMR reflected he had not been in the NF long enough to have a BIMS assessment completed for his cognition level. Record review of Resident #1's Admission Assessment, dated 4/9/2025 at 4:12 pm, by LVN-B, reflected he was drowsy/stuporous but oriented to person, place, time, situation and that his cognition was intact. Record review of Resident #1's POC, dated 4/23/25, reflected no nutrition/hydration entry for 4/9/2025 or 4/11/2025. There were 3 entries on 4/10/2025 at 8:00 AM, 12:00 PM and 5:00 PM in the 0-25% column . Record Review of Resident #1's vital signs revealed he had an admission weight of 134 pounds on 4/9/2025 at 3:35 pm. Vital signs taken between 4/10/2025 and 4/11/2025 revealed resident's oxygen saturation, blood pressure and respirations were within normal limits. Further review of Resident #1's pulse rate revealed pulse rate was elevated and outside of the normal limits (60-100 beats per minute) as follows: 4/10/2025, 10:11 am - 108 bpm (beats per minute) 4/10/2025, 11:57 am - 104 bpm 4/10/2025, 6:19 pm - 105 bpm 4/11/2025, 9:44 am - 116 bpm During an interview with RP/FM on 4/17/2025 at 11:58 am, RP stated they were not aware Resident #1 had been refusing to eat or drink since he arrived at the NF. They stated they first they new something was wrong was the morning of 4/11/2025 when a nurse called them to say Resident t#1 was being sent to the ER because he was lethargic and had low vitals. They stated when they got to the ER, Resident #1 told them he had not had anything to eat or drink since he had been admitted on [DATE]. The RP stated if they had known he wasn't eating or drinking they could have gone up to the NF and encourage him to eat, but no one notified them. The RP stated Resident #1 was diagnosed with Kidney Failure and severe dehydration and was very sick and was still in the hospital trying to recover. They stated Resident #1 had been admitted to the NF for rehabilitation and returned to the hospital less than 2 days after he left in worse shape then before. During an interview with CNA-A on 4/17/2025 at 1:52 PM, she stated if a resident refused meals, they were trained to tell the charge nurse. She stated she worked on 4/10/2025 and Resident #1 refused all his meals and hydration except for a small sip of juice. She stated resident was offered 3 meal on 4/10/2025 and refused all of them. She stated she informed the charge nurse and documented in the EMR/POC the resident had consumed 0-25% of his meals. She stated they did not have the ability to choose 0% the only option was a range from 0-25%. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 4/18/2025 at 9:54 AM, LVN - B stated she completed Resident #1's admission assessment on 4/9/2025 and was the charge nurse for Resident #1 on 4/10/2025. She stated CNA- A informed her Resident #1 had refused meals. She stated CNA-A and her both had tried a couple of times to try and get him to eat and drink and she tried as well, but she refused. She stated she didn't document any of Resident #1's refusals in the EMR because I got busy and didn't get to it. She stated she did not call the RP and notify them of his refusal to eat because I don't know, I guess I thought he was his own RP. She stated at some point during the day, NP D was in the building doing rounds, but she didn't remember if she had told NP D about Resident #1 refusing to eat or drink. She stated a resident who refused to eat or drink could have lower blood pressure, lots of issues with UTIs, dehydration and have to go to the hospital. She noted resident should have been offered at least 4 meals between 4/9/2025 and 4/11/2025 and he was offered dinner on 4/9/25 and 3 meals (breakfast/lunch/dinner) on 4/10/25 and refused all nutrition and hydration expect for a small sip of water in the evening on 4/9/2025. She sated she wasn't sure if Resident #1 had been offered breakfast on 4/11/2025 before the NP-D saw him and ultimately sent him out to the emergency room . During an interview on 4/23/2025 at 12:02 PM, NP-C stated she saw Resident #1 on 4/11/2025 in the morning and he was hard to wake up and wasn't following commands and his heart rate was high, so she gave orders to have him sent to the ER for further care. She stated she reviewed Resident #1's progress notes before going in the building and did not see anything about him refusing meals/hydration. She stated when she arrived at the NF and checked in with Nurse B, Nurse B did not mention anything about Resident #1 missing meals. She stated she would have been concerned if she had known the resident had eaten or drank for 4 meals, and she would have followed up and put interventions in place if she had known which included imagining, labs and perhaps fluid replacement via IV. She stated her concerns for residents refusing that many meals would be dehydration, AMS, and changes in electrolytes. She stated if a resident missed more than 2 meals, her expectation was that staff will reach out to the practitioner so interventions can be started . During an interview on 4/23/2025 at 12:14 PM, NP-D stated she saw Resident #1 in the morning on 4/10/2025 for his initial visit upon admission and noted Resident #1 was Awake, Alert, Calm, Cooperative, Difficulty with speech articulation; PSYCHIATRIC- Oriented times three [indicating resident was alert and oriented to person, place, situation], Clear, Lucid, Normal mood; COGNITIVE- Normal memory. She stated Nurse B did not say anything to her about the resident refusing nutrition or hydration. She stated her concerns for residents who skipped meals was dehydration, possible changes in their vital signs - low blood pressure and increased heart rate, potential changes in cognition. She stated profound dehydration could lead to cardiac disturbances [problems with the heart]. During an interview on 4/17/2025 at 4:05 PM, the DON stated Resident #1 was seen in person by NP- C and NP-D and reviewed their notes but did not see any notes related to poor intake. She stated her expectation was if a resident missed a couple of meals the staff would notify upper management, the RP and the practitioner. She stated she was not aware the resident had refused to eat or drink and was not aware his RP had not been notified. She stated it was the Nurse B's responsibility to notify the NP and RP of refusal to eat and drink. She stated she was aware his RP was notified when he was sent to theER on [DATE]. She mentioned the NF had NPs in the building 5 days a week and LVN- B should have notified the NPs of Resident's refusal to eat/drink so they could possibly help. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 4/17/2025 at 4:05 PM, the ADM stated he was unaware Resident #1 had refused meals. He stated his expectation was Staff would notify the DON, RP and practitioner when residents refused meals/hydration. During an interview on 4/23/2025 at 1:55 PM, MDS- E stated she reviewed Resident #1's POC in the EMR and there was not an entry for the evening meal consumption on 4/9/2025 and no entry for breakfast meal consumption on 4/11/2025. She stated three meals were documented for 4/10/2025 showing a 0-25% for each meal that day. She stated there was no way to document 0% of a meal consumed in POC, the nurse would have to put in a progress note in the EMR. She stated she had not seen any progress notes in Resident #1's EMR for 4/10/2025. During an interview on 4/23/2025 at 1:16 PM, the MD stated he was not aware of Resident #1 missing that many meals and he never got any calls about his refusal to eat/drink. He stated even with a couple of days a resident could potentially have kidney issues or dehydration. He stated he reviewed Resident #1 hospital records and noted he had an Acute Kidney Injury, and it took him several days in the hospital to return to his baseline. He stated Resident #1's labs showed he was definitely dehydrated. He stated he would like to know within 2-3 meals if a resident was refusing nutrition/hydration. The MD stated the RP should have been notified if resident was not alert or if the resident was not his own RP. Further, the MD stated, this one didn't go as planned (referring to the notification to the NP's and RP) and the NPs should have been notified of the resident refusing to eat/drink. Record review of the facility's policy, dated/copyright 2025, Resident Rights reflected: Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 2. Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including: a. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition . Record review of the facility's policy dated/copyright 2024, Notifications of Changes reflected: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1b. Potential to require physician intervention. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	This may include: a. Life-threatening conditions, or b. Clinical complications. PLAN OF REMOVAL (Immediate Jeopardy) Tag: F580 - The facility failed to notify immediately, the physician and resident representative of a significant change. Facility: Lakeshore Village Nursing and Rehabilitation Date IJ Identified: 5-8-25 Date Plan of Removal Implemented: 5-8-25 Person Responsible for Oversight: Administrator/Designee Immediate Actions Taken to Remove the Immediate Jeopardy 1. Resident #1 (Affected Resident): Upon identification of the issue, Resident #1 no longer resides in the facility. 2. Identification of At-Risk Residents (Facility-Wide Review): DON/Designee initiated a full audit of all residents to identify any with poor intake or refusal trends on 5-8-25 . This was report pulled from PCC and retained for proof. 6 residents were identified with low or declining intake (<25%) and were immediately evaluated by nursing. NP/MD and RP notifications initiated. Care plans updated accordingly by DON/Designee. No other residents with undetected nutritional significant change. No notifications were required. No other resident with undetected significant change that required notification. 3. System Correction: DON was in-serviced on 5/8/25 by Regional Nursing to notifying MD/NP and RP for 2 consecutive days of missed meals or poor intake (<25%), accurate documentation in nurses note and communication expectations with return demonstration. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	DON/ Designee will in-service licensed nursing staff/licensed agency starting 5/8/25 re-educated and directed to notify Practitioner and RP for 2 consecutive days of missed meals or poor intake (<25%), accurate documentation in nurses note and communication expectations . This will be added to licensed nurses' general orientation for new hires. Mandatory in-services will be completed 5/9/25 with all current and oncoming nursing staff prior to start of shift worked. DON/Designee will complete competency validation conducted for licensed nurses/ licensed agency on meal percentages documentation and training above per visual aides and return demonstration. This will be added to licensed nurses' general orientation for new hires. Administrator was in-service on department head meal manager schedule and details on 5/8/25 by Texas Area President. Department Heads will be in-serviced by administrator on meal manager requirements. 4. Administrative Oversight/Monitoring: DON/designee will monitor for residents with poor intake on PCC dashboard in the morning meeting or remotely daily for 30 days and then weekly for 4 weeks ensure that interventions are initiated, and Practitioner and RP are notified immediately but not later than 24 hours from identification of nutritional change. This will be documented on a monitoring tool. Any issues will be reported to the QAPI Committee meeting monthly. Administrator will lead Ad hoc QAPI to review the deficiency and the process for POR will be completed 5/9/25. 5. Completion Date: 5/9/25 The surveyor monitored the POR on 5/10/2025 as follows: ADM was in serviced by area president on 5/8/2025 on the following: meal managing, reporting meal percentages under 25% to charge nurse, charge nurse reports to NP and RP, and audit completion of residents with poor meal intake. DON was in serviced by regional nurse staff on 5/8/2025 on the following: reporting to physician and families when resident eat less than 25% of meal, meal percentages, accurate reporting of meal percentages, and auditing meal percentages. Interviews with three Nurses, three CNAs and one CMA 5/10/2025 reflected they had been in serviced on letting the charge nurse know when residents consume less than 25% of their meals, and when resident's decline nutrition for two days straight, know percentages and how to validate and document in EMR. The facility completed a complete audit of all resident's meal percentages and identified 6 residents with declining intake and the NP and RPs were notified. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	AD hoc QAPI was held on 5/9/2025 and the following staff were in attendance: ADM, DON, Regional Nurse, ADONs, Medical Director. The staff reviewed the IJ template for F580 and F692 and reviewed the plan of removal and plan of correction. Record Review revealed the ADM was in serviced on 5//8/2025 on Department head meal manager schedule and details. Record review revealed nursing staff had been in serviced on meal percentages, reporting when residents decline nutrition, and notification of NP/MD and RPs when residents design nutrition for two days. While the IJ was removed on 05/10/2025 at 5:50 pm, the facility remained at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review the facility failed maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not a possible or resident preference indicated otherwise and is offered sufficient fluid intake to maintain proper hydration and health for one of five (Resident #1) residents reviewed for nutrition and hydration. The facility failed to ensure Resident #1 maintained acceptable parameters of nutritional status as demonstrated by Resident #1 refusing meals and hydration from dinner on 4/9/2025 to breakfast on 4/11/2025. Resident was sent to theER on [DATE] with altered mental status resulting in a diagnosis of Acute encephalopathy [altered brain function], Acute renal failure [decreased blood flow to the kidneys] and profound dehydration. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 5/8/2025 at 12:25 pm; the facility was notified and given an IJ template. While the IJ was removed on 05/10/2025 at 5:50 pm, the facility remained at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for immediate harm to their health and safety related to decreased nutritional status, dehydration, UTI's or hospitalization . Findings include: Review of Resident #'s face sheet dated 4/17/2025 reflected a [AGE] year-old male admitted to the NF on 4/9/2025 with diagnoses that included: Cerebral Infarction (stroke - when blood flow to the brain in blocked), Hypertension (high blood pressure), Neoplasm related pain (tumor related pain), Heart Disease, Ataxia (impaired coordination) and Myocardial Infarction (heart attack). Resident #1' s face sheet indicated a FM was his RP and his emergency contact #1. Resident #1's Care Plan dated 4/23/2025 reflected the following problem made on 4/11/2025 after resident was sent to the ER: Potential for alteration in nutrition r/t mechanically altered diet. Resident has been found to pocket food. The following interventions were listed for this problem: document meal intake in the clinical record, notify physician as needed. Review of Resident #1's progress notes dated 4/9/2025 - 4/11/2025 reflected no entries regarding refusal of nutrition or hydration, no entries that practitioners were notified of refusal of nutrition/hydration and no entries that RP was notified of refusal of nutrition/hydration by Resident #1. Review of Resident #1's EMR reflected he had not been in the NF long enough to have a BIMS assessment completed for his cognition. Review of Resident #1's Admission assessment dated [DATE] at 4:12 pm reflected he was drowsy/stuporous but oriented to person, place, time, situation and that his cognition was intact. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #1's POC dated 4/23/25 reflected no nutrition/hydration entry for 4/9/2025 or 4/11/2025. There were 3 entries on 4/10/2025 at 8:00 am, 12:00 pm and 5:00 pm in the 0-25% column . Record Review of Resident #1's vital signs revealed he had an admission weight of 134 pounds on 4/9/2025 at 3:35 pm. Vital signs taken between 4/10/2025 and 4/11/2025 revealed resident's oxygen saturation, blood pressure and respirations were within normal limits. Further review of Resident #1's pulse rate revealed pulse rate was elevated and outside of the normal limits (60-100 beats per minute) as follows: 4/10/2025, 10:11 am - 108 bpm (beats per minute) 4/10/2025, 11:57 am - 104 bpm 4/10/2025, 6:19 pm - 105 bpm 4/11/2025, 9:44 am - 116 bpm Record review of Resident #1's ER hospital records, dated 4/18/2025, reflected he arrived at theER on [DATE] at 11:33 AM and upon arrival Patient hypoxic [absence of enough oxygen in the tissue to sustain bodily functions] and hypotensive [blood pressure below normal limits] enroute with BP 75/45, placed on 2L NC . presenting with c/o generalized weakness and AMS. Resident #1 was diagnosed with Acute encephalopathy [altered brain function], Acute renal failure [decreased blood flow to the kidneys] and profound dehydration which required him to be admitted for further treatment. The records indicated Resident #1 was still hospitalized as of 4/18/2025. During an interview with RP/FM on 4/17/2025 at 11:58 AM, the RP stated they were not aware Resident #1 had been refusing to eat or drink since he arrived at the NF. They stated they first knew something was wrong was the morning of 4/11/2025 when a nurse called them to say Resident t#1 was being sent to the ER because he was lethargic and had low vitals. They stated when they got to the ER, Resident #1 told them he had not had anything to eat or drink since he had been admitted on [DATE]. RP stated if they had known he wasn't eating or drinking they could have gone up to the NF and encourage him to eat, but no one notified them . During an interview with CNA A on 4/17/2025 at 1:52 pm she stated if a resident refuses meals, they are trained to tell the charge nurse. She stated she worked on 4/10/2025 and Resident #1 refused all his meals and hydration except for a small sip of juice. She stated she informed the charge nurse and documented in the EMR/POC that resident had consumed 0-25% of his meals. She stated they do not have the ability to choose 0% the only option is a range from 0-25%. During an interview with Nurse B on 4/18/2025 at 9:54 am she stated she was the charge nurse for Resident #1 on 4/10/2025. She stated the CNA A informed her that Resident #1 had refused meals. She stated CNA A tried a couple of times to try and get him to eat and she tried as well, but her refused. She stated she didn't document any of Resident #1's refusals in the EMR because I got busy and didn't get to it She stated she did not call RP and notify them of his refusal to eat because I don't know, I guess I thought he was his own RP. She stated at some point during the day, NP D was in the building doing rounds, but she didn't remember if she had told NP D about Resident #1 refusing to eat or drink. She stated a resident that refuses to eat or drink could have lower blood pressure, lots of issues with UTIs, dehydration and have to go to the hospital. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 4/23/2025 at 12:02 pm, NP C stated she saw Resident #1 on 4/11/2025 in the morning and he was hard to wake up and wasn't following commands and his heart rate was high, so she gave orders to have him sent to the ER for further care. She stated she reviewed Resident #1's progress notes before going in the building and did not see anything about him refusing meals/hydration. She stated when she arrived at the NF and checked in with Nurse B, Nurse B did not mention anything about Resident #1 missing meals. She stated she would have been concerned if she had known that resident had eaten or drank for 4 meals, and she would have followed up and put interventions in place if she had known including imagining, labs and perhaps fluid replacement via IV. She stated her concerns for residents refusing that m any meals would be dehydration, AMS, and changes in electrolytes. She stated if a resident misses more than 2 meals, her expectation is that staff will reach out to the practitioner so interventions can be started. During an interview on 4/23/2025 at 12:14 pm, NP D stated she had seen Resident #1 in the morning on 4/10/2025 for his initial visit upon admission and noted Resident #1 was Awake, Alert, Calm, Cooperative, Difficulty with speech articulation; PSYCHIATRIC- Oriented times three [indicating resident was alert and oriented to person, place, situation], Clear, Lucid, Normal mood; COGNITIVE- Normal memory. She stated Nurse B did not say anything to her about resident refusing nutrition or hydration. She stated her concerns for residents that skip meals is dehydration, possible changes in their vital signs - low blood pressure and increased heart rate, potential changes in cognition. She stated profound dehydration could lead to cardiac disturbances [problems with the heart]. During an interview on 4/17/2025 at 4:05 PM, the DON stated Resident #1 was seen in person by NP- C and NP-D and reviewed their notes but did not see any notes related to poor intake. She stated her expectation is was that if a resident misses missed a couple of meals that the staff will would notify upper management, the RP and the practitioner. She stated she was not aware the resident had been refusing to eat or drink and was not aware his RP had not been notified. She stated it was the Nurse B's responsibility to notify the NP and RP of refusal to eat and drink. She stated she was aware his RP had been notified when he was sent to theER on [DATE]. She mentioned that the NF has had NPs in the building 5 days a week and that LVN- B should have notified the NPs of Resident's refusal to eat/drink so they could possibly help. During an interview on 4/17/2025 at 4:05 pm, ADM stated he was unaware that Resident #1 had been refusing meals. He stated his expectation is that Staff will notify DON, RP and practitioner when residents refuse meals/hydration. During an interview on 4/23/2025 at 1:16 pm, MD stated he was not aware of Resident #1 missing that many meals and that he never got any calls about his refusal to eat/drink. He stated even with a couple of days a resident could potentially have kidney issues or dehydration. He stated he reviewed Resident #1 hospital records and noted he had an Acute Kidney Injury, and it took him several days in the hospital to return to his baseline. He stated Resident #1's labs showed he was definitely dehydrated. He stated he would like to know within 2-3 meals if a resident is refusing nutrition/hydration. MD stated the RP should have been notified if resident was not alert or if resident was not his own RP. Further, the MD stated, this one didn't go as planned (referring to the notification to the NP's and RP) and the NPs should have been notified of the resident refusing to eat/drink. Record review of the facility's policy Nutritional Management, copyright 2025, reflected: (continued on next page)

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	05/10/2025

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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Definitions: Acceptable parameters of nutritional status refers to factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values. Nutritional Status includes both nutrition and hydration status. 5. d. The physician will be notified of: i. Significant changes in weight, intake, or nutritional status ii. Lack of improvement toward goals iii. Any complications associated with interventions. 6. Informed consent: a. The resident/representative has the right to choose and decline interventions designed to improve or maintain nutritional or hydration status. b. The facility shall discuss the risks and benefits associated with the resident/representative decision and offer alternatives, as appropriate. PLAN OF REMOVAL (Immediate Threat) Tag: F692 - Failure to Maintain Acceptable Parameters of Nutritional Status Facility Date IJ Identified: 5-8-25 Date Plan of Removal Implemented: 5-8-25 Person Responsible for Oversight: Administrator/Designee Immediate Actions Taken to Remove the Immediate Threat 1. Resident #1 (Affected Resident): Upon identification of the issue, Resident #1 no longer resides in the facility. 2. Identification of At-Risk Residents (Facility-Wide Review): DON/Designee initiated a full audit of all residents to identify any with poor intake or refusal trends on 5-8-25. 6 residents were identified with low or declining intake (25% or less) and were immediately evaluated by nursing. NP/MD and RP notifications initiated. (continued on next page)

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	05/10/2025

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Care plans updated accordingly by DON/Designee. No other residents with undetected weight loss No other resident with undetected significant change that required notification. 3. System Correction: DON/ Designee will in-service Licensed nursing/ licensed agency staff immediately re-educated and directed to notify Practitioner and RP for 2 consecutive days of missed meals or poor intake (<25%), accurate documentation in nurses note and communication expectations . This will be added to licensed nurses' general orientation for new hires. DON/ Designee will in-service CNAs/Agency CNA immediately re-educated and directed to notify charge nurse of missed meals or poor intake (<25%), accurate documentation and communication expectations . This will be added to CNAs general orientation for new hires. Mandatory in-services will be completed 5/9/25 with all current and oncoming nursing staff prior to start of shift worked. Competency for License staff and CNAs/Agency CNAs validation conducted on meal percentages documentation and training above per visual aides and return demonstration. This will be added to licensed nurses/CNAs general orientation for new hires. Administrator was in-serviced on department head meal manager schedule and details on 5/8/25 by Texas Area President. Department Heads will be in-serviced by administrator on meal manager requirements . 4. Administrative Oversight/Monitoring: DON/designee will monitor for residents with poor intake on PCC dashboard in the morning meeting or remotely daily for 30 days and then weekly for 4 weeks to ensure that interventions are initiated, and Practitioner and RP are notified immediately but not later than 24 hours from identification of nutritional change. This will be documented on a monitoring tool. Any issues will be reported to the QAPI Committee meeting monthly. Ad hoc QAPI to review the deficiency and the process for POR will be completed 5/9/25. 5. Completion Date: 5/9/25 POR monitoring as above in F580 While the IJ was removed on 05/10/2025 at 5:50 pm, the facility remained at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.