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	12/11/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision that could prevent accidents for 1 of 1 resident (Resident #1) reviewed for supervision. The facility failed to ensure Resident #1's safety when OT was inattentive due to using her phone. This failure could place residents at risk of experiencing accidents and injuries.The findings included:Record review on 12/11/2025 of Resident #1s chart reflected he is a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis of senile degeneration of brain, not elsewhere classified (age-related brain shrinkage and cognitive decline). Record review of Hearing Speech and Vision MDS dated [DATE] reflected Resident #1 had a BIMS of 11, indicating moderate cognitive impairment, with Moderately impaired - limited vision.Record review of the Care plan for Resident #1, dated 7/26/2023 and revised on 11/07/2025, reflected that Resident #1 has ADL Self Care Performance Deficits r/t Disease Process (COPD) & Fatigue. Interventions: Independent with: Walk 10/50/150 feet. Observation on 12/11/2025 at 11:45 a.m., OT was walking Resident #1 on the 500 Hall to the activity room. Resident #1 was walking using a cane. OT was behind Resident #1, pushing his wheelchair. While OT was pushing Resident #1's wheelchair, she was on her phone, looking at pictures and not paying attention to Resident #1In an interview on 12/11/2025 at 11:55 p.m., The OT stated she was walking with Resident #1 to the activity room. OT stated when she walked with a resident, she should not be on her phone. OT stated if Resident #1were to fall while on her phone, he could get seriously injured because she was not paying attention. OT stated that during resident care, staff are not permitted to use their phones. OT said she has received in-service training on not using phones during resident care. In an interview on 12/19/2025 at 2:06 PM, DON stated that when staff are providing resident care, they should focus on the resident and not on their phone. Staff should monitor the residents for safety to prevent injuries. DON mentioned that if staff do not monitor residents during care, a fall could occur, resulting in severe injury. DON also stated that she has not observed staff using their phones while providing resident care and that she has received in-service training on the facility's phone policy.In an interview on 12/19/2025 at 3:05 PM, ADM stated that staff may keep their phones on the floor for business purposes. ADM mentioned that staff should not have their phones while providing resident care. ADM explained that using phones during resident care could lead to falls and injuries. ADM stated that staff have received in-service training on the facility's phone policy. Record review of the Personal Cell Phone policy not dated indicated the following: It is the policy of this facility to provide quality care to our residents without interruption. This facility allows employees to use personal cell phones for professional communication while in the facility. Cell phones may be used by employees for personal use while on a scheduled break in break areas only.Record review of the facility Cell Phone Use During Patient Ambulation that was not dated indicated the following: Therapy Staff are not permitted to use personal cell phones while walking or providing mobility assistance to a patient. This includes texting, talking, browsing or any other phone-related activity. Cell phone use diverts attention and decreases situational awareness. Distraction increases the risk of patient falls, collisions, or loss of balance. Staff must be able to respond immediately to changes in patient gait, stability, and environment. Maintaining full attention demonstrates professionalism and supports high-quality patient care.