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	02/20/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observations, interviews, and record review the facility failed to treat residents with respect and dignity for one (Resident #11) of six residents reviewed for dignity. The facility failed to speak to Resident #11 in a way that promoted her dignity and self-worth. This failure could place resident at risk of a decline in their sense of dignity, level of satisfaction with life, and feeling of self-worth. The findings were: Review of Resident #11's quarterly MDS, dated [DATE], reflected a [AGE] year-old female originally admitted to the facility on [DATE] with a re-admitted [DATE]. Her diagnoses included high blood pressure, high cholesterol, diabetes mellitus (high blood sugar levels), depression, anxiety, senile degeneration of the brain, and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Resident #11 had a BIMS score of 12, indicating moderate cognitive impairment. She required setup or clean-up assistance with eating. Review of Resident #11's care plan dated last reviewed 11/18/2024 reflected the following: Observe/document/report PRN any s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Resident #11 had ADL Self Care Performance Deficit r/t impaired mobility. Will maintain current level of ADLs through the next review date. Setup or clean up assistance with: Eating. In an interview and observation on 02/18/2025 at 12:55 PM with Resident #11 she asked CNA C who was outside her room delivering lunch trays, what was being served for lunch. CNA C responded with, Looks like you're going to be having kitty litter today. Then sat Resident #11's tray on a table in her room and walked out. When the state surveyor asked Resident #11 how the comment made by CNA C made her feel. She stated that she did not really hear the comment, but that she would not have eaten the food if she was told that, and that the staff say way worse things to the residents when the state was not in the building. She stated she tried to not ask certain staff questions or for help because of how rude they talked to her. She stated that she would ask for help if she really needed it but only to the staff who didn't treat her like a bother and who did their jobs. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/19/2025 at 10:10 AM with the ADM he stated that it was not okay for a staff member to talk to a resident in the manner CNA C did to Resident #11 and he immediately went to speak with Resident #11. The ADM stated that there has not been a professional communication targeted in-service but that abuse in-servicing was routinely done and was most recently conducted earlier in the month. Review of facility's Resident Rights policy dated last revised February 2021 reflected, Employees shall treat all residents with kindness, respect, and dignity. 2. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. A dignified existence; d. Be treated with respect, kindness, and dignity; Review of facility's Identifying Types of Abuse policy dated last revised September 2022 reflected, As part of the abuse prevention strategy, volunteers, employees, and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents. 1. Abuse of any kind against residents is strictly prohibited. 2. Abuse prevention includes recognizing and understanding the definitions and types of abuse that can occur. 3. It is understood by the leadership in this facility that preventing abuse requires staff education, training, and support, and a facility-wide culture of compassion and caring. 4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. b. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. 2. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. 3. Examples of mental and verbal abuse include, but are not limited to: a. harassing a resident; b. mocking, insulting, ridiculing; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. yelling or hovering over a resident, with the intent to intimidate; d. threatening residents, including but not limited to, depriving a resident of care, or withholding a resident from contact with family and friends; and e. isolating a resident from social interaction or activities.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observations, interviews, and record review the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 3 of 8 residents (Resident's #112, #72, and #99's) reviewed for resident rights. The facility failed to ensure Resident's #112 and #99's call light was within reach on 02/18/25 and 02/19/25. The facility failed to ensure Resident #72's call light was within reach on 02/19/25. This failure could place residents at risk of needs not being met. Findings included: Record Review of Resident #99's face sheet dated 02/20/25 reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included pneumonia (an infection that that inflames air sacs, which may fill up with fluid, in the lungs), myocardial infarction (a condition when one or more areas of the heart muscle don't get enough oxygen), dysphagia (difficulty in swallowing), diabetes (a disease that result in too much sugar in the blood), and hypertension (a condition in which the force of the blood against the artery walls is to high). Record Review of Resident #99's MDS dated [DATE] reflected Resident #99 was dependent on staff for eating, toileting, bathing, and personal hygiene. MDS reflected Resident #99 had a BIMS score of 09 which indicated Resident #99 was moderately impaired. Record review of Resident #99's care plan dated 12/16/23, updated on 7/18/24 reflected: Resident had physical functioning deficit related to CVA with left sided weakness (hemiplegia). Interventions included call bell within reach. The care plan initiated 12/28/23 At risk for falls related to generalized weakness, impaired cognition, and safety awareness. Interventions included call light and personal items available and in easy reach or provide reacher. In observation on 02/18/25 at 10:23 AM Resident #99 was lying in bed resting quietly and had no signs of pain or distress. The resident did not respond when the state surveyor called his name. The residents call light was out of reach on the floor between the bed and wall. The resident was on EBP and had a peg tube (enteral tube inserted into the stomach). In an observation on 02/19/25 at 10:23 AM, Resident #99 was lying in bed resting. The residents call light was out of reach on the floor between the bed and wall. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #112's face sheet dated 02/20/25 reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included chronic respiratory failure (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide over an extended period), dysphagia (difficulty in swallowing), traumatic brain injury (an injury to the brain caused by an external force), sarcopenia (a type of muscle loss that occurs with aging and/or immobility), and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition). Record review of Resident #112's admission MDS dated [DATE] reflected Resident #112 was dependent on staff for eating, toileting, bathing, and personal hygiene. Record review of Resident #112's admission MDS dated [DATE] reflected Resident #112 had a BIMS score of 0 which reflected Resident #112 was severely cognitive impaired. Record review of Resident #112's care plan dated 12/03/24 reflected: Focus: Resident #112 had Impaired physical functioning related to: Cognitive loss, mobility impairment, self-care impairment, sarcopenia. Goals: Staff will assist Resident #112 to remain clean, dry, and comfortable through next review date. Interventions included: Call bell within reach. In an observation on 02/18/25 at 12:41 PM, Resident #112 was lying in bed with his blankets pulled up to his chest area. Resident #112 opened his eyes when his name was called but did not respond verbally. Resident #112 was on EBP and had a tracheostomy and peg tube. Residents call light was observed out of reach and was hanging to the left side of the head of the bed out of resident's reach. The resident was resting quietly and had no sign of pain or distress. In an observation on 02/19/25 at 10:15 AM, Resident #112 was lying in bed with his blankets pulled up to his chest area. The resident did not respond when his name was called. The residents call light was observed out of reach and was hanging to the left side of the head of the bed out of the resident's reach. The resident was resting quietly and had no sign of pain or distress. Record Review of Resident #72's face sheet dated 02/20/25 reflected the resident was an [AGE] year-old male admitted on [DATE]. His diagnoses included senile degeneration of the brain (a progressive decline in cognitive function that occurs with aging), spinal stenosis (an abnormal narrowing of the spinal canal or neural foramen that results in pressure on the spinal cord or nerve roots), dysphagia (difficulty in swallowing), and thoracic aortic aneurysm (the ballooning of the upper aspect of the aorta, above the diaphragm). Record review of Resident #72's quarterly MDS dated [DATE] reflected Resident #72 had a BIMS score of 15 which meant Resident #72 was cognitively intact. Resident #72 required supervision or touching assist for eating, and partial or moderate assist for toileting, bathing, and personal hygiene. Record review of Resident #72's care plan dated 11/13/23 reflected: Focus: Resident #72 had an ADL Self Care Performance deficit r/t impaired mobility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goals: Resident #72 will improve current level of function in GGs, especially sit to lying, through the next review date. Interventions included: Encourage to use bell to call for assistance. In an interview and observation on 02/19/25 at 10:25 AM, Resident #72 stated he was doing well, and the staff treated him well. He stated he used the call light to call for help when needed and the staff responded to the call light pretty quickly usually. Resident #72 was sitting up in his wheelchair beside the bed and stated he could not get to his call light at that time because the CNA had just made the bed and she had put it where he could not reach it. Resident #72's call light was observed out of site and stuck in between the wall and bed, covered by blankets. The resident demonstrated with his hands and a reaching device that belonged to him that he could not reach the call light at that time. He stated if he needed help, he guessed he would go out into the hallway or yell for someone to come. In an interview on 02/19/25 at 10:17 AM, LVN A, stated Resident #112 was not able to move his arms or legs but he may have made a jerking movement every now and then. She stated Resident #112's call light should be within his reach at all times. LVN A went into Resident #112's room and saw that residents call light was hanging on the side of his bed out of his reach. She stated she did not feel that Resident #112 was capable of pressing the call button, but the call light was not in an appropriate place, and he could not have pressed the button if he tried. She stated she had been trained on call light placement and if a resident did not have their call light in reach, the resident could have fallen or may not have been able to call for help. In an interview on 02/19/25 at 10:27 AM, the ADON stated Resident #99 had the ability to use the call light. She stated Resident #99's call light should be within reach at all times. She stated she had been trained on call light placement. When asked what could happen if the resident did not have their call light in reach, she stated she wasn't sure what the state surveyor was asking. In an interview on 02/19/25 at 10:38 AM, CNA C, stated all residents call lights should be in reach at all times. CNA C entered Resident #72's room and observed the residents call light on the side of the bed stuck between the bed and the wall and covered by blankets. She stated Resident #72's call light was out of his reach at that time. She stated she had been trained on call light placement and if a resident's call light was out of reach, they could fall trying to get to the light or could not call for help. In an interview on 02/19/25 at 10:43 AM, CNA D stated all residents call lights should be in reach at all times. She stated she was trained on call light placement and if a resident did not have their call light within reach, it could have led to an accident. In an interview on 02/19/25 12:41 PM, CNA B, stated Resident #112 did not move around in his bed, but his call light should still be within reach. CNA B entered Resident #112's room and observed the resident's call light hanging to the left side of his bed. She stated Resident #112's call light was not where it should have been, and it was probably moved out of the way when the resident was changed. She stated she had been trained on call light placement and all resident's call lights should be within the resident's reach at all times. She stated if a resident's call light was out of reach, anything could happen, such as a resident could have fallen, hurt themselves, or have tried to walk without assistance, and they would not be able to call for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/20/25 at 09:52 AM, the ADM stated in most cases it was his expectation that all residents have their call lights within their reach. He stated some residents had requested that their call light be clipped to their curtain, and they had that care planned, and there were also some residents that were not able to use their call lights due to their condition. He stated for those that could not use their call lights, the staff made more frequent rounds and tried to anticipate their needs. He stated the staff were trained on call light placement. He stated if a resident could use the call light, they could probably still call out by yelling, but they may not have been able to call by using the call light. In an interview on 02/20/25 at 10:02 AM, the DON stated it was her expectation that all residents had their call lights within reach for those residents that could use them. She stated some residents wanted their call light clipped to their curtain and those residents had been care planned for that. She stated for those residents that could not use the call lights, the staff tried to anticipate the residents needs and made rounds on them more frequently. She stated staff had been trained on call light placement. She stated if a resident could use the call light and the call light was out of their reach, they may have had a need that was unmet. Record review of the facility policy titled Answering the Call Light and dated 2001 (revised July 2023) reflected Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observations, interviews, and record review, the facility failed to ensure that the resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident for four of six residents (Resident #11, Resident #43, Resident #53, and Resident #108) whose care was reviewed. The facility failed to allow Residents #11, #43, #53, and #108 to enjoy the salad bar that was served in the dining room because they either preferred to eat in their rooms or were bed ridden. This failure could place residents at risk of diminished feelings of self-worth and/or diminished quality of life. Findings included: Observation on 02/18/2025 at 12:54pm in the facility's 1 of 2 dining rooms revealed a kitchen aide serving hot dogs out of a crock pot, topping it with chili, cheese, and optional onions. When residents were being brought into the dining room by staff, or walking into the dining room, the aide would ask them if they wanted onions on their chili cheese dogs, and how many they wanted. The residents in the dining room were served plates with chili cheese dogs with a side of potato chips. Once residents appeared to be finished, staff who were assisting in the dining room would ask if the residents were full, if they had enough to eat, if they wanted another chili dog, or if they wanted to go back to their room. No plates of food that contained the posted menu in the dining room were observed to be offered and/or served to any of the seated residents in the dining room. The trays being loaded onto carts to go to the halls were observed to only contain the facility posted menu items. Review of Resident #11's quarterly MDS, dated [DATE], reflected a [AGE] year-old female originally admitted to the facility on [DATE] with a re-admitted [DATE]. Her diagnoses included high blood pressure, high cholesterol, diabetes mellitus (high blood sugar levels), depression, anxiety, senile degeneration of the brain, and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Resident #11 had a BIMS score of 12, indicating moderate cognitive impairment. She required setup or clean-up assistance with eating. Review of Resident #11's care plan dated last reviewed 11/18/2024 reflected the following: Observe/document/report PRN any s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Resident #11 had ADL Self Care Performance Deficit r/t impaired mobility. Will maintain current level of ADLs through the next review date. Setup or clean up assistance with: Eating. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/18/2025 at 12:55 PM with Resident #11 she stated that she sometimes goes to the dining room to eat and sometimes chose to eat in her room. She said that if she goes to the dining room a different meal would be served than what was given to residents who eat in their room. She stated that she had to go to the dining room at lunch to find out what was being served and if she did not like it, she would go wait in her room for her tray. She said that she must go to the dining room to check because that special meal was only given to residents who go to the dining room, they would not bring it to the residents in their room. Review of Resident #43's quarterly MDS, dated [DATE], reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), heart failure, high blood pressure, diabetes mellitus (high blood sugar levels), high cholesterol, lack of coordination, morbid obesity, pressure ulcer of right heel, and need for assistance with personal care. Resident #43 had a BIMS score of 12, indicating moderate cognitive impairment. He required supervision or touching assistance with eating, where the helper provides verbal cues and/or touching /steadying and/or contact guard assistance as resident completed activity. Assistance may be provided throughout the activity or intermittently. Review of Resident #43's care plan dated last reviewed 02/18/2025 reflected Resident #43 was at risk for alteration in nutrition r/t high BMI and therapeutic diet. The dietary staff were to evaluate current dietary intake, eating habits, nutritional status, and review his food preferences, likes/dislikes. In an interview on 02/20/2025 at 11:15 AM with Resident #43 he stated that he mostly stayed in his room, and he ate his meals in his room because he did not like crowds. He was not aware that if residents go to the dining room, they get served something different than the meal that was on the menu. He said that if they were serving something he liked he would like to have the meal, but he did not want to go to the dining room, and he didn't know what special meal would be served. It would make him feel good if they served something he really enjoyed and brought it to his room. He stated he knew about the alternative menu but had no idea they served items like chili cheese dogs and chicken fajitas. Review of Resident #53's quarterly MDS, dated [DATE], reflected a [AGE] year-old female originally admitted to the facility on [DATE], with a re-admitted [DATE]. Her diagnoses included anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), high blood pressure, seizure disorder, unspecified abnormalities of gait and mobility, muscle weakness, and depression. Resident #53 had a BIMS score of 11, indicating moderate cognitive impairment. She was independent and required no assistance from a helper with eating. Review of Resident #53's care plan dated last reviewed 11/08/2024 reflected the following: serve diet as ordered, observe intake, and record every meal, regular diet, regular texture, regular consistency. In an interview on 02/20/2025 at 11:25 AM with Resident #53 she stated that she did not know that the facility had a special meal in the dining room, and she was not aware that chili cheese dogs and chips were served on 02/18/2025 in the dining room. She stated that if she knew special meals were served and she heard it was something she enjoyed eating, she would love to have that meal, but that she almost always ate in her room with her roommate. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #108's comprehensive MDS, dated [DATE], reflected a [AGE] year-old man originally admitted to the facility on [DATE] with a re-admitted [DATE]. His diagnoses included paraplegia, iron deficiency, malnutrition, post-traumatic stress disorder, lack of coordination, contracture of muscle, hearing loss, pressure ulcer of the right hip, right hip open wound, and left hip open wound. Resident #108 had a BIMS score of 14 indicating intact cognition. He required supervision or touching assistance with eating. He was dependent on staff for all functional abilities (rolling in bed, sitting up, and transfers). Review of Resident #108's care plan dated last revised 11/08/2024 reflected Resident #108 had an ADL self-care performance deficit r/t limited ROM, musculoskeletal impairment, and pain. He was to be provided supportive care and assistance with mobility as needed. His diet and food texture were to be provided as tolerated and to be encouraged with food and fluid intake. In an interview on 02/20/2025 at 08:40 AM with Resident #108 he stated that he was not aware a special meal was served in the dining room and that it was not fair to people like him who were not able to go to the dining room. He stated he would have wanted to have chili cheese dogs and chips on 02/18/2025 as well as anything else that was offered that sounded appealing to him. He said it was not right for the facility to only serve it to residents who go to the dining room and not to offer it to residents in their rooms. In an interview on 02/19/2025 at 11:51 AM with the DM she stated that meals served in the dining room were not listed on the menu. Chili dogs, brisket, salad, baked potatoes, fajitas, taco soup, pulled pork potatoes, clam chowder soup, were not listed on the menu. It was like a side dish. She stated those don't need a menu or recipe. She was not aware of any policy. She knew all the resident's meal types and knew which residents could have which kinds of meal textures. The different food served in the dining room was an incentive to bring residents out of their rooms to get different food. The residents that eat in their rooms could not get this special meal. She created the idea and has been doing it for about 2 months. There was no process about it. In a follow up interview on 02/20/2025 at 9:54 AM with the DM she stated that she came up with the easy meal about 2-3 months ago and that residents must go to the dining room to have it because it was an incentive to get them to go eat in the dining room. She stated that the food served was not posted in the facility, and it was only served Monday through Friday due to there being more staff such as speech therapists who could sit in the dining room and watch any residents who may have an altered diet (such as mechanical soft, minced, and moist, puree) and want to try the special meal of the day. She stated that there was no policy or procedure regarding this easy meal. In an interview on 02/20/2025 at 11:29 AM with CNA E, who has worked at the facility for 2 years, stated that the special meals served in the dining room have been going on for a couple months and that sometimes the kitchen staff would tell the nursing staff what would be served. Then the nursing staff could tell the residents who were awake, but that did not always happen. She stated that the kitchen staff have been asked by nursing staff if residents who eat in their rooms could be brought those meals to which the kitchen staff have told them that those residents get what's on their tray. If they wanted the meal being served in the dining room, they could go to the dining room. CNA E stated that it was not right, and all residents should get the option to have that special meal because it could make residents feel left out. (continued on next page)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/20/2025 at 01:13 PM, the ADM stated that the meal served in the dining room was set up as an appetizer, and that dietary staff would take it down the halls to residents who requested it. The ADM stated that the policy and procedure for food that is served was that multiple staff including speech therapists monitor in the dining room. Whoever was serving at the steam table had the serving list. He stated there wasn't a menu, and that resident's just know things were going to be new and different every day. The ADM stated the dietitian she knew about the meals. For residents who were primarily bed bound, he stated that residents talk about the meal and they will just know something is different. He said it is considered an appetizer bar and that residents still receive their trays. The ADM stated that all residents, no matter their abilities are allotted the same rights when it comes to food choices, and they have an always available menu that they can order from. In an interview on 02/20/2025 at 02:09 PM with CNA F she stated that she did not know how the special meal in the dining room worked and there was a lot of confusion amongst residents. The residents who stayed in their rooms would hear about other residents eating something different than what they received on their trays, and they ask how they could get that. She stated that the residents in their rooms were not offered the special meal by the kitchen staff, and that they have a right to enjoy the same foods. Review of facility's Resident Rights policy dated last revised February 2021 reflected, Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. A dignified existence; b. Be treated with respect, kindness, and dignity; d. Be free from involuntary seclusion; Review of the facility's Holiday and Special Meals Policy dated October 1, 2018, reflected, The facility believes that the quality of life for its residents should be maximized whenever possible. On holidays or special occasions, all residents will be served the same menu provided the physician has approve diet liberalization on such occasions. Procedure: 1. Upon admission, the physician will indicate whether the resident may have a liberalized diet on special occasions. Approval will be noted on the resident's order sheet. 2. The menu for the holiday or special occasion will be planned during the resident council meeting or other meeting where resident input can be obtained. 3. The consultant NDTR or RDN will review and approve the holiday or special occasion menu for adequacy and appropriateness for the resident population. The menu will be extended by the dietitian/NDTR for all diets offered at the facility. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For any resident not approved for a liberalized diet, the dietitian/NDTR will develop an extension of the holiday or special occasion menu to allow the resident to have as many items on the menu as possible. 5. Texture modifications, such as ground meats or pureed, will be prepared for residents requiring texture modification. Thickened liquids will be provided as ordered by the physician.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observations, interviews, and record review the facility failed to ensure residents were given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs) for 1 of 4 residents (Resident #231) reviewed for ADL abilities. Resident #231's glasses were dirty and had built-up grime present to both lenses on 02/19/25. This deficient practice could place residents who required assistance at risk for not receiving care and services to meet their needs and avoid ADL decline. Findings included: Record Review of Resident #231's face sheet dated 02/20/25 reflected the resident was a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). Record review of Resident #231's uncompleted admission MDS dated [DATE] reflected Resident #231 had a BIMS score of 05 which reflected Resident #231 was severely cognitively impaired. The MDS reflected Resident #231 used corrective lenses (contacts, glasses, or magnifying glass). Record review of Resident #231's care plan dated 02/18/25 reflected: Focus: Resident #231 was At risk for falls/injury r/t history of falls, poor safety awareness. Goals: Resident #231 will be free from injury r/t falls through next review date. Interventions included: Assess for adaptive equipment needs. In an interview on 02/19/25 at 09:55 AM, Resident #231 stated she was doing ok. She stated the staff treated her well and she felt safe in the facility. Resident #231's glasses were dirty and had built-up grime present to both lenses. Resident stated nobody cleaned her glasses but her and the nurses and the glasses had not been cleaned in a long time. Resident #231 stated she could still see out of her glasses but did not know if she would have been able to see better if they had been cleaned. Resident #231 removed her glasses when speaking to the state surveyor and only touched the frames of the glasses. The resident's hands were clean and did not have any visible dirt or matter present that would have transferred to the glasses at that time. In an interview on 02/19/25 at 10:01 AM, the OT stated she did not know who was ultimately responsible for cleaning the resident's glasses but when the resident's came to therapy, she tried to keep the resident's glasses as clean as possible. She stated Resident #231's vision could have been impaired by having dirty glasses and that she did not think Resident #231's glasses were as dirty on the previous day. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/19/25 at 10:38 AM, CNA C, stated the residents' glasses were supposed to be checked and cleaned daily and it should have been done every morning. She stated she was trained on keeping residents belongings, which included glasses, cleaned and if a resident's glasses were dirty, it could have increased resident's risk of having a fall. In an interview on 02/19/25 at 10:43 AM, CNA D stated it was the CNA's responsibility to clean resident's glasses. She stated she automatically knew to clean the resident's glasses and dentures and things like that. She stated she went through that training with her CNA clinicals and anyone taking care of the residents should know to do that. She stated if a resident wore glasses and the glasses were dirty, the resident may not be able to see well. In an interview on 02/20/25 at 09:52 AM, the ADM stated that resident's glasses should be cleaned when they were dirty or when the resident asked, but there was no policy that said the glasses should be cleaned daily. He stated if a resident had dirty glasses, it could cause irritation for the resident. In an interview on 02/20/25 at 10:02 AM, the DON stated resident's glasses should be cleaned as needed and if they were visibly dirty. She stated staff were trained on keeping the resident's glasses cleaned for those that could not do it themselves. She stated the expectation was if a resident could not meet their own needs which regarded their personal things or other things, staff would meet those needs for the residents. She stated if a resident's glasses were dirty and they could not see through them clearly, it could cause a nuisance for the resident. Record review of facility policy titled Activities of Daily Living (ADLs), Supporting dated 2001 revised March 2018, reflected Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy Interpretation and Implementation: I. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. a. The existence of a clinical diagnosis or condition does not alone justify a decline in a resident's ability to perform ADLs. b. Unavoidable decline may occur if he or she: (1) Has a debilitating disease with known functional decline; (2) Has suffered the onset of an acute episode that caused physical or mental disability and is receiving care to restore or maintain functional abilities; 2. Appropriate care and services will be provided for residents who are unable to cany out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); 6. Intervention to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment dated 2001 and revised September 2022 reflected Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. Policy Interpretation and Implementation: b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact sk.in (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (Note: Some items that may come in contact with non-intact skin for a brief period of time [e.g., hydrotherapy tanks, bed side rails] are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.) c. non-critical items are those that come in contact with intact skin but not mucous membranes. (I) Non-critical resident-care items include bedpans, blood pressure cuffs, crutches, and computers. (2) Non-critical environmental surfaces include bed rails, bedside tables, etc. (3) non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions. Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA registered disinfectant products are followed (e.g., use-dilution, shelf life, storage, material compatibility, safe use, and disposal). a) Low-level disinfection is defined as the destruction of all vegetative bacteria (except tubercle bacilli) and most viruses, some fungi, but not bacterial spores. Examples of low-level disinfectants include EPA- registered hospital disinfectants with an HBV and HIV label claim. Low-level disinfection is generally appropriate for most non-critical equipment. b) Intermediate-level disinfection is traditionally defined as destruction of all vegetative bacteria, including tubercle bacilli, lipid and some nonlipid viruses, and fungi, but not bacterial spores. EPA-registered hospital disinfectants with a tuberculocidal claim are intermediate-level disinfectants. Intermediate-level disinfection is considered for non-critical equipment that is visibly contaminated with blood. However, a low-level disinfectant with a label claim against HBV and HIV may also be used. 5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). A. Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals). In an interview on 02/19/25 at 09:55 AM, Resident #231 stated she was doing ok. She stated the staff treated her well and she felt safe in the facility. Resident #231's glasses were dirty and had built-up grime present to both lenses. Resident stated nobody cleaned her glasses but her and the nurses and the glasses had not been cleaned in a long time. Resident #231 stated she could still see out of her glasses but did not know if she would have been able to see better if they had been cleaned. Resident #231 removed her glasses when speaking to the state surveyor and only touched the frames of the glasses. The resident's hands were clean and did not have any visible dirt or matter present that would have transferred to the glasses at that time. In an interview on 02/19/25 at 10:01 AM, the OT stated she did not know who was ultimately responsible for cleaning the resident's glasses but when the resident's came to therapy, she tried to keep the resident's glasses as clean as possible. She stated Resident #231's vision could have been impaired by having dirty glasses and that she did not think Resident #231's glasses were as dirty on the previous day. In an interview on 02/19/25 at 10:38 AM, CNA C, stated the residents' glasses were supposed to be checked and cleaned daily and it should have been done every morning. She stated she was trained on keeping residents belongings, which included glasses, cleaned and if a resident's glasses were dirty, it could have increased resident's risk of having a fall. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 50176 Based on observation, interview, and record review, the facility failed to ensure that the menus met the nutritional needs of residents in accordance with established national guideline, were prepared in advance, were followed or appropriate substitutions were made, and reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy for 1 of 1 kitchen reviewed for menu accuracy. 1) The facility failed to ensure the DM created a menu in advance and the menu had reviewed and approved by the regional dietitian for the special incentive lunch meal served in the dining room. 2) The facility failed to ensure [NAME] H served adequate portion sizes for residents during the lunch meal on [DATE] when he did not use the correct scoop size and served food portions with his hands. 3) The facility failed to make sure that its menus were followed and documented any substitutions made to the menus for soft mechanical and puree diets for 10 residents on [DATE]. These failures placed residents at risk of poor intake, possible weight loss, and diminished quality of life. Findings included: Observation and interview in the kitchen on [DATE] at 08:56 AM revealed [NAME] H pulled meatballs out of the oven and put them in the grinder. He stated those were for the soft mechanical and puree diets. At 9:04 AM, [NAME] H was observed placing the ground beef meatballs on the steam table. Observation of the main dining on [DATE] at 12:05 PM revealed no menu was posted on the bulletin board labeled Today's menu. The wall next to the kitchen revealed a posted menu for the week, in very small print, which was not easily viewed by residents. Residents in the dining room were served chili hot dogs, potato chips, and baked potatoes. No meal tickets were observed for the hot dogs with chili, baked potatoes, or potatoes chips that were observed (not on menu). Staff were observed to yell out the resident's order. Review of meal tickets on meal carts being served to residents eating in their rooms reflected, [NAME] sugar glaze ham, candied sweet potatoes, fried okra, [NAME], cornbread, fresh orange slices and other condiments. Observation in the kitchen on [DATE] at 12:40 M revealed [NAME] H used his gloved hands to portion out pieces of ham and fried okra on residents' trays. He did not use the correct utensils or spoon. Also observed a container of macaroni and cheese. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on [DATE] at 12:50 PM, revealed the kitchen had run out of glazed ham and ten residents' plates were left to be served on the 200 hall. The DM stated that they would serve hamburger patties as an alternative because they ran out of glazed ham. Observed planned menu for lunch: brown sugar glazed ham, candied sweet potatoes, fried okra, margarine, cornbread, sugar, salt, pepper, non-diary creamer, fresh orange slices, coffee or tea, and milk. In an interview on [DATE] at 09:19 AM the DM stated the thawed beef patties would be served at lunch. In an interview on [DATE] at 11:51 AM the DM stated using hands to serve food was not acceptable. Staff needed to use utensils for portion control and to avoid cross contamination. Everything was measured out according to the diet type and recipe and some residents could only have a few ounces of food and others needed double portions. That would not meet her expectations because staff could not measure portion sizes with their hands. These behaviors were not good, and it did not meet her expectations. The DM stated the meal served in the dining room was not listed on the menu. She came up with the idea and had been doing it for about two months. She gave examples of what had been served: Chili dogs, brisket, salad, baked potatoes, fajitas, taco soup, etc. and those were not listed on the menu. It was like a side dish and stated those didn't need a menu or recipe. She was not aware of any policy or procedure and there was no process. She stated she knew all the residents' meal types and knew which residents could have which kinds of meal textures. The different food served in the dining room was an incentive to bring residents out of their rooms to get different food. Residents that ate in their rooms could not get this special meal. Observation on [DATE] at 01:22 PM of the lunch test tray revealed a beef hamburger patty with brown gravy, baked potato, cooked zucchini, apple slices, roll, and sour cream. Review of the menu and a meal ticket reflected rosemary sage beef, baked potato, seasoned zucchini, margarine, wheat roll, sugar, salt, pepper, non-dairy creamer, fresh apples slices, coffee or tea, and milk. In an interview on [DATE] at 09:20 AM, the DA stated that she received training on using the correct scoop, per the recipe, when serving out residents' food trays. She stated that she would never use her hand to serve food due to the risk of cross contamination. She said the side bar was created by someone, but there were no menus, and she didn't know if there was a policy. The staff would tell residents what was being served after they arrived in the dining room. There were no meal tickets for the side bar but the DM or the therapist were in the dining room and knew which residents could have certain meal types. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 09:33 AM, [NAME] I stated she received orientation training on different types of meal, how to serve plates, menu, reading the meal ticket, hair nets, glove use, hand hygiene, using scoops for serving food, and many other topics. [NAME] I stated she would never use her hands to portion food for residents' plates, even if she was wearing gloves because it was not sanitary and could make the residents sick. [NAME] I stated that if the kitchen ran out of the main protein/entree or any other item listed on the menu, she would use an alternative that was listed on the menu for that day/that meal. That information would be documented on a substitution form kept in the kitchen and stated she had to list the date, item on menu that was substituted, what was the substitution and why it was substituted so it could be approved. If they ran out of glazed ham and had to serve hamburger patties instead, that information would be listed on the menu substitution approval form kept in the kitchen. There was no menu for the items served on the salad/side bar in the main dining room. She stated residents have meal tickets printed in the kitchen and the kitchen staff knew which residents have different meal types and that was how they controlled ensuring the correct meal type was given to the resident. In an interview on [DATE] at 09:58 AM, the DM again stated that she created the special dining room meal and there were no menus. She stated that the nurses and therapy staff were in the dining room with the residents to ensure they were getting the correct meal. In an interview on [DATE] at 10:04 AM, the ST stated she was not aware who had come up with the idea of the special meal served in the dining room and was not sure if they had a process, policy, or procedure about it. There were no menus about the food. She was not aware of any residents being served the wrong texture diet. In an interview on [DATE] at 10:13 AM, the DON stated the kitchen staff should be using measured spoons for the correct portion size and not serve food with their hands due to infection control concerns. Also, the residents must get a certain number of calories and the amount that was ordered and there was no way to accurately measure portions with your hands. This would not meet her expectations. The DON stated that the DM came up with the idea of the special incentive meals served in the dining room, also known as the salad bar only after the ADM suggested the residents needed more food options. It had been going on for about 3 to 6 months. She stated there was no way to monitor how much nutritional value from the salad bar so the residents were offered the regular meal as well and they could accept or decline it. There were no menus for the food items being served and therefore, no meal tickets. The DON stated it is the nurse's responsibility to monitor and review the meal tickets to ensure the residents were getting the appropriate meals (low sodium, low carbohydrate, mechanical soft, puree, etc.) and it started in the kitchen with kitchen staff reviewing those meal tickets. (continued on next page)

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	675438	A. Building B. Wing	02/20/2025

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a telephone interview on [DATE] at 11:10 AM, the dietitian stated that she visited the kitchen once a month and completed a walk-through checking for, among other things, tray line for portion sizes, scoop sizes, tray accuracy, and monitoring temperatures, which have all been ongoing issues. She stated she was aware of the special meal service for the dining room residents. She was not involved in the process, and she did not believe there was any formal process or procedure. There were no menus. She had not approved a menu, but when she had looked at what was being served sometimes, she thought it appeared balanced and never commented on it. She stated it was the resident's rights to request the special dining food, even if it was not aligned with the resident's dietary orders. When asked if she thought chili hot dogs were considered an appropriately meal for a resident with low sodium or low carbohydrate, the dietitian did not answer and stated it was the resident's right to request this special food. When asked if she thought chili hot dogs were considered an appropriately for a resident with a mechanical soft diet and she stated only if they got the speech therapist involved and the speech therapist approved it. Observation of the main dining on [DATE] at 12:10 PM revealed no menus were posted. The staff did not know what was being served on the special incentive meal and were overhead asking kitchen staff what was being served. Lunch in the dining room was potato clam soup, salad with tomatoes and cucumbers, and fresh fruit (whole red and green grapes, cut strawberries, blueberries, and blackberries). Review of the menu for [DATE] reflected lunch was chicken parmesan or glazed meatloaf, buttered spaghetti or garlic mashed potatoes, buttered beets, tossed salad, wheat bread with margarine, chilled pears, and other condiments and drinks. In an interview on [DATE] at 01:14 PM, the ADM stated the special meal in the dining room was set up to encourage residents to come to the dining room for service. The DM came up with the idea. The ADM stated the speech therapist and multiple nurses were in the dining room to ensure residents were getting the correct meal type/diet order. There were no menus, because it was not considered a meal, but rather an appetizer. It varied and was different daily. The residents were still being offered their regular meal trays. He was not aware of any policy or procedure for this. Observation on [DATE] at 01:32 PM of the lunch test tray revealed chicken parmesan, buttered spaghetti, tossed salad, wheat bread, chilled pears, and a drink. Review of the kitchen in-service training dated [DATE] reflected kitchen staff had been trained on the topic of tray line and checklists for menu compliance. Review of the kitchen in-service training dated [DATE] reflected kitchen staff had been trained on following recipes, using scoop and ladle sizes, and the conversion table. Review of the facility's Menu Substitution Approval Form dated February 2025 reflected no entries for [DATE]. On [DATE], the only substitution listed was for coffee cake at breakfast. Substitutions made on [DATE] and [DATE] did not list the meal or reason for the substitution. Review of the facility's undated Menu Substitution Guide reflected, Choose any food within the same list as a substitute for the unavailable food. Substitute only within each group. Record the substitution on the menu and have the dietitian initial the change . Review of the facility policy titled Tray Line Service approved [DATE] reflected: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy: The consultant dietitian will monitor the tray line to ensure that diets are served accurately and in the correct portions and that patient/resident preferences are met . The following guidelines should be followed. Guidelines: 1. A dated copy of the daily menu extensions with any changes is posted in the kitchen near the tray line so that the servers can use the extensions to correctly serve the diets. 2. The trays are prepared by the server using the diet extensions and the portion sizes listed on the extensions. 4. Each tray is checked by the tray line personnel to ensure that the diet is served as ordered, the portion size of each item is correct, and preferences are met. The Dietary Manager conducts a tray line audit once each week for each meal to ensure that diets are served correctly and to identify any training needs. Review of the facility policy titled Holiday and Special Meals Policy approved [DATE], reflected: Policy: The facility believes that the quality of life for its residents should be maximized whenever possible. On holidays or special occasions, all residents will be served the same menu provided the physician has approved diet liberalization on such occasions. Procedure: 2. The menu for the holiday or special occasion will be planned during the resident council meeting or other meeting where resident input can be obtained. 3. The consultant NDTR or RDN will review and approve the holiday or special occasion menu for adequacy and appropriateness for the resident population. The menu will be extended by the dietitian/NDTR for all diets offered at the facility. 5. Texture modifications, such as ground meats or pureed, will be prepared for residents requiring texture modification. Thickened liquids will be provided as ordered by the physician. Review of the facility policy titled Menu Planning approved [DATE] and revised [DATE], reflected: Policy: The facility believes that nutrition is an important part of maintaining the wellbeing and health of its residents and is committed to providing a menu that is well balanced, nutritious and meets the preferences of the resident population. A standardized menu which meets the nutritional recommendations of the residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences will be used. Modifications for resident population and preferences may be made as appropriate. Procedure: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure: 1. Residents will be informed on admission that there is an alternate for each meal and will also be informed of substitutions which are available on a daily basis. 2. Residents will be served the main menu at each meal unless they request the alternative. 5. Nursing staff will observe the residents at mealtime. Any resident not eating will be offered the alternate meal or a substitute from the items available in the kitchen. The items offered must be compatible with any dietary restrictions or texture modifications. Review of the facility's policy titled Portion Control dated [DATE] reflected: Policy: The facility will use standard portion control procedures and utensils to ensure that adequate portions are served to residents. Procedure: 1. Standardized recipes should be used to prevent over-production. Recipes should be adjusted as needed to provide the amount of servings required. Amounts may vary when various serving methods and menus are utilized. 2. A dated copy of the daily menu extensions with portion sizes should be posted in the kitchen near the preparation and serving areas. 3. Portions for each food item should follow the specific portion sizes listed on the menus. 4. Food items should be served using standard size ladles, scoops, spoodles and spoons. Standard scoop and ladle sizes are listed . Note: Weights vary greatly with different foods, depending on how compact they are. The best practice is to weigh an item before proceeding with portioning. Dipper numbers are usually portions per quart.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observations, interviews, and record review, the facility failed to ensure each resident received and the facility provided food that accommodated resident preferences for 4 of 12 residents (Resident #9, Resident #11, Resident #43, and Resident #53) reviewed for food preferences. The facility failed to ensure Resident #9's lunch tray excluded gravy, in accordance with her dislikes which were listed on her meal ticket, on 02/20/2025 when the facility served Resident #9 two hamburger patties covered in brown gravy. The facility failed to ensure Resident #11's lunch tray included margarine and sweet and low, in accordance with her meal ticket as well as her preferences, (which were not listed on her meal ticket), on 02/18/2025, 02/19/2025, and 02/20/2025 and failed to include her coffee or tea on her lunch tray on 02/19/2025. The facility failed to ensure Resident #43's breakfast tray excluded oatmeal, in accordance with his dislikes that were not listed on his meal ticket on 02/20/2025 and failed to include margarine on his lunch trays on 02/18/2025, 02/19/2025, and 02/20/2025 in accordance with his meal ticket as well as his preferences (which were not listed on his meal ticket). The facility failed to ensure Resident #53 received an alternate meal of hamburgers for lunch on 02/18/2025, 02/19/2025, and 02/20/2025 in accordance with her meal substitute request form. These failures placed residents at risk of poor intake, possible weight loss, and diminished quality of life. Findings included: Review of Resident #9's quarterly MDS, dated [DATE], reflected a [AGE] year-old female originally admitted to the facility on [DATE] with a re-admitted [DATE]. Her main diagnoses included quadriplegia (paralysis of all four limbs and the torso), traumatic brain injury, epilepsy (seizure disorder), anxiety, and dysphagia (difficulty swallowing). Resident #9 had a BIMS score of 15, indicating no cognitive impairment. Her speech was unclear. She was dependent and required total assistance with eating. Resident had a regular diet. Review of Resident #9's care plan dated 12/12/2024 reflected resident was dependent in all activities of daily living due to quadriplegia. The resident needed staff to assist with feeding and interventions included: Observe/document/report PRN any symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Resident #9 had a potential nutritional problem due to anemia and impaired mobility. Interventions included: Determine individual likes and dislikes .and provide, serve diet as ordered. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 02/18/2025 at 01:21 PM in resident's room revealed Resident #9 was being served lunch. Resident #9's meal ticket listed, [NAME] sugar glaze ham as the main item and listed preferences of no gravy, no sauce. Resident #9's lunch plate had two beef hamburger patties covered in brown gravy. In an interview, Resident #9 stated she did not like sauce nor gravy because it was too salty but had no diet restrictions. Resident #9 stated she was not okay eating the hamburger patties and stated, But no one cares. She stated she would not eat the hamburger patties because they had gravy on them but would eat the other items offered. In an interview on 02/18/2025 at 02:18 PM Resident #9 stated lunch was shitty. She did not eat the hamburger patties covered in gravy. She stated staff did not care and did not pay attention to things like her meal ticket. Resident #9 stated she knew she could ask for an alternative but did not ask for one. Resident #9 stated she had food available in the room if she got hungry. Review of Resident #11's quarterly MDS, dated [DATE], reflected a [AGE] year-old female originally admitted to the facility on [DATE] with a re-admitted [DATE]. Her diagnoses included high blood pressure, high cholesterol, diabetes mellitus (high blood sugar levels), depression, anxiety, senile degeneration of the brain, and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Resident #11 had a BIMS score of 12, indicating moderate cognitive impairment. She required setup or clean-up assistance with eating. Review of Resident #11's care plan dated last reviewed 11/18/2024 reflected the following: Observe/document/report PRN any s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Resident #11 had ADL Self Care Performance Deficit r/t impaired mobility. Will maintain current level of ADLs through the next review date. Setup or clean up assistance with: Eating. No review of food preferences, likes/dislikes were noted on the care plan. Observation on 02/18/2025 at 12:54 PM in resident's room revealed Resident #11 had a meal ticket on her lunch tray with margarine printed as one of the menu items, but margarine was not on her tray. Observation on 02/19/2025 at 01:14 PM in resident's room revealed Resident #11 had a meal ticket on her lunch tray with margarine printed as one of the menu items, but margarine was not on her tray. Observation on 02/20/2025 at 01:10 PM in resident's room revealed Resident #11 had a meal ticket on her lunch tray with margarine printed as one of the menu items, but margarine was not on her tray. In an interview on 02/18/2025 at 12:55 PM with Resident #11 she stated that she never gets butter (margarine) on her tray. She always asked the aide who brought the tray to go get her butter but that they just set the tray down and leave her room and don't come back until they were taking the trays away. She stated that some of the aide's act bothered by having to do anything for the residents and it makes her not want to ask for assistance. She stated that she liked to have sweet and low with her tea, but they often don't bring that either even thought her meal ticket says it should be on her tray. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43's quarterly MDS, dated [DATE], reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), heart failure, high blood pressure, diabetes mellitus (high blood sugar levels), high cholesterol, lack of coordination, morbid obesity, pressure ulcer of right heel, and need for assistance with personal care. Resident #43 had a BIMS score of 12, indicating moderate cognitive impairment. He required supervision or touching assistance with eating, where the helper provides verbal cues and/or touching /steadying and/or contact guard assistance as resident completed activity. Assistance may be provided throughout the activity or intermittently. Review of Resident #43's care plan dated last reviewed 02/18/2025 reflected Resident #43 was at risk for alteration in nutrition r/t high BMI and therapeutic diet. Dietary staff were to evaluate current dietary intake, eating habits, and nutritional status, review his food preferences, likes/dislikes. Observation on 02/18/2025 at 12:50 PM in resident's room revealed Resident #43 had a meal ticket on his lunch tray with margarine printed as one of the menu items, but margarine was not on his tray. Observation on 02/19/2025 at 01:10 PM in resident's room revealed Resident #43 had a meal ticket on his lunch tray with margarine printed as one of the menu items, but margarine was not on his tray. Observation on 02/20/2025 at 01:07 PM in resident's room revealed Resident #43 had a meal ticket on his lunch tray with margarine printed as one of the menu items, but margarine was not on his tray. In an interview on 02/18/2025 at 10:22 AM with Resident #43 he stated that he had food preferences but that the facility did not honor them. He stated that he did not like oatmeal, but he gets it anyway on days oatmeal was served. He said that he regularly refused the oatmeal by pushing it to the side of his tray and telling the aides when they pick up his tray. He has told his aides he did not like it, as well as other items he could not specify at the time. He stated they often get bread with lunch but that he never gets butter (margarine) with it when the meal ticket says it was supposed to have it. He stated that the aides just bring the trays and leave. He stated that he did not like to use his call button often because it took a long time for the aides to come back and they did not want to get small things for them, like butter. Review of Resident #53's quarterly MDS, dated [DATE], reflected a [AGE] year-old female originally admitted to the facility on [DATE], with a re-admitted [DATE]. Her diagnoses included anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), high blood pressure, seizure disorder, unspecified abnormalities of gait and mobility, muscle weakness, and depression. Resident #53 had a BIMS score of 11, indicating moderate cognitive impairment. She was independent and required no assistance from a helper with eating. Review of Resident #53's care plan dated last reviewed 11/08/2024 reflected the following: serve diet as ordered, observe intake, and record every meal, regular diet, regular texture, and regular consistency. No review of food preferences, likes/dislikes were noted on the care plan. Observation on 02/18/2025 at 12:47 PM in resident's room revealed Resident #53 had the lunch meal that was posted on the facility menu, but she had requested a burger for lunch. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/19/2025 at 01:07 PM in resident's room revealed Resident #53 had the lunch meal that was posted on the facility menu, but she had requested a burger for lunch. Observation on 02/20/2025 at 01:03 PM in resident's room revealed Resident #53 had the lunch meal that was posted on the facility menu, but she had requested a burger for lunch. In an interview on 02/18/2025 at 12:47 PM with Resident #53 she stated that she almost always wants a burger for lunch, but she never gets it unless her FM brings one to her. She said that her FM will come to the facility and bring her a burger but also fill out some papers and take them to the kitchen so that the resident could get burgers but that she did not get them. In an interview on 02/19/2025 at 01:42 P.M with a FM of Resident #53 she stated that Resident #53 did not always like what was offered to eat at the facility. The FM visits the resident once a week and will fill out a form for the resident to receive burgers for lunch, but when the FM calls the resident to ask if she received a burger for lunch, the resident often says that she did not get the burger on her lunch tray. The FM will bring the resident a burger for lunch on the days she visited because the facility will not honor her food preferences for lunch. Observation on 02/18/2025 at 12:50 PM in the kitchen revealed the kitchen staff ran out of brown sugar glazed ham that was listed on the menu for lunch. In an interview on 02/18/2025 at 01:26 PM CNA E, stated she was going to assist Resident #9 with feeding. CNA E acknowledged that the meal ticket said, no gravy, no sauce and the hamburger patties were covered in gravy. CNA E stated that usually she would go tell the nurse, but Resident #9 had food in her room and therefore, would proceed with feeding the resident the other items on the tray and not inform the nurse. In an interview on 02/19/2025 at 11:51 AM the DM stated resident's meal preferences were listed on meal tickets and staff should read and put the correct items on the tray to honor food preferences. The DM stated the cooks, and she were responsible for checking meal tickets to ensure accuracy of residents' preferences. When asked about a resident receiving hamburger patties covered in gravy on 02/18/2025 who had a preference of no gravy, no sauce listed on a meal ticket, the DM stated that the kitchen ran out of the glazed ham and hamburger patties were served as a substitution. The DM responded, We really dropped the ball yesterday and no, that would not meet my expectation. An interview was attempted on 02/20/2025 at 09:20 AM, with CK F regarding residents' meal preferences; however, the employee had been terminated and no longer worked at the facility. In an interview on 02/20/2025 at 09:20 AM, the DA stated that she had received orientation and in-service trainings regarding her job duties. She worked the tray line, set up meal trays, and checked meal tickets for accuracy. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/20/2025 at 09:54 AM, the DM stated that residents could put in orders for alternative meals if they did not want what was being served. She stated that alternate meal requests must be turned in by a certain time of day and if they were not turned in the resident would not get an alternate meal. She said that Resident #53 would put the wrong dates on her forms, if the DM was working, she would notice the wrong date and honor the alternate request but if she was not working than more than likely the resident would not get the alternate meal because the person reading the request would think it's for the date written. She stated that no one goes to check with the resident to see what date was meant to be written. No alternate meal request forms were able to be provided to the state surveyor. In a telephone interview on 02/20/2025 at 11:10 AM the dietitian stated that she visited the kitchen once a month and audited the tray line, among other things, for tray line accuracy, which had been an ongoing issue. The dietitian stated she had provided training on this and other topics. During an interview on 02/20/2025 at 01:13 PM, the ADM stated that all residents could choose from the always available menu and that their preferences should be honored. Review of the kitchen in-service training dated 09/30/2024 reflected kitchen staff had been trained on the topic of tray line and checklists for menu compliance. Review of the facility policy titled Tray Line Service approved 12/01/2011 reflected, The consultant dietitian will monitor the tray line to ensure that diets are served accurately and in the correct portions and that patient/resident preferences are met. The following guidelines should be followed. 3. Staff on the tray line check each resident's tray card to ensure that dietary preferences and dislikes are honored, and appropriate substitutions provided. 4. Each tray is checked by the tray line personnel to ensure that the diet is served as ordered, the portion size of each item is correct, and preferences are met. The Dietary Manager conducts a tray line audit once each week for each meal to ensure that diets are served correctly and to identify any training needs. Review of the facility's Alternate Food Choices and Substitutions and Honoring Preferences policy date approved October 1, 2018, reflected, The facility believes that adequate nutrition is essential to each resident's well-being and good health. An alternate entree and vegetable will be offered at each meal. The facility also supports resident choice and allowing residents to choose foods by honoring their food preferences. Other substitutions will also be available in the event a resident does not choose the main meal or the alternate. 1. Residents will be informed on admission that there is an alternate for each meal and will also be informed of substitutions which are available on a daily basis. (continued on next page)

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	675438	A. Building B. Wing	02/20/2025

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

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The Nutrition & Food service Manager or designee will obtain the resident's food preferences upon admission and record preferences in the tray card system. 3. Residents will be served the main menu at each meal unless they request the alternate. 4. If a resident's preferences indicate they dislike the main meal, the alternate will be served unless the resident requests a substitution. 5. Nursing staff will observe the residents at mealtime. Any resident not eating will be offered the alternat meal or a substitute from the items available in the kitchen. The items offered must be compatible with any dietary restrictions or texture modifications. 6. Nursing staff will inform the Nutrition & Food service department of the resident's request. The Nutrition & Food service department will prepare the alternate or substitution and give it to Nursing to serve the resident. 7. The Nutrition & Food service Manager will be informed by the Nutrition & Food service staff of the resident's request so that the resident's preferences can be updated. 8. If a resident consistently refuses meals, alternates, and substitutions for three or more meals, the Nutrition & Food service Manager will be notified. The Nutrition & Foodservice Manager will visit the resident to determine if a change in diet or preferences is appropriate. 50176

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen and two of two nourishment rooms reviewed for food and nutrition services. 1) The facility failed to close food product bags in the three-door freezer to prevent exposure to air. 2) The facility failed to label and date food items in the side-by-side refrigerator, freezer, and the two nourishment refrigerators. 3) The facility failed to ensure that one of their three-door freezers was maintained at acceptable temperatures which resulted in frozen foods thawing out and then re-freezing without being discarded. 4) The facility failed to maintain a sanitary environment for food preparation when [NAME] H was observed opening a package of food with his mouth, eating a bowl of cereal while cooking, and using his gloved hand to portion food for resident trays after touching multiple surfaces in the kitchen. 5) The facility failed to ensure proper hair restraints were worn in the kitchen. 6) The facility failed to reheat and hold food at the proper temperature when they reheated cold chili on the steam table and served it from a crockpot. 7) The facility failed to maintain the proper temperature of the refrigerator in nourishment room A. 8) The facility failed to maintain a sanitary open front refrigerator/freezer in the nourishment room A. 9) These failures could place residents at risk of cross contamination, loss of nutritional value, and foodborne illness. Findings included: Observation of the kitchen on [DATE] at 08:46 AM of the facility's three door side by side freezer revealed two open bags of frozen beef patties that were not properly sealed, were exposed to air, not dated, and one bag had significant freezer burn and ice. Also inside the freezer was an open bag of unidentified frozen patties that were not properly sealed, were exposed to air, not dated nor labeled, a closed bag of unidentified frozen food dated [DATE], and open box of frozen boneless, skinless chicken breast with rib meat with the bag inside opened and exposed to air and not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 08:53 AM of the kitchen side by side refrigerator revealed an open cardboard box dated [DATE] containing two plastic bags of thawed chicken legs and other chicken pieces. Both bags had been previously opened and were closed and neither bag was dated. There was also one large unopened tube of thawed ground beef that was not dated. Observation on [DATE] at 08:56 AM revealed [NAME] H wore a beard guard around his chin/beard, but not his full mustache. The beard guard was pulled down to expose his mustache. Observation on [DATE] at 09:02 AM revealed a cold container of chili dated ,d+[DATE] on a cart in the kitchen. At 09:10 AM it was moved to the kitchen counter and the state surveyor felt the outside of the foil container, which was cold to the touch. Then observed the DM put in in the steam table. Observation on [DATE] at 09:07 AM revealed the DW wore a beard guard around his chin/beard, but not his full mustache. The beard guard was pulled down to expose his mouth and mustache. Observation on [DATE] at 09:08 AM revealed [NAME] H used his teeth to open a plastic bag of brown gravy mix and then poured the mix into a pot on the stove and made gravy. While cooking, at 09:13 AM, [NAME] H ate two bowls of cereal as he stood at the food prepping table next to the cornbread he had just taken out of the oven, and while he walked around the kitchen. Observation on [DATE] at 12:04 PM in the main dining room revealed a table set up on the side with three uncovered crockpots: One contained chili, one had hotdogs, and the other was full of foil wrapped baked potatoes. The crockpot containing the chili was plugged in and the green power light was flashing, but it was not set to low, high, or warm. The crockpot containing the hot dogs had a missing knob. There was not a knob to indicate if it was off, low, high, or the warm setting. The residents in the dining room were being served chili hot dogs. Observation and interview on [DATE] at 12:21 PM revealed the DM unplugged two crockpots. The DM stated that they took temperatures on the steam table before moving the food to the crockpots and then kept the crock pots on low. The DM stated that one crockpot knob had broken off when it was on low and that was how she knew what temperature setting it was on. The DM stated they took temperature readings during serving. The survey team did not observe this. The DM checked the temperature of the hot dogs, by laying the thermometer in the liquid that read 140 degrees, not the hot dog. When the state surveyor asked the DM to re-measure, the DM picked up the thermometer and stuck it in the hot dogs and said, see, it's 140 degrees. The DM stated that food on the steam table needed to be held at 140 degrees Fahrenheit or higher. At 12:25 PM, the DM measured the temperature of the chili at 110 degrees Fahrenheit. The DW stated that the chili had lost heat due to sitting unplugged on the table and stated that the temperature should be at least 140 degrees Fahrenheit to avoid making residents sick due to food borne illnesses. The DM stated it was not her expectation that the crockpots be covered because it was a salad bar and salad bars are open and not covered. Observation on [DATE] at 12:39 PM of the kitchen side by side refrigerator revealed an unlabeled open bag of what appeared to be bacon bits dated [DATE] that was not properly sealed and had no use by date. The thawed chicken pieces and ground beef were still there undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 12:40 PM revealed [NAME] H wore a beard guard around his chin that exposed his mustache. [NAME] H used his gloved hands to portion food for resident trays on the tray line. Without changing gloves, [NAME] H picked up pieces of ham and fried okra and put them on residents' plates, touched other clean plates, the food tray and cover, the meal cart, and the steam table surface. At 12:47 PM [NAME] H used the same gloved hand to pick up a large pan and handle frozen meat patties. Observation in the kitchen on [DATE] at 07:35 AM revealed [NAME] H wore a beard guard around his chin, but not covering his mustache. At 7:40 AM the side-by-side refrigerator was observed with one unlabeled sandwich in plastic baggy, a foil covered container containing lettuce/salad that was not labeled nor dated, a large tube of thawed ground beef not dated (the same tube seen as on [DATE]), and one opened tube of thawed ground beef that was not properly sealed, exposed to air, and not dated. The same box of chicken pieces dated [DATE] was there with the same thawed chicken pieces. Observation on [DATE] at 07:44 AM revealed that the facility's second three door freezer's exterior thermometer displayed 41.3 degrees Fahrenheit. The freezer had a temperature log on the middle door which indicated the last recorded AM temperature of 41 on [DATE] and the last PM temperature of -1.2 degrees on [DATE]. Observation revealed the last of the three doors were open because a box on the top shelf stuck out and prevented the door from closing all the way. Observation of interior contents of the freezer revealed several boxes of sealed seafood items, a bag of fish sticks, several bags of beef patties, unlabeled and undated bag of frozen food, and large brisket/roast meats. The beef patties and fish sticks were not frozen and easily broken or crumbled when the state surveyor touched them. The unlabeled bag of food had condensation inside the plastic bag and the contents were soft to the touch. All the food items that were not boxed, that the state surveyor could see, were not frozen, except for the very large brisket/roast meats. Observation and interview on [DATE] at 09:19 AM revealed that the facility's second three door freezer's exterior thermometer displayed 26.3 . The DM stated she was not aware of the freezer temperature until she observed the state surveyor looking at the freezer earlier that morning. The DM stated that when the freezer temperature was noticed, a corrective action should have been done, including checking for the source of the problem, and reporting it to her. The DM stated the thawed beef patties would be served at lunch. She did not do anything with the fish sticks nor other items in the freezer and stated the freezer temperature had returned to normal, so no action was needed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the same interview, the DM stated it was the facility's policy to have an open date when food was opened to ensure it was used timely. When asked about the frozen beef patties with no open date and freezer burn, the DM threw them in the trash and stated that staff had probably left them too long on the counter and they thawed and then refroze. The DM stated it was important to throw out the meat because they had reached unsafe temperatures, thawed out and it would reduce the quality of taste. The DM stated there was a poster on the wall that listed how long meat could stay in the refrigerator before it was used. Regarding the open box of thawed chicken pieces in the refrigerator, the DM stated that chicken should have been labeled and dated and put in the refrigerator or cooked the same day. It was already thawed and there was no way for her to know how long it had been in the refrigerator since it was not dated. This did not meet her expectations. The DM took the box of chicken and placed it outside to throw away. Regarding the tube of thawed ground beef, the DM stated that she thought it was thawed on Sunday, [DATE], and left it in the fridge. She stated it was it was the kitchen staff's responsibility to label and date food items taken out to thaw. The DM stated that she walked through the kitchen twice a week to audit the refrigerator and would discard food with no date. If it had no date, she had no way of knowing how old the food was and if used, could make residents sick. She had not noticed the food that was not properly labeled and dated, and this did not meet her expectations. In an interview on [DATE] at 09:41 AM and 10:26 AM, [NAME] H stated he checked the temperature on the freezer around 6:30 AM and it was 41 . He logged it on the temperature log. [NAME] H stated he did not notice the freezer door was open until he saw the state surveyor looking at the freezer. He did not take any action and did not notify anyone. He could not say what he should have done. He stated that he continued cooking breakfast. He did not know how long the temperature had been out of range and stated he did not know how to answer the question about if the temperature out of range concerned him. [NAME] H stated it was important for frozen foods to stay frozen because otherwise the food would thaw and go bad. Expired food or food not kept at the appropriate temperatures could make residents sick. Cook H stated he had received training in hand and kitchen hygiene, hair nets and beard guards, and other kitchen trainings. He stated he should wear a hair net and beard guard anytime he was in the kitchen due to the risk of hair getting in food, which could cause cross contamination. He stated he trimmed his mustache yesterday because it was long. When asked if he should wear his beard guard over his mustache he answered yes. [NAME] H stated that he regularly opened bags of food with his fingers or teeth because he did not have time to grab a pair of scissors. [NAME] H stated that it was not sanitary to use his teeth to open a food bag because his germs could get in the food, and it would not be sanitary. [NAME] H stated that meat was thawed and then cooked. He could not say how long thawed meat should be in the fridge before it was used. He did not know how long the thawed chicken or ground beef had been in the refrigerator and he could not say what the process was for labeling and dating. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on [DATE] at 09:59 AM, revealed the DW wore a beard guard around his beard, but not his mustache. The DW hand carried clean dishes and plate covers from the dishwasher area into the food prep area. The DW stated before starting work, he received training on hairnets, beard guards, and hand sanitation. The DW stated he knew to wear a hairnet anytime he handled food and always a beard guard when he was in the kitchen. The DW stated the beard guard should cover all his hair on his face and he acknowledged it did not cover his mustache. The DW then pulled the beard guard over his mouth and covered his mustache. The DW stated it was important to cover all his hair to avoid hair getting on plates or in the food, which would not be sanitary and could make residents sick. Observation on [DATE] at 11:37 AM, revealed the DW stood in the dishwasher area and wore a beard guard around his beard, but not his mustache. In an interview on [DATE] at 11:51 AM the DM stated using hands to serve food was not acceptable. Staff needed to use utensils for portion control and to avoid cross contamination. The DM stated all male kitchen staff should wear beard guards that cover all facial hair and not doing so could cause cross contamination and make residents sick if hair got in the food. The DM stated that using teeth to open food containers was inappropriate. She stated that if a staff could not open the container with their hands, then they should use the kitchen scissors to avoid the risk of cross contamination. The DM stated that the kitchen staff had training on these topics and know what to do and what not to do in the kitchen. Staff should not be eating in the kitchen prep areas. These behaviors were not good, and it did not meet her expectations. In an interview on [DATE] at 09:20 AM, the DA stated that she received training on proper hair restraints, hand hygiene, and using the correct scoop, per the recipe, when serving out residents' food trays. She stated that she would never use her hand to serve food due to the risk of cross contamination. The DA stated that all food should have three dates on them. Food was to be labeled with the date received, date it was opened, and expiration date/used by. She did not know how long food could stay in the refrigerator but thought it was , d+[DATE] days. She did not do anything with thawed food and did not know the process. She received training not to eat in the kitchen due to the risk of cross contamination. She did not check the temperatures on refrigerators or freezers and stated that was the cooks or DM's responsibility. In an interview on [DATE] at 09:33 AM, [NAME] I stated she received orientation training on different types of meals. How to serve plates, menu, reading the meal ticket, hair nets, glove use, hand hygiene, using scoops for serving food, and many other topics. [NAME] I stated she would never use her hands to portion food for residents' plates, even if she was wearing gloves because it was not sanitary and could make the residents sick. She stated you could not eat in the kitchen food preparation area due to the risk of cross contamination and it would not be sanitary. [NAME] I stated they have a break room staff could use. [NAME] I stated she would use scissors to open food containers and would never use her mouth to open food containers or bags due to germs and cross contamination. [NAME] I stated she thawed meat in cold running water. At night, staff might take out frozen food and put in refrigerator to thaw and it needed to have a date on it. The food must be labeled with three dates: the date received, the date opened, and date to use by. [NAME] I stated she didn't know how long thawed meat could stay in the refrigerator because she always used it the same or next day. She was able to find a piece of paper in the kitchen that showed the length of time food could remain in fridge before being used or discarded. Without a date, she wouldn't know when it had been placed in the refrigerator and would discard the food to ensure it was safe for residents and not make them sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 10:13 AM, the DON stated the kitchen staff should be using measured spoons for the correct portion size and not serve food with their hands due to infection control concerns. The DON stated kitchen staff should not use their mouths to open food containers because mouths were dirty, and it was an infection control concern. The DON stated she didn't know what the policy was about eating in the food preparation area but would not do it due to cross contamination and that would not be sanitary. All kitchen staff must wear proper hair nets and beard restraints when in the kitchen to avoid cross contamination and not doing so would not meet her expectations. In a telephone interview on [DATE] at 11:10 AM the dietitian stated that she visited the kitchen once a month and completed a walk-through checking for sanitary conditions. She also checked the tray line for portion sizes, scoop sizes, tray accuracy, and monitoring temperatures, which have all been ongoing issues. The dietitian stated that once frozen food had thawed, it must be cooked the same day or throw it away. It should not be re-frozen as food had reached an unsafe temperature where bacteria could grow making the food hazardous to eat. She stated she provided training to kitchen staff regarding proper hair restraints, beard guards, hand sanitization, and not eating near the food preparation area. She stated that kitchen staff could use their clean gloved hands to serve food if it had not touched any other surface and they would need to change gloves after each task. Serving food after touching the counter, meal tray, plate, and other food items would not be sanitary and would not meet her expectations. In an interview on [DATE] at 01:14 PM, the ADM stated his expectation was for staff to wear proper hair nets and beard guards while in the kitchen, not to eat in the kitchen, and not use their teeth or mouth to open food containers because that was gross and was not sanitary conditions. The ADM was unaware of the freezer temperature conditions and could not say what to do. The ADM stated he would consult with the DM, dietitian, and review policy. Observation and interview on [DATE] at 03:11 PM of nourishment room A revealed a sign on the refrigerator door listed, Label and date all residents food or it will be thrown away and to fill out temperature logs. The temperature log on [DATE] at 0200 (02:00 AM) showed 40 degrees. In the refrigerator, there were three plastic bags with food inside with a date on the outside of the bag but was not labeled with a resident's name. A bag of fast food was not labeled nor dated and contained a sandwich. The fridge door shelf and inside bottom shelf was dirty with red and brown stains. Observation of the inside thermometer revealed 44 degrees Fahrenheit. The freezer shelf was dirty with brown residue stains. Three frozen food items in freezer were not labeled with resident's names nor dated. The DON stated residents do not have access to the nutrition rooms, only the nursing staff, and food should be labeled with residents' names to keep track of whose food it was. Observation and interview on [DATE] at 03:18 PM of nourishment room B revealed a sign on the refrigerator door, Please do not place anything in fridge without date, resident's name, and date open on milk, etc. There was a tray of snack food containing, among other items, three half sandwiches that were not labeled nor dated. An unidentified nurse staff came in and stated those were three chicken salad sandwiches. She had just put that food tray in and was about to label and date it but had to go get a pen. The DON stated nursing staff should be cleaning weekly. There was no cleaning log. The DON was not aware of any policy regarding food brought in by residents or family members, but stated the process was to label each food item with the resident's name and date. Fresh food, like the fast-food sandwich observed, would be discarded within 24 hours if not eaten. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the kitchen in-service training dated [DATE] and [DATE] (no year listed) reflected kitchen staff had been trained on staff hygiene, including hair nets and beard guards. Training reflected All Food Handlers Are Required to wear effective hair restraints that cover all exposed body hair. o Include Caps, hats. nets, scarves, bear restraints, and other reasonable hair containment forms. Hair Nets/Beard Guards serve two purposes: o Keep hair from contacting exposed food, clean and sanitized equipment, utensils and linens, or unwrapped single-service articles. o Keep worker's hands out of their hair. Review of Hair restraints summary dated [DATE] was signed by [NAME] H on [DATE]. Review of the kitchen's in-service training undated titled Monthly Review reflected: Make sure all items have 3 label dates. Examples are the date that we receive the item and the date we open an item. Make sure that hair restraints are worn thought your shift. Review of the kitchen in-service training dated [DATE] revealed kitchen staff had been trained on food handling, including no eating in the food preparation areas and how to open food items. Review of the facility policy titled Employee Sanitation date approved [DATE] reflected, Policy: The Nutrition & Foodservice employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Procedure: 3. Employee Cleanliness Requirements b. All employees must wear clean outer clothing. Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces . e. Employees will not eat or drink in food storage and preparation areas, or in areas containing exposed food or unwrapped utensils, or where utensils arc cleaned or stored. 6. Use of Gloves a. Gloves are not a substitute for thorough and frequent hand washing. When using gloves, always wash hands before touching or putting on new gloves. c. Use single use gloves for one task. d . Change gloves: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. Between each food preparation task. ii. After touching items, utensils, or equipment not related to task. iii. After touching hair, face, or any other source of contamination. iv. When leaving food preparation area for any reason. vi. Every hour for all tasks taking longer than one hour. Review of the facility policy titled Food Storage revised [DATE] reflected: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Procedure: 2. Refrigerators a. Keep fresh meat, poultry, seafood, dairy products, and most fresh fruit and vegetables in the refrigerator at an internal temperature of 41 For less . d. Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. 3. Freezers a. Store all frozen meats, poultry, seafood, fruits and vegetables, and some dairy products, such as ice cream, in the freezer at a temperature that maintains the frozen state of the foods . e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated . h. Place a thermometer inside freezers near the door where the temperature is warmest. Check the temperature of all freezers using the internal thermometer to make sure the temperature stays at 0 F or below. Temperatures should be checked each morning and again on the PM shift. Record the temperatures on a log that is kept near the freezer. i. Once frozen food has been thawed, it must be maintained at 41 F or less prior to cooking. Review of the facility policy titled Food Holding and Service date approved [DATE] reflected: Policy: The consultant dietitian will monitor the holding and service of food to ensure that all food served by the facility is of good quality and safe for consumption. All food will be held and served according to the state and Federal Food Codes. See Section 6 for Quality Assurance Monitor forms and schedule. The following guidelines should be followed. (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	02/20/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Guidelines: 1. All hot foods are served at a temperature of ? 140 F and all cold food at ? 40 F. The temperature is adjusted to account for the time the food will be held prior to service on the steam table and on the tray carts. 2. Foods are held prior to service for less than one hour, maintaining the temperatures noted above. Foods are covered to maintain temperatures except for foods that will be served crispy. 3. Food is placed on the steam table no more than 30 minutes prior to meal service. 4. If hot foods drop below 140 F, it is reheated to 165 F for a minimum of 15 seconds. 7. Temperatures of all hot foods and cold foods are taken at the beginning, middle, and end of tray service. Review of the facility's undated policy titled Foods Brought by Family/Visitors reflected: Policy Statement Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Policy Interpretation and Implementation 1. Family members and visitors are asked to inform nursing staff when foods are brought for a resident. 2. Foods brought by family/visitors for individual residents are not shared with or distributed to other residents. 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. a. Non-perishable foods are stored in re-scalable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. b. Perishable foods are stored in re-scalable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. 6. The nursing staff will discard perishable foods on or before the use by date.