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	04/22/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR) Level I assessment accurately reflected the resident's status for 2 of 5 residents (Resident #1 and Resident #4) reviewed for PASARR Level I screenings.1. The facility failed to ensure the accuracy of the PASARR Level 1 screening for Resident #1 and Resident #4. The PASARR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis PTSD (post-traumatic stress disorder) with an onset was present upon Resident #1 and Resident #4's admission.2. The facility did not complete a 1012 form to update Resident #1 and Resident #4's PASARR Level 1 with the new diagnosis.This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASARR Evaluation), individualized care, or specialized services to meet their needs.Findings included:Resident #1Record review of Resident #1's face sheet indicated a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of schizophrenia, anxiety disorder, and need for assistance mobility.Record review of Resident #1's MDS record dated 04/10/2026 did not have diagnosis of schizophrenia triggered at that time.Record review of Resident #1's care plan record indicated Resident #1 had prescription for antidepressants, antipsychotics, antianxiety related to anxiety and schizophrenia.Record review of Resident #1's level 1 PASARR dated 03/12/2026 indicated that Resident #1 had no evidence of a primary diagnosis for this individual, individual had a mental illness, an intellectual disability and/or evidence that this individual has a developmental disability.Resident #4Record review of Resident #4's face sheet, dated 04/21/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Post-Traumatic Stress Disorder (a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world), schizoaffective disorder, depressive type (a chronic mental health condition that combines symptoms of schizophrenia, such as hallucinations and delusions, with mood disorder symptoms, including depression or mania), auditory hallucinations (are false perceptions of sound, where an individual hears voices or noises that are not present in the environment), major depressive disorder of brain, not elsewhere classified (a psychiatric diagnosis used when a patient has symptoms consistent with major depression but does not fit into a more specific category), altered mental status, unspecified (a change in cognitive function, awareness, or consciousness without a clearly identified cause).Record review of Resident #4's quarterly MDS assessment, dated 3/17/26, reflected he had a BIMS score of 14, which indicated intact cognition. Resident #4. The MDS assessment reflected Resident #4 required setup or clean-up assistance with eating, required supervision or touching assistance for toileting, showering, and personal hygiene.Record review of Resident #4's PASARR Level 1 Screening, dated 12/09/2025, reflected that in Section C Mental Illness was marked as no, which indicated Resident #4 did not have a mental illness.Record review of Resident #4's care plan dated 01/09/26 reflected Resident #4 had a diagnosis of post-traumatic stress disorder and was at risk for behaviors associated with PTSD.Goal: Resident will feel more peaceful and at ease with improved quality of life.Interventions included (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer physician prescribed anxiolytics and monitor for side effects. Psych Referral as needed to evaluate and follow in house or outpatient.An interview conducted on 04/22/2026 at 10:26AM with MDS A stated they had worked at the facility for 3 years, in MDS role. MDS A stated that MDS was responsible for making sure that PASARR was completed correctly. MDS A stated that the purpose of a completed and accurate PASARR was to make sure that the resident was eligible for PASARR services and should be provided with the services as desired. MDS A stated PASARR should be completed before admission or within 48 hours of admission into the facility. MDS A stated she would ensure that the PASARR was accurate once the resident admitted to the facility. MDS A stated that diagnoses of schizophrenia, bipolar, major depressive disorder, severe anxiety, and PTSD would trigger a positive level 1 PASARR. She stated if a resident had one of those diagnoses, their PASARR status would be positive. MDS A stated if the PASARR was positive, the facility would refer to the resident for a level 2 PASARR screening. She stated if the resident had an inaccurate PASARR the resident may not get the services they need right away. MDS A stated Resident #1 had a negative PASARR level 1. She stated that because Resident #1 had a diagnosis of schizophrenia, his PASARR should have been positive, not negative.An interview conducted on 04/22/2026 at 12:10PM with the DON stated they had worked at the facility for 5 years. The DON stated MDS department was responsible for ensuring the PASARR was completed accurately. She stated that the purpose of an accurate PASARR was to ensure that the services are provided to the residents who are eligible based off their diagnosis. The DON stated that PASARR should be completed upon admission and/or before admission. She stated that diagnosis would trigger a positive PASARR but could not indicate which diagnosis. She stated that the residents would not receive their eligible services if the PASARR was incorrect.An interview conducted on 04/22/2026 at 12:41PM with the ADM stated he had worked at the facility for 9 years. The ADM stated that the MDS team was responsible for accurate PASARR's. He stated that the purpose of an accurate PASARR was to organize services for PASARR positive residents. He stated that the PASARR should be completed when they enter the facility and/or before. The ADM stated if a resident had diagnosis criteria, then the PASARR would be positive. He stated that if the PASARR was positive then they would communicate that to the PASARR nurse. He stated that a lot of mental health issues like major depressive disorder would indicate a positive PASARR. He stated that he believes a resident would have a positive PASARR if they had diagnoses like major depressive disorder. The ADM stated that if the PASARR was inaccurate, then the residents could have missed services that they are eligible for. The ADM does not know if Resident #1's diagnosis of schizophrenia, would indicate a positive level 1 PASARR. Record review of facility provided policy titled Resident Assessment-Coordination with PASARR program dated 05/05/2025 indicated the following:The facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admissioni. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. The facility designee shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include:a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interviews, record reviews, and observations, the facility failed to ensure food was stored in accordance with professional standards for food safety. The facility failed to ensure food was labeled and dated correctly in the refrigerator and freezer on 04/20/26. This failure could place the residents at risk of foodborne illnesses.Findings include: Observation on 04/20/26 at 9:02 AM of the kitchen revealed the following:An opened package of small bite sized oval shaped pieces, with a crumbly breaded coating and a pale golden color that was in the freezer, did not have a label, a delivery date, an opened date, or a disposal date on it.An opened package of provolone cheese in the refrigerator did not have a delivery date or an opened date. However, there was a used by date of 03/11/26.An opened package of French toast in the freezer had a delivery date of 03/10/26, opened date of 04/13/26, but did not have a disposal date. Interview on 04/20/26 at 10:48 AM with DM revealed that food in the refrigerator and freezer should have 3 dates on them: the date the food was delivered to the facility, the date the food was opened, and a disposal date. She also stated that all food items should be labeled. DM stated the disposal date was between 3 - 5 days from the opened date, depending on the product. She stated this was important so that staff would be able to determine what the product is and the product's freshness. She stated she was the one who checked the food when it was delivered and was responsible for ensuring that the delivery date was written on each package. She stated she did not know why each package was not labeled and did not have a delivery date on it as she normally tried to make sure it was done. She advised staff to be trained in labeling and dating food. She stated that she would follow up with kitchen staff to ensure that all items in the refrigerator and freezer were labeled correctly, had a delivery date, an open date, and disposal date on them. She stated that they have a food dating policy. Interview on 04/22/26 at 8:34 AM with CK1 revealed the food in the refrigerator and freezer should be labeled and have 3 dates on them: the date the food was delivered to the facility, the date the food was opened, and a disposal date. He stated the disposal date was between 3 - 5 days from the open date, depending on the product. He stated this was important because staff would know what they got out of the refrigerator and freezer and to keep the residents from getting sick with foodborne illnesses. He stated the DM was the one who checked the food when it was delivered and the rest of the kitchen staff was her backup when DM was not there. He stated that the facility had a food dating policy. Interview on 04/22/26 at 8:42 AM with the ADM revealed the facility had a food storage and dating policy. He stated the DM was responsible for ensuring that the policy was followed. He stated all food should be labeled and dated when it was delivered to the facility, but he did not mention there should be an open date or a disposal date on them. He stated it was important to ensure the dates were on the food packages to ensure residents did not get sick with foodborne illnesses. Record review on 04/20/26 of the food receiving and storage policy revised 10/2017, revealed the following: Policy Statement:Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation:8. All food stored in the refrigerator or freezer will be covered, labeled, and dated (use by date).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help to prevent the development and transmission of communicable diseases and infections for 3 of 3 residents (Resident #132, Resident #120, and Resident #58) reviewed for infection control. LVN A failed to disinfect the blood pressure cuff between residents (R#58, R#132, R#120) while performing medication administration. This failure place residents at risk for cross contamination and the development of infections.Findings include:In an observation of medication administration on 4/21/2026 at 8:00 AM LVN A utilized the blood pressure cuff on Resident #58, Resident #132, and Resident #120 and failed to disinfect the blood pressure cuff between residents.In an interview on 4/21/2026 at 9:02 AM LVN A stated that she was frequently in-serviced on infection control. She stated that it was policy to cleanse the blood pressure cuff with each use between residents. She stated that she has been working in the facility for 20 years and knows she should have wiped the blood pressure cuff off with the sanitizing wipe between each resident. She stated that by not cleansing the blood pressure cuff between residents she could potentially spread germs and cause residents to get sick. She did not have a reason why she failed to clean the blood pressure cuff.In an interview on 4/22/2026 at 10:38 AM with DON she stated she frequently services the nursing staff on infection control. She stated that the policy states that reusable medical equipment was cleansed between each resident. She stated that if items are not cleansed between each resident, they can spread infection. She stated it was her expectation that her staff disinfect items between each resident.In an interview on 4/22/2026 at 12:42 PM with ADM he stated he has been the Administrator for the facility for 9 years. He stated that the staff are frequently in-serviced on infection control. He stated the staff should cleanse reusable equipment such as a blood pressure cuff between residents and that is his expectation. He stated that if reusable equipment is not cleansed between each resident, it could pass infection if they had something and it would be just grossness.Review of facility policy titled, Infection Prevention and Control Program, dated 4/11/2025 which stated, This facility has established and maintains infection prevention and control program to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy explanation and compliance guideline #10-Equipment protocol stated, a. All reusable items and equipment requiring special cleaning, disinfecting, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment., c. Reusable items potentially contaminated with infectious materials shall be cleaned and disinfected as per manufacturer guidelines by staff, d. Staff will decontaminate equipment with a germicidal detergent prior to storing for reuse.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interviews the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 1 of 1 days reviewed (4/21/2026) reviewed for nurse staffing posting. The facility failed to post accurate daily staffing information on 4/21/2026. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included:During an observation on 4/21/2026 at 12:00 PM, the daily staffing census information was posted on the wall in the entrance area dated 4/20/2026. During an interview on 4/21/2026 at 12:11 p.m., the DON stated it was her job to post the daily staffing. She stated nobody would know what the staffing would be. During an interview on 4/21/2026 at 12:17 p.m., the ADM stated it was the DON job to post the daily schedule, and the negative outcome was that staff would not know their hours and where to go. It was not posted but it was done. During an interview on 4/22/26, 12:10 pm ADON stated she was not responsible for posting the daily staffing. Staffing coordinator was responsible for posting the daily staffing. Family and residents will not know the staff to resident ratio. During an interview on 4/22/26, 12:14 pm Staff Coord stated the daily staffing posting was posted daily. She stated she was responsible for the daily sign-in sheet for the staff and where the staff will be assigned for that day. A negative outcome would be family, and residents would be confused of who is scheduled to work for the day. She stated HR was responsible for posting the daily staffing at the entrance of the building. ADM stated there was no policy regarding the daily posting of the schedule.