STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675560	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Nursing and Rehabilitation Center	169 Lake Park Rd Lewisville, TX 75057

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 - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to incorporate the recommendations from the PASARR evaluation report into the resident's assessment, care planning, and transitions of care for 1 (Resident #1) of 3 residents reviewed for PASRR services.The facility failed to submit a complete and accurate request for nursing facility specialized services in the long-term care online portal within 20 business days after the annual interdisciplinary team meeting on 03/04/2025. Resident #1 did not receive a repositioning wedge as recommended on the PASRR Comprehensive Service Plan. This failure could place residents at risk of not receiving individualized care and specialized services to meet their needs. The findings include: Record review of Resident #1's Face Sheet, dated 09/16/2025, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included frontal lobe executive function deficit (impacts the ability to manage thoughts, emotions, and behavior effectively) following cerebral infarction (blood vessel to the brain is blocked), bipolar disorder (extreme mood swings, including emotional highs and lows), schizophrenia (severe mental disorder marked by impairments in how reality is perceived, leading to symptoms such as hallucinations, delusions, and disorganized thinking), and other voices and resonance disorders (affects the way a person speaks or produces sounds). Record review of Resident #1's PCSP (form used to streamline the process of documenting and managing specialize services for individuals with disabilities), dated 03/04/2025, reflected an annual meeting was conducted with Resident #1. The PCSP indicated Resident #1 was PASRR (screening tool used to ensure residents are not inappropriately placed in nursing facilities for long term care) positive for intellectual and developmental disabilities only. The PCSP indicated a repositioning wedge was recommended for Resident #1. Record review of Resident #1's Quarterly MDS (tool used to assess health status) Assessment, dated 08/22/2025, reflected intact cognition with a BIMS (screening tool to assess cognitive status) score of 15. Section I (Active Diagnoses) reflected Resident #1 was diagnosed with functional quadriplegia, morbid (severe) obesity, and limitation of activities due to disability. Section O (Special Treatments, Procedures, and Programs) indicated Resident #1 received physical therapy, occupational therapy, and speech therapy services. Record review of Resident #1's Comprehensive Care Plan, dated 08/20/2025, reflected the resident was PASRR positive for developmental disability. Interventions included therapy services as ordered, notifying the local authority of any significant changes, completing IDT (a group of professionals from various disciplines who work together to support the health and well-being of individuals) meeting as required, and providing specialized services as determined by the interdisciplinary team meeting. Resident #1's Comprehensive Care Plan did not reflect the use of a repositioning wedge. Record review of Resident's #1's Order Summary report, dated 09/16/2025, reflected the resident did not reflect an order for a repositioning wedge. During an interview on 09/16/2025 at 2:02 PM, the MDS Coordinator stated the facility completed PASRR assessments on admission and annually and the local authority completed quarterly assessment. The MDS Coordinator stated she was not working at the facility when the care plan meeting was held on 03/04/2025 and the previous MDS Coordinator was no longer employed at the facility. She stated she was not aware of the request for a positioning wedge. She stated if a request for services required follow up, the MDS Coordinator was responsible for that. During an interview on 09/16/2025 at 3:45 PM, the DON stated each morning staff met and discussed care plans and interventions to put in place. She stated resident #1 had been at the facility for a long time and received ongoing PASRR services. She stated she was unaware a positioning wedge was recommended for Resident #1 on 03/04/2025. She printed Resident #1's PCSP which reflected the recommendation for a repositioning wedge. She stated page 7 of the PCSP did not reflect any changes to his care plan. She stated if new needs were identified, they would be documented there. She stated Resident #1 had his last PCSP meeting on 08/25/2025 and it reflected a repositioning wedge was not needed. During an interview on 09/16/2025 at 3:55 PM, the Administrator stated after an IDT meeting, staff members discussed any items that needed follow up and he followed up with the MDS Coordinator to ensure the PCSP was complete. The Administrator stated he was not told Resident #1 needed a positioning wedge or the facility would have already purchased one. He stated it was important for the facility to provide recommended services to ensure the resident's needs were met.During a telephone interview on 09/19/2025 at 4:30 PM, the Habilitation Coordinator stated the repositioning wedge was recommended during the 03/04/2025 interdisciplinary team meeting, because Resident #1 leaned to one side, and she had approved it. She stated the nursing facility

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #2) of five residents observed for infection control. The facility failed to ensure that LVN B washed her hands or used hand sanitizer while administering medication to Resident #2 on 09/16/2025. This failure could place the residents at risk of cross-contamination and the development of infections.Findings include:Review of Resident #2's Face Sheet, dated 09/16/2025, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 had diagnoses which included hypertension (elevated blood pressure) and cellulitis (skin infection) of the right lower limb. Review of Resident #2's Quarterly MDS Assessment, dated 08/30/2025, reflected moderately impaired cognition with a BIMS score of 08. Section I (Active Diagnoses) reflected Resident #2 was treated for cellulitis and Section N (Medications) indicated the resident was administered antibiotics. Review of Resident #2's Comprehensive Care Plan, dated 08/28/2025, reflected Resident #2 had cellulitis of the lower right leg related to trauma. Interventions included Give antibiotics for infection and mild analgesics to relieve discomfort as prescribed by Physician. During an observation and interview on 09/16/2025 at 9:22 AM, LVN B was observed administering medication to Resident #2. The medication cart was parked outside Resident #2's door. LVN B opened the laptop on the medication cart to view the resident's orders and removed the medications to administer. The pills were placed in a medicine cup on top of the medication cart. LVN B put on clean gloves to open a capsule and poured the contents into a medicine cup. She crushed the other pills as ordered and removed her gloves. LVN B was not observed performing hand hygiene before putting on gloves or after removing the gloves. LVN B opened the pudding container on top of the cart and used a clean plastic spoon to remove the pudding and mixed it with the crushed medication. LVN B took the cup of medication to the resident's room and placed it on the bedside table. She used the bed controller to raise the head of the resident's bed and administered the medication. Resident #2 requested medication for pain. LVN B returned to the medication cart and viewed the resident's orders. LVN B was not observed to have performed hand hygiene upon exiting the resident's room. She removed pain medication from the locked box in the medication cart and documented it in the narcotic log. LVN B opened the top of the pudding container and used a clean plastic spoon to add pudding to the medicine cup. LVN B administered pain medication to Resident #2. LVN B washed her hands in the resident's restroom before leaving the room. LVN B stated she should have used hand sanitizer or washed her hands each time she entered and exited the resident's room. She stated she should have used hand sanitizer between the glove change. LVN B stated it was important to prevent cross contamination when caring for the residents. During an interview on 09/16/2025 at 4:50 PM, the DON stated the expectation was for staff to wash their hands or use hand sanitizer when removing gloves or in between touching surfaces that could be dirty. She stated it was important for staff to sanitize when going in and out of a resident's room. She stated it was important to prevent the spread of germs, and the facility had begun in-service training for staff. During an interview on 09/16/2025 at 4:55 PM, the Administrator stated it was important for staff to wash or sanitize their hands before going in or leaving a resident's room. He stated that anytime a staff member removed their gloves, it was important to sanitize. He stated it was important to prevent the spread of infection. Review of the facility's policy Hand Hygiene: Infection Control, revised 10/2022, reflected Hand hygiene is one of the most effective measures to prevent the spread of infection. Studies show that effective hand decontamination can significantly reduce the rate of healthcare associate infection. Use and alcohol based hand rub or alternatively soap and water for the following situations . Before and after direct contact with residents; Before preparing or handling medications. After contact with objects in the immediate vicinity of the resident; After removing gloves.