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	11/28/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to make sure every resident had full visual privacy for 1 of 4 residents (Resident #1) reviewed for dignity. The facility failed to ensure Resident #1 had full visual privacy and dignity by leaving Resident #1 lying in bed dressed only in a shirt and brief without a bed sheet, blanket, curtains, or a closed door from 2:19 AM to 4:43 AM. This was determined to be past non-compliance from 11/04/2025 to 11/5/2025 due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place residents at risk of emotional or psychosocial harm by not receiving appropriate measures for privacy and dignity. Findings included: Review of the Care Plan dated 11/07/2025 for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Dementia (Persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), Malignant Neoplasm of the Pancreas (Pancreatic Cancer), Anxiety (Persistent fear or worry), Hypertension (High Blood Pressure), Hypothyroidism (Thyroid does not produce enough hormones, underactive), and Depression (Sadness and loss of enjoyment), Frequent Falls, and Pain. Review of the BIMS (Brief Interview for Mental Status) dated 9/29/2025 for Resident #1 revealed that he received a score of 3, indicating severe cognitive impairment. Review of Video dated 11/04/2025 from 2:19 AM to 4:43 AM revealed LVN I entered the open door of Resident #1's room. She provided incontinent care and removed the sheet and blanket from Resident #1's bed. She left the room with the door open. At 4:43 AM LVN I returned to check on Resident #1, his door remained open the entire time between 2:19 AM to 4:43 AM. She then left the room and had a conversation with CNA J. The audio revealed that LVN I had previously instructed CNA J to take care of Resident #1, but that CNA J had forgotten. In the audio CNA J was heard telling LVN I that it was an accident and that she had gotten busy. CNA J then entered the room and made sure Resident #1 had appropriate clothing and linens for privacy and dignity. Review of the Inservice for Dignity dated 11/05/2025, revealed staff received training on Bed Lining Changes with Incontinence Care, Communication and Customer Service. The in-service stated Care should be provided every 2 hours or per resident request. It also stated, When bed lining are soiled you must change the bed pad, and or lining if required. Review of the Grievance dated, 11/05/2025, revealed Family Member F had concerns about the incontinent episode that occurred overnight on 11/05/2025. The immediate brief change was taken care of by LVN I but there was a delay in getting the linen replaced properly. There was an in-service with staff on incontinent care. Review of the Employee Statement written by LVN I on 11/05/2025 at 7:00 AM revealed LVN I stated she had gone to pass medications and perform her rounds. She discovered Resident #1 was wet. She stated that his penis was outside of his brief above the waistband of his brief. She reportedly removed his wet linens and brief and provided peri-care. It was documented that CNA J finished the task. Later, she circled back and discovered CNA J had not yet provided clean linens, so LVN I went (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to get CNA J at that time to finish the task. CNA J was highly apologetic to LVN I. Review of the Employee Statement written by CNA J on 11/05/2025. Confirmed LVN I had provided peri-care and asked CNA J to assist with the linen change. CNA J stated that she was busy and didn't go immediately but did eventually assist Resident #1. During an interview on 11/07/25 at 1:30 PM, Administrator G, stated that he was aware of the incident that involved Resident #1 being left in a brief and shirt without linens. Administrator G stated that in-services were performed for incontinent care. Administrator G stated that LVN I was an agency nurse and would not be returning to the facility. During an interview on 11/10/25 at 3:15 PM, Director of Nursing B, stated that Family Member F was upset that Resident #1 was left in his bed with nothing more than a brief and a shirt. She stated that the staff had been in-serviced on 11/05/2025 to make sure that it did not happen again. She stated that LVN I had provided incontinent care to Resident #1 but left him in the room without linens because CNA J was instructed to finish the rest of the task. She stated the staff did eventually bring the linens but that it was at a later time. During an interview on 11/10/25 at 4:00 PM, CNA J, stated that she was aware of the incontinent episode that occurred on 11/05/2025. She stated that she entered the room around 4 AM and saw that Resident #1 was lying in bed with nothing but underwear, socks, and shirt. She stated that he did have a pillow on the bed, but he did not have linens covering him. She stated that his door had been open, so he was visible from the hallway to anyone passing by his room. She stated that she had to get a fitted sheet for Resident #1's bed because he did not have one on the bed when she entered the room. She stated she had to get him a blanket and top sheet also. She stated that she was told by LVN I to go to his room about 10 minutes prior to entering. She stated that it was the expectation that he was to be checked on every 2 hours. She stated that she received in-service training. During an interview on 11/17/25 at 3:49 PM, LVN A stated that on 11/04/2025 she became aware of the incident that occurred overnight from Family Member F. She stated she was told Resident #1 was left in nothing but a shirt and a brief for 2-4 hours after an incontinent change. Review of facility policy dated 7/2017 and titled Resident Rights reflected the following: As a resident of this nursing facility, you have the right to a dignified existence. Respect and Dignity: You have the right to be treated with respect and dignity. Review of facility Long Term Care Ombudsman Program document dated 1/2025 and titled Your Rights in a Nursing Facility reflected the following: Dignity and Respect Live in safe, decent, and clean conditions Be treated with dignity, courtesy, consideration and respect

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to administer medications according to physician's orders for 1 of 4 residents (Resident #1) reviewed for medications. The facility failed to input a physician's order on the day that the order was received to ensure Resident #1 received Hydromorphone 4mg/ml MG every 4 hours instead of every 6 hours as previously scheduled. This was determined to be past non-compliance from 11/04/2025 to 11/5/2025 due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place residents at risk of harm by not receiving their scheduled medication in a timely manner. Findings included: Review of the Care Plan dated 11/07/2025 for Resident #1 reflected an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Dementia (Persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), Malignant Neoplasm of the Pancreas (Pancreatic Cancer), Anxiety (Persistent fear or worry), Hypertension (High Blood Pressure), Hypothyroidism (Thyroid does not produce enough hormones, underactive), and Depression (Sadness and loss of enjoyment), Frequent Falls, and Pain. Review of the BIMS (Brief Interview for Mental Status) dated 9/29/2025 for Resident #1 revealed that he received a score of 3, indicating severe cognitive impairment. Review of physician orders for Resident #1 reflected an order was written 11/04/25 for Hydromorphone 4mg/ml. The order was changing the frequency of doses to every 4 hours from every 6 hours. A standing PRN order for Hydromorphone 4mg/ml was also issued. Review of the MAR (Medication Administration Record) dated 11/10/2025 for Resident #1 revealed that although the facility did not input the order of Hydromorphone 4mg/ml to be given every 4 hours per physician order, the facility still administered Hydromorphone 4mg/ml as needed by the previous standing Hydromorphone 4mg/ml PRN order. Resident #1 was still receiving pain medication uninterrupted from 11/04/2025 until 11/05/2025. Review of the Progress Note dated 11/04/2025 at 5:34 PM for Resident #1 revealed LVN A documented that a new order was received from Hospice Nurse D. Per orders the Hydromorphone 4mg/ml every 6 hours was discontinued and replaced by a new order of Hydromorphone 4mg/ml every 4 hours. An additional Hydromorphone 4mg/ml as PRN was included. Review of the Inservice for Physician Orders dated, 11/05/2025, revealed LVN A received training on how to input orders, communication, checking the system to make sure the orders were inputted successfully, and customer service. During an interview on 11/10/25 at 1:00 PM, Hospice Nurse D stated that she delivered a written order to LVN A and DON B to change Resident #1's Hydromorphone 4mg/ml MG to every 4 hours instead of every 6 hours. She stated that Resident #1 had been receiving the scheduled medication every 6 hours in combination with PRN. She stated that the facility was giving the PRN routinely so it was decided that Resident #1 should be on a more frequent schedule to keep him comfortable. She stated that the facility should have implemented the order on the same day so that there was not any risk to Resident #1 missing the newly scheduled regiment. During an interview on 11/10/25 at 1:30 PM, Hospice Director E stated that the facility failed to input the order for Resident #1 that was delivered to LVN A and DON B from Hospice Nurse D on 11/04/2025. She stated that since Resident #1 had a PRN order and still received pain medication as ordered then the resident would likely be at a low risk of injury. The issue would have been if the facility did not give the PRN pain medication as required for the time leading up until they discovered their mistake. She stated that had Resident #1 not have had a PRN medication to cover for their mistake then it could have been a risk to his comfort level since the pain medication is to keep him from being in pain and agitated while on hospice services for end of life care. She stated that the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility should have implemented the order on the same day so that there was not any risk to Resident #1 missing the newly scheduled regiment. During an interview on 11/10/25 at 3:15 PM, Director of Nursing B, stated that Hospice Nurse D delivered a written order to the facility on [DATE]. She stated that Hospice Nurse D arrived right before she was leaving for the day. She stated Hospice Nurse D attempted to give her the written order but that she told Hospice Nurse D to go talk to LVN A about inputting the order. She stated that Hospice Nurse D placed them in a box and told LVN A that DON B knows about the orders. She stated that she interviewed LVN A and discovered that LVN A observed DON B and Hospice Nurse D having a conversation about the orders and assumed that DON B was going to handle the order. She stated that she did not input the order. She stated that the next day the situation was resolved. She stated that LVN A received a communication in-service discussing checking orders and following up on orders so that this issue does not happen again. She stated that Resident #1 was to be changing his pain medication from every 6 hours to every 4 hours. She stated that Resident #1 had a PRN medication that was being given in the time period that covered their mistake. She stated that there was no lapse in his care or medication. During an interview on 11/14/25 at 4:20 PM, Hospice Physician F stated that it is her expectation that the facility input written orders on the same day that they are received. She stated that the risk would be if a resident failed to receive medications as ordered. She stated that Resident #1 was at a low risk of injury from missing his medications and being in pain. She stated that he was already receiving his medications every 6 hours with an additional PRN order available to him if he needed it. She stated that the reason for the change to every 4 hours was because the facility was giving Resident #1 his PRN order already and they decided to go ahead and schedule it every 4 hours because Resident #1 was more agitated or uncomfortable. She stated that if the facility continued to give the PRN medication in addition to the previous 6-hour regiment then he was at a low risk of injury. During an interview on 11/17/25 at 3:49 PM, LVN A stated that 11/04/2025 was her first day to work with Resident #1. She stated that she was not familiar with Resident #1 or his previous orders. She stated that Hospice Nurse D had called the facility to speak with her and attempted to change Resident #1's order over the telephone. She stated that she informed Hospice Nurse D that she could not take an order over the telephone and that she needed the written order. She stated Hospice Nurse D arrived at the facility for her scheduled visit and also brought the written order with her. Hospice Nurse D was instructed to go discuss the order change with Family Member F. Afterwards, Hospice Nurse D attempted to talk to LVN A but LVN A told her that she was on the phone and to go talk to DON B. Hospice Nurse D approached DON B with the order and was told to deliver the orders to LVN A. She stated that she observed DON B and Hospice Nurse D talking about the orders, so she assumed that the orders were being handled by DON B. The next day she arrived at work and DON B approached her about the orders. It was discovered that the orders were supposed to be put in by LVN A. She stated that she received an in-service on communication and inputting orders. She stated that Hospice Nurse D should have communicated with her about DON B's expectations. She stated that although she failed to input the order, she did have knowledge of the order because Hospice Nurse D had already expressed what the order was about prior. She stated that she inputted a progress note and initiated a 24-hour report so that the staff knew when to administer the medications for the new order change. The only issue was the order itself was not input and had the problem not been fixed within the 24-hour period it may have gone unnoticed, and Resident #1 would have gone back to receiving medication every 6 hours. She stated that it did not happen that way and that there were no gaps in his medication administration. She stated that anytime an order is given the facility should input it and she can verify that it was not done on 11/04/2025 because on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/05/2025 she doublechecked and it was not there. She stated that if she had not documented the medication change in the 24-hour report and/or progress note then harm could have been done to Resident #1. She stated that he would have been in pain without his medication as ordered. However, that was not the case. Resident #1 still received the new changes and doses required by the order because she put it in the 24-hour report. That means for the next 24 hours it would show the nursing staff the scheduled doses. However, after 24 hours if the order was not placed it would disappear as if there were no order changes for Resident #1. The residents could have been at harm after the 24-hour period of missing their medications. Review of facility policy dated 1/2025 and titled Physician Orders reflected the following: It is the policy of this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments 4. Verbal orders must be recorded immediately in the residents' chart by the person receiving the order and must include the date and time of the order. 6. Orders for medications must include:A. Name and strength of the drug;B. Quantity or specific duration of therapy;C. Dosage and frequency of administration;D. Route of administration if other than oral; andE. Reason or problem for which given.