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	01/26/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #228) of 5 residents reviewed for dignity. The facility failed to treat Resident #288 with dignity and promote enhancement of her quality of life when the resident was not provided a privacy bag for his catheter bag. This failure could place residents at risk of not having their right to a dignified existence maintained and a decline in their quality of life. Findings included: Review of Resident #228's Face Sheet dated 01/24/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included acute kidney failure and neuromuscular (combination of the nervous system and muscles) dysfunction of the bladder. Review of Resident #228's Quarterly MDS assessment dated [DATE] reflected resident had a moderately impaired cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated resident had an indwelling catheter. Review of Resident #228's Physician Order dated 01/18/2024 indicated, POSITION PRIVACY BAG & TUBING BELOW THE LEVEL OF THE BLADDER. Review of Resident #228's Comprehensive Care Plan on 01/24/2024 reflected resident was not care planned for catheter care Observation on 01/24/2024 at 9:15 AM revealed Resident #288 was on his bed resting. Resident #288 had a catheter bag hanging on the side frame of the bed. The catheter bag with urine inside was observed visible upon entrance to the room. The catheter bag did not have a privacy bag. Observation on 01/25/2024 at 8:36 AM revealed Resident #288 was on his wheelchair eating breakfast. Resident #288's catheter bag was hanging below the wheelchair seat. The catheter bag did not have a privacy bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #288 on 01/25/2024 at 8:39 AM, Resident #288 stated he had the catheter for six days. Resident #288 said he never saw his catheter bag with a privacy bag. Interview and observation with the ADON on 01/25/2024 at starting at 8:43 AM, the ADON stated catheter bags must have a privacy bag because nobody needed to know the resident had a catheter. The ADON said an exposed catheter bag could lead to embarrassment if other residents or visitors could see the catheter bag with or without urine in it. The ADON acknowledged Resident #288's catheter bag did not have a privacy bag. The ADON said she would get something to cover up the catheter bag. The ADON left the room and came back with an improvised cover for the catheter bag. The ADON put the improvised privacy bag on Resident #288's catheter bag. The ADON said she would remind the staff to put privacy bags on catheter bags. Interview with CNA S on 01/25/2024 at 9:09 AM, CNA S stated she transferred Resident #228 from bed to wheelchair and also transferred the catheter bag from the side of the bed to the bottom of the seat of the wheelchair. CNA S said she noticed Resident #288's catheter bag did not have privacy bag. CNA S added she was not able to notify the nurse there was no privacy bag but added it was also her responsibility to put a privacy bag on the catheter bag. She said there should be a privacy bag whether the resident was inside the room or outside the room to avoid humiliation. CNA S said the resident might not want to go out of the room because the catheter bag was exposed. Interview with the DON on 01/25/2024 at 4:25 PM, the DON stated the catheter bag should have been placed inside a privacy bag to avoid embarrassment. The DON said all the staff, including her, were responsible in providing dignity to the residents with catheter. The DON said the expectation was for the staff to make sure the catheter bag had a privacy bag when the resident was on the bed, in the wheelchair, inside the room, and outside the room. She concluded that she would continually remind the staff the importance of catheter care through an in-service. Interview with the Administrator on 01/25/2024 at 4:34 PM, the Administrator stated a catheter bag without a privacy bag was a dignity issue. The Administrator said all the staff were responsible in providing dignity to all residents. He added the staff must do their due diligence in ensuring the residents had a dignified existence while in the facility. The Administrator, along with the DON and the ADON, would monitor that the catheter bags were not exposed. Review of facility policy, Dignity and Respect, Policy/Procedure - Nursing Administration rev. 05/2007 revealed Policy: It is the policy of this facility that all residents be treated with kindness, dignity, and respect.

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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** 47743 Based on observation, interview, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #228, Resident #7, and Resident #39) of twelve residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Residents #228, #7, and #39's rooms were in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #228 Review of Resident #228's Face Sheet dated 01/24/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included fracture of the humerus (long bone in the arm that runs from the shoulder to the elbow) of the right arm and falls. Review of Resident #228's Quarterly MDS assessment dated [DATE] reflected resident had a moderated impairment of cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated resident had fracture and weakness. Review of Resident #228's Fall Risk assessment dated [DATE] reflected the resident had a medium risk for fall. Review of Resident #228's Comprehensive Care Plan dated 01/26/2024 reflected resident was at risk for falls related to weakness and one of the interventions was to be sure the call light was within reach and encourage the resident to use it for assistance. Observation and interview with Resident #288 on 01/24/2024 at 9:15 AM revealed Resident #288 was on his bed resting. Resident #288's call light was noted on the drawer of the side table at the right side of the bed. The call light was located on the far right corner of the drawer. Resident #288 stated he could not reach his call light. Resident #288 said was not needing something at the moment but it would be great if the call light was near him in case he needed the assistance of the staff. Resident #7 Review of Resident #7's Face Sheet dated 01/25/2024 reflected the resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included seizure disorder (convulsion), muscle wasting (loss of muscle mass), and abnormalities of gait. Review of Resident #7's Fall Risk assessment dated [DATE] reflected the resident had a high risk for fall. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact with a BIMS score of 15. Resident #7 required supervision for bed mobility, transfer, dressing, grooming, toilet use, and personal hygiene. Review of Resident #7's Comprehensive Care Plan dated 12/21/2023 reflected resident was at risk for falls related to weakness and poor positioning at times in recliner. No interventions for fall noted Observation and interview on 01/25/2024 at 9:50 AM revealed Resident #7 was on her recliner, awake. Resident #7's call light was on the floor near her feet. She said sometimes the call light would fall because they do not secure it before going out of the room. Resident #7 started to scoot forward, searched for the cord of the call light with her left hand, and pulled the call light from the floor. Resident #7 said she was getting frustrated with her call light being on the floor. She said it was hard for her to bend over because her back was already tight and was hurting. Review of Resident #7's edited Comprehensive Care Plan dated 01/26/2024 reflected resident was at risk for falls related to weakness and poor positioning at times in recliner. One of the interventions was to be sure the call light was within reach and encourage the resident to use it for assistance. Resident #39 Review of Resident #39's Sheet dated 01/25/2024 reflected the resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included lack of coordination and abnormalities of gait. Review of Resident #39's Quarterly MDS assessment dated [DATE] reflected the resident was unable to complete the interview to determine the BIMS score. Resident #39 required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. Review of Resident #39's Comprehensive Care Plan dated 012/21/2023 reflected resident was at risk for falls. One of the interventions was to be sure the call light was within reach and encourage the resident to use it for assistance. Review of Resident #39's Fall Risk assessment dated [DATE] reflected the resident had a medium risk for fall. Observation and interview on 01/25/2024 at 8:33 AM revealed resident #39 was on her wheelchair watching tv. The resident's call light was noted on the drawer behind the resident. Resident #39 said resident she do not know where her call light was. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN S on 01/25/2024 starting at 8:39 AM, LVN S stated call lights were important for the residents because they use the call lights to communicate with the staff. LVN S said the call lights were the residents' tool to let the staff know they needed something as simple as a refill of water, if they were having shortness of breath, or had fallen out of the bed. LVN S said the bathroom also had a call light so the residents could call if they fell inside the room or needed assistance with hygiene. LVN S said the residents might fall, be mad, or be frustrated if their call lights were not within reach. LVN S said all staff were responsible for ensuring the call lights were with the residents. LVN S said he would educate the CNAs to ensure call lights were with the residents. LVN S went inside Resident #39's room, took the call light from the drawer, and put it on Resident #39's lap. In an interview with the ADON on 01/25/2024 at 8:49 AM, the ADON stated the call lights should be with residents all the time. The ADON said the call lights were important because the call lights were the residents' means of communication to let the staff know they needed help or assistance. The ADON said the resident might fall trying to get what they needed or trying to get the call light. The ADON said all the staff were responsible in making sure the call lights were with the residents. The ADON added the expectation was the staff would make sure the call lights were with the residents when they leave the room. The ADON concluded she would in-service the staff about call lights being within the reach of the residents. Interview with the DON on 01/25/2024 at 4:25 PM, the DON stated the call lights must be always within the reach of the residents. The DON said the residents used the call lights to alert the staff they needed some assistance. The DON added a lot of things could happen if the call lights were not with the residents. She continued the residents might try to get up on their own and fall on the process. The DON said the expectation was for the staff to check if the call lights were within the reach of the residents. The DON said all the staff, including the management, nurses, CNAs, therapists, and housekeeping, were responsible in placing the call lights within reach. The DON said he would make an audit of the call lights to make sure they were working and within the reach of the residents. Interview with the Administrator on 01/25/2024 at 4:34 PM, the Administrator stated the call lights must be within the reach of the residents so the residents could notify the staff if they needed something, if they were not feeling well, or if there was an emergency. If the residents would not be able to call the staff because they do not have their call lights, their needs would not be met. The Administrator said the expectation was the staff to do more rounds and pay closer attention to the needs of the residents. Record review of facility's policy Accommodation of Needs Policy/Procedure rev. 08/2023 revealed Policy: it is the policy of this facility to assure that a resident . with reasonable accommodation of individual needs and preferences . Procedures . 6. Have the call light within reach. Record review of facility's policy Call Light/Bell Policy/Procedure - Nursing Clinical rev. 05/2020 revealed Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedures . 5. Leave the resident comfortable. Place the call device within reach before leaving the room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for areas in the facility for 6 (Resident #5, #19, #30, #33, 43, and #51) of 20 resident rooms observed for a safe, clean, comfortable, and homelike environment. The facility failed to ensure that Resident #5, #19, #30, #33, 43, and #51's rooms were cleaned, sanitized, and maintained. This deficient practice could place residents at risk of infections and living in an uncomfortable environment leading to a decreased quality of life. Findings included: Observation of Resident #30's room on 01/24/24 at 10:49 AM reflected the bedside table had white fluid stains along the bottom rail. The bathroom floor had brownish stains near the toilet and the corners of the wall. Observation of Resident #19 and 33's room on 01/24/24 at 10:53 AM reflected the floor along the walls had built up black dirt stains. The wall behind the entry door had dark brown stains. Observation of Resident #5 and 43's room on 01/24/24 at 11:00 AM reflected the sink in the resident's bathroom had light brown stains around and on the faucet. The floor behind the Resident #5's bed had white particles along the wall and was thicker near the headboard area. Observation of Resident #51's room on 01/24/24 at 11:30 AM reflected the sink in the resident's bathroom had thick light brownish stains around and on the faucet. A disposal container located in the bathroom, had a dark brown stain on it. The room floor had brownish stains near the corners of the wall. In an interview on 01/26/24 at 03:15 PM with the Housekeeping Manager, she stated she had been at the facility for [AGE] years and she trained her staff to clean the entire room to include wiping down the bed side table, cleaning the floors, cleaning the bathroom, and wiping down the walls. She stated she checked most of the rooms after they had been cleaned and had not noticed the concerns. She stated that the areas viewed should have been cleaned by her staff and she would have the resident rooms cleaned. She stated the risk of rooms not being thoroughly cleaned could result in infection . She stated her staff was Spanish speaking only so they were not interviewed. In an interview on 01/26/24 at 03:40 PM with the DON, she stated leadership were to complete Angel rounds daily, which consisted of Key Leadership being assigned rooms to visit daily. She stated one of the task was for key leadership to observe the rooms for cleanliness. She stated that they had a lot of empty key leadership roles vacated so it had not been done as effectively. She stated the risk of the rooms not being thoroughly cleaned could result in infection. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/25/24 at 03:55 PM with the Administrator, he stated he was made aware of the concerns observed in the resident rooms and he stated that he was confident his housekeeping supervisor will have the issue resolved. He stated the leadership team does complete Angel rounds but had but had not been consistent in making their rounds consistently because of the vacated leadership positions within the facility. He stated the concerns observed not being addressed is an infection control concern. Review of the facility's policy on Safe/Comfortable/Homelike Environment (01/2022) reflected Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observations, interviews, and record reviews, the facility failed to ensure the resident was free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 8 (Resident #13) residents reviewed for restraints. The facility failed to ensure they had physician orders for the scoop mattress being used for Resident #13. These failures could unnecessarily inhibit the residents' freedom of movement or activity. Findings included: 1. Record review of Resident #13's MDS assessment, dated 10/16/23, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her cognitive status was severely impaired. Her diagnoses included right hip fracture and multiple falls. Record review of Resident #13's January 2024, Physician Orders reflected there were no orders for a scoop mattress. (a mattress with elevated sides used to limit the ability to get out of bed). Record review of Resident #13's Comprehensive Care Plans, not dated, reflected there was not a care plan for the scoop mattress. An observation on 01/24/24 at 9:25 AM revealed Resident #13 was asleep in bed. She was laying on a scoop mattress. An interview on 01/25/24 at 2:38 PM with the ADON revealed Resident #13 had a scoop mattress because she had a history of falls. The ADON said she did not know if the resident had an order for the scoop mattress or if an assessment for the scoop mattress had been completed. An interview on 01/25/24 at 03:02 PM with the DON revealed Resident #13 had a scoop mattress because the family had asked that the resident be placed in restraints. The facility placed her on a scoop mattress instead. The DON said the scoop mattress allowed the resident to get off of it, and it allowed staff more time to get to her. The DON said Resident #13 had a history of falls because she would get out of bed and forget that her legs did not work properly. The DON said the resident was supposed to have an assessment, order, and care plan for the scoop mattress but said she knew the resident was able to get off of the mattress. A record review of the facility policy, Freedom From Abuse, Neglect, Exploitation, revised October 2022 reflected: Policy (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for two (Resident #288 and Resident #7) of six residents reviewed for Care Plans. The facility failed to ensure Resident #288 was care planned for catheter care. The facility failed to ensure Resident #7 had interventions on her care plan for fall. These failures could place the residents at risk of needs not being met. Findings included: Resident # 228 Review of Resident #228's Face Sheet dated 01/24/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included acute kidney failure and neuromuscular (combination of the nervous system and muscles) dysfunction of the bladder. Review of Resident #228's Quarterly MDS assessment dated [DATE] reflected resident had a moderated impairment of cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated resident had an indwelling catheter. Review of Resident #228's Physician Order dated 01/18/2024 indicated, POSITION PRIVACY BAG & TUBING BELOW THE LEVEL OF THE BLADDER. Review of Resident #228's Physician Order dated 01/18/2024 indicated, CATHETER CARE EVERY SHIFT. MONITOR URETHRAL SITE FOR S/S (signs and symptoms) OF SKIN BREAKDOWN, PAIN/DISCOMFORTS, UNUSUAL ODOR, URINE CHARACTERESTIC OR SECRETIONS, CATHETER PULLING CAUSING TENSION. Review of Resident #228's Physician Order dated 01/23/2024 indicated, CATHETER TYPE: 14 FR (14 French catheter: gauge used to measure the size of the catheter) 10 ML (milliliter) _ TO CLOSED URINARY DRAINAGE SYSTEM . Review of Resident #228's Physician Order dated 01/23/2024 indicated, CHANGE FOLEY CATHETER MONTHLY ON _ DAY OF EACH MONTH. REINSERT PRN (as needed) FOR ACCIDENTAL REMOVAL, DISLODGEMENT, OBSTRUCTION OF URINE FLOW. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #228's Comprehensive Care Plan on 01/24/2024 reflected no care plan for an indwelling catheter. Observation on 01/24/2024 at 9:15 AM revealed Resident #288 was on his bed resting. Resident #288 had a catheter bag hanging on the side frame of the bed. Resident #7 Review of Resident #7's Face Sheet dated 01/25/2024 reflected the resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included seizure disorder (convulsion), muscle wasting (muscle loss), and abnormalities of gait. Review of Resident #7's Fall Risk assessment dated [DATE] reflected the resident had a high risk for fall. Review of Resident #7's Quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact with a BIMS score of 15. Resident #7 required supervision for bed mobility, transfer, dressing, grooming, toilet use, and personal hygiene. Review of Resident #7's Comprehensive Care Plan dated 12/21/2023 reflected resident was at risk for falls related to weakness and poor positioning at times in recliner. There were no interventions provided pertaining to fall. Interview and observation with RN R on 01/25/2024 starting at 10:09 AM, RN R stated care plans were done to ensure each resident would have an individualized care. RN R said without the care plan, the current health concerns of the residents would not be addressed. If the medical issues were not addressed, the resident will not attain the care needed. RN R started to check the system for Resident #288's care plan for catheter care and Resident #7's care plan for fall. RN R stated Resident #288 did not have a care plan for catheter care and Resident #7 did not have a care plan for fall. RN R said she would call the attention of the DON to let them know that Resident #288 did not have a care plan for catheter care and Resident #7 did not have interventions for fall. Observation and interview with MDS Nurse on 01/26/2024 at 9:15 AM, MDS Nurse stated she was responsible in doing the care plans of the residents. The MDS Nurse said the purpose of the care plan was to make sure the specific needs of the residents were assessed, evaluated, and the needed goals and interventions were in place. She said without the care plan, the needs of the residents would not be addressed. MDS Nurse checked the care plan for Resident #288 and stated the resident did not have a care plan for catheter care. MDS Nurse said if the resident had a catheter, there should be a care plan for the catheter. MDS Nurse checked the Resident #7's care plan and stated the resident did not have interventions for fall. MDS Nurse said a care plan for fall was important for the residents especially if they were high risk for fall. The MDS Nurse entered the care plan of Resident #288 for catheter care and then entered the interventions for fall for Resident #7. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 01/26/2024 at 1:14 PM, the DON stated care planning is a team approach. The DON said the MDS nurse was the one responsible in making the care plans for the residents. The DON added without a care plan, the current health issues will not be addressed and managed accordingly. The DON further stated the care plan was done upon admission, quarterly and when there was a change of condition in the part of the residents. The DON said that it is not acceptable that a resident does not have a care plan because the resident will not be taken care of. The DON said the expectation is for every health issues of the residents were care planned. The DON concluded she will audit the residents' care plans to check if every medical concerns have a plan of care. Interview with the Administrator on 01/26/2023 at 1:26 PM, the Administrator stated that there should be a care plan for each resident or else the residents will not have care needed. The Administrator concluded that the expectation was the staff will ensure every issue of the residents were care planned. Record review of facility's policy, Comprehensive Person-Centered Care Planning, Policy & Procedure, Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident . Procedure: . 3. The facility team will provide a written summary . initial goals . any services and treatments to be administered.

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	675560	A. Building B. Wing	01/26/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45055 Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 3 residents (Resident #51) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #51 received showers consistently. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings Included: Resident #51 Record review of Resident #51's face sheet dated 01/26/24 reflected an [AGE] year-old male who was originally admitted to the facility on [DATE]. Relevant diagnosis included need for assistance for personal care, history of falls, and right artificial hip. Record review of Resident #51's Quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 05 (severe cognitive impairment). The resident required assist with ADL care. Record review of Resident #51's Comprehensive Care Plan dated 10/19/23 reflected the resident was care planned for having ADL self-care performance deficit and the goal for the resident was to maintain current levels function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. An intervention included Educate resident/family/caregivers of possible outcomes of not complying with treatment or care. Records review of Resident #51's Bath/Shower Sheets from 01/01/24 to 01/25/24, revealed the resident was scheduled to receive showers on Tuesdays, Thursdays, and Saturdays. The facility was only able to provide shower sheets for the following dates: 01/08/24: Refused bath 01/18/24: Refused bath 01/19/24: Refused bath Records review of Resident #51's progress notes for the month of January 2024 in the facility's system of records Point Click Care (PCC) revealed no documentation regarding the resident refusing showers and attempts being made to persuade the resident into taking a shower. There was no documentation of family members, or the resident physician being notified. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 01/24/24 at 11:15 Am with Resident #51, he stated he was not receiving his showers. The resident was observed wearing soiled shirt and pants, and he did not have any linen on his bed. In an interview on 01/26/24 at 02:06 PM with CNA V, she stated she had been at the facility for [AGE] years. She stated she provided care to Resident #51 whenever she covers the resident's hall. She stated he refused a lot of things, including showers. She stated they were to report to the LVN/Charge nurse S, and she tried communicating with the resident, but he would not listen. She stated they had to complete shower sheets for all residents, whether they had refused a shower or received one. She stated she always filled out a shower sheet for the resident but was not sure if all of the other CNAs did. She stated the risk of the resident not getting his showers when scheduled could result in skin problems. In an interview on 01/26/24 at 02:45 PM with LVN/Charge nurse S, he stated the CNA were supposed to complete a shower sheet whether the resident received or refused a shower. He was asked about Resident #51 only having 4 shower sheets on record for the resident and all four shower sheets reflected the resident had refused showers all four times and there were no notes in PCC of the resident refusing care. He stated when his CNA came to him about the resident refusing showers and he normally made three attempts to get encourage him to take a shower. He stated the nurses had to document issues such as the resident refusing showers and he was not sure why he had never documented the resident refusal for showers. He stated the risk of the resident not getting showers could result in skin break down. In an interview on 01/26/24 at 03:40 PM with the DON, she was advised of Resident #51, not having any records of receiving a shower for the month of January 2024, and only three shower sheets being observed for the resident, which all indicated he refused showers. She stated the CNA are supposed to complete shower sheets for residents whether the resident received or refused a shower. She stated she knows this resident refused care and could get aggressive if he feels as if he was being forced into doing something he did not want to do. She stated the nurses were supposed to attempt to persuade the resident into taking a shower and if that did not work, they were to contact a family member to assist and notify his physician. She stated not having a ADON prevents her from staying on top of all resident care. She stated the risk of the resident not receiving showers would result in skin breakdown. Record review of the facility's policy regarding Bath, Shower, dated 05/2020, reflected It is the policy of this facility to promote cleanliness, stimulate, circulation and assist in relaxation. Document all appropriate information in the medical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews and record reviews the facility failed to provide an environment that was free from accident and hazards to prevent accidents for 1 (Resident #54) of 6 residents reviewed for accidents free of hazards. The facility failed to ensure Resident #54's fall mat was placed alongside her bed while she was laying in the bed. This failure placed the residents at risk of accidents and hazards. Findings Included: Record review of Resident #54's Face Sheet, dated 01/24/23, reflected she was an 82 -year-old female admitted on [DATE]. Relevant diagnoses included muscle wasting and atrophy (decrease in muscle tissue), and repeated falls. Record review of Resident #54's Quarterly MDS dated [DATE] reflected the resident's BIMS was 00 (Severe Cognitive Impairment). The MDS indicated the resident had an active diagnosis for syncope (fainting) and collapse. Record Review of the Resident #54's Comprehensive Care Plan updated 01/18/24 reflected the resident was care planned for repeated falls, with the last fall occurring on 01/17/24, and an intervention included the use of a fall mat. In an interview and observation on 01/24/24 at 11:10 AM with LVN N, she stated Resident #54 was a fall risk and the resident's bed were to be placed at the lowest position and a fall mat should be placed next to the resident's bed. LVN N observed the resident lying in bed and her bed was in a low position, but the fall mat was leaning against the 4-drawer chest. She took the fall mat and placed it alongside the resident's bed. She stated the risk of the resident not having the fall mat placed next to the bed could result in the resident falling without the mat and injuring herself. She stated all staff should be checking to ensure the resident's environment was free of hazards and all the precautions were in place. She stated they observe resident rooms at least every 2 hours. In an interview on 01/26/24 at 03:40 PM with the DON, she was advised of Resident #54 observed not having the fall mat alongside her bed while she was laying in the bed on 01/24/24, she stated her expectation was for staff to ensure residents areas are free of hazards. She stated staff should have ensured that the resident bed was lowered to the lowest position, the call light within reach, and her fall mat alongside her bed. She stated staff must had forgotten to place the fall mat alongside the bed after the resident had eaten her lunch. She stated all staff should be checking for this whenever they enter the resident's room. She stated not having the fall mat in place could result in the resident having a fall without the fall mat and hurting herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review if the facility's policy regarding Fall Management, dated 06/2018, reflected It is the policy of this facility to provide an environment that remains free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if falls occur.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #58 and Resident #10) of three residents reviewed for respiratory care. The facility failed to ensure Resident #58 and Resident #10's nasal cannula was properly stored when not in use. The facility failed to ensure Resident #58 and Resident #10's humidifier bottles had water in it. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #58 Review of Resident #58's Face Sheet dated 01/24/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included respiratory failure with hypoxia (insufficient amount of oxygen in the body), pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection), and shortness of breath. Review of Resident #58's Quarterly MDS assessment dated [DATE] reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated Resident #58 was on oxygen therapy while a resident of the facility. Review of Resident #58's Comprehensive Care Plan dated 01/20/2024 reflected resident had oxygen therapy and one of the interventions was oxygen via nasal prongs/mask at 3 - 4 liters continuously. Review of Resident #58's Physician Order dated 01/09/2024 reflected O2 (oxygen) AT 3 L/MIN (liters per minute) CONTINUOUS PER NASAL CANNULA. Observation and interview on 01/24/2024 starting at 10:55 AM revealed Resident #58 was on his bed, resting. Resident #58's was on oxygen supplement via nasal cannula. The nasal cannula was connected to a humidifier. The humidifier bottle did not have water in it. Resident #58 stated he had been on oxygen even before coming to the facility. He said he was not aware his humidifier did not have any water. Resident #10 Review of Resident #10's Face Sheet dated 01/24/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included respiratory failure with hypoxia (insufficient amount of oxygen in the body), and respiratory bronchiolitis interstitial lung disease (small airway inflammation and scarring of the lung tissue). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's Quarterly MDS assessment dated [DATE] reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated Resident #58 was on oxygen therapy while a resident of the facility. Review of Resident #10's Comprehensive Care Plan dated 01/20/2024 reflected resident had altered respiratory status/difficulty breathing interstitial lung disease and one of the interventions was administer medications/puffers as ordered. Review of Resident #10's Physician Order dated 10/17/2024 reflected O2 (oxygen) AT 2 L/MIN (liters per minute) CONTINUOUS PER NASAL CANNULA. Observation on 01/24/2024 at 11:09 AM revealed Resident #10 was on his bed, resting. Resident #10's was on oxygen supplement via nasal cannula. The nasal cannula was connected to a humidifier. The humidifier bottle did not have water in it. Observation and interview with LVN B on 01/24/2024 starting at 11:16 AM. LVN B said the purpose of the humidifier was to prevent nasal and throat irritation. She said the water in the humidifier moisten the nasal passage that facilitated ease of breathing. LVN B said she would get distilled water and would go to Resident #58 and Resident #10's rooms and put water in their humidifiers. LVN B got some distilled water and filled up Resident #58's humidifier bottle up to the 500 millimeter mark. LVN B then went to Resident #10's room and filled up Resident #10's humidifier bottle up to 500 millimeter mark. Observation and interview with Resident #58 on 01/25/2024 at 8:20 AM revealed the resident had a portable oxygen tank situated in an oxygen cylinder cart. A nasal cannula was connected to the oxygen tank. The tubing of the nasal cannula was loosely coiled on the oxygen tank with some part of the nasal cannula tubing almost touching the wheel of the oxygen cylinder cart. Resident #58 stated he used the portable oxygen everytime he went out of the room. He said when he returned to his room, he would use the oxygen concentrator again and the staff would wrap the nasal cannula tubing around the oxygen tank. Observation on 01/25/2024 at 8:27 AM revealed Resident #10 had a portable oxygen tank behind his wheelchair. A nasal cannula was connected to the oxygen tank. The tubing of the nasal cannula was wrapped around the backrest of the wheelchair. Observation and interview with RN R on 01/25/2024 starting at 8:32 AM, RN R stated residents used an oxygen supplement or a breathing treatment because of their respiratory issues. RN R said the things used for breathings should be kept clean to prevent exacerbation of respiratory issues. RN R said the nasal cannula should be bagged when not in use to prevent it from falling the ground or touching anything unclean. RN R went inside the Resident #58's room, pulled the nasal cannula from the portable oxygen tank on an oxygen tank cylinder. RN R then went inside Resident #10's room and pulled the nasal cannula from the portable oxygen tank behind the backrest of the wheelchair. RN R said she would get new nasal cannula for both residents before they use it again when they go out to the dining hall for lunch. RN R went to the stock room to get the nasal cannula, returned to the respective rooms, attached the new nasal cannula, and placed the nasal cannula in a plastic bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADON on 01/25/2024 at 8:43 AM, the ADON stated it was not right that the nasal cannula were coiled to the portable oxygen tank or the wrapped around the wheelchair. The ADON said the nasal cannula should be in a plastic bag when the residents were not using it. She said the portable oxygen were used by the residents with order for continuous oxygen. When the residents went back to their rooms, they would use again their oxygen concentrator. The ADON said if the nasal cannula were not bagged, it could cause respiratory infections that would be detrimental to the health of the residents. The ADON said the humidifier should always have water on it to prevent any irritation on the respiratory passageway. She said this was to prevent irritation to the nose and throat. She said the nurses were responsible in ensuring the humidifier had water in it. She said the nurses and the CNAs were responsible in bagging the nasal cannula when not in use. She added the DON and the ADON were responsible in ensuring the nurses were doing the best practice regarding respiratory care. The ADON said her expectation was for the staff would be watchful in monitoring if there was water in the humidifier and if the nasal cannula were bagged when not in use. The ADON said she would do an in-service about respiratory care. Interview with DON on 01/25/2024 at 4:25 PM, the DON stated the humidifier should always have water in it to prevent irritation to the lining of the nose and throat. She said the purpose of the humidifier was to moisten the nasal linings and prevent dryness of the nose, throat, and lips. The DON said the staff should had make sure there was water on the humidifier so the breathing of the residents would not be compromised. The DON said the best practice was to use a humidifier during administration of supplemental oxygen. The DON also stated the nasal cannula should not be left coiled to oxygen tank and wheelchair to prevent respiratory infections and exacerbations of respiratory issues for those residents that already had respiratory challenges. The DON said the expectation was for the staff to monitor if the humidifier had water and if the nasal cannula were bagged. Interview with the Administrator on 01/25/2024 at 4:34 PM, the Administrator stated everything used by the residents should be kept clean. He said the nasal cannula should be stored properly prevent respiratory issues. The Administrator said if the humidifier needed to have water to provide relief for the residents, then the staff should ensure the humidifier had water on it. The Administrator said the expectation is for the staff to do their due diligence in order to provide the highest level of care. Review of facility policy, Oxygen delivery & Maintenance revealed Procedure: The administration of oxygen will follow professional guidelines for safe administration of a medical gas . 9. When tubing is not in use, place delivery device components into bag.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45055 Based interviews and record reviews, the facility failed to maintain the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, reviewed for RN coverage. The facility failed to ensure the facility maintained the required RN coverage for 14 days between August - September 2023. This failure placed residents at risk of receiving higher levels of patient care. Findings included: Review of the facility provided time sheets for Registered Nurses (RN) for the review period from August 2023 - January 2024, revealed the facility failed to have the required RN coverage of at least 8 consecutive hours a day, for the following dates: 08/05/23: 4 hours recorded 08/06/23: 4 hours recorded 08/12/23: 4 hours recorded 08/13/23: 4 hours recorded 08/19/23: 4 hours recorded 08/20/23: 4 hours recorded 08/26/23: 4 hours recorded 08/27/23: 4 hours recorded 09/02/23: 4 hours recorded 09/03/23: 4 hours recorded 09/09/23: 4 hours recorded 09/10/23: 4 hours recorded 09/23/23: 4 hours recorded 09/24/23: 4 hours recorded (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 01/26/24 at 01:50 PM with the DON, she stated they had a hard time keeping a scheduler and they were currently trying to find a new one. She was advised of the dates where there was no RN coverage and she stated she was not aware of this until she ran the report for this survey. She stated during the lapse of coverage, an ADON was assigned the role of scheduling RN coverage, but she failed to complete her responsibilities and after disciplinary discussions, the ADON had resigned. She stated they were still attempting to full this role. She stated currently she had the new ADON managing this role. She stated the risk of not having RN coverage could result in resident missing out on care only an RN could execute. In an interview on 01/25/24 at 03:55 PM with the Administrator, he stated he was made aware of the lapse in RN coverage on the weekends by the DON. He stated they did have concerns with RN staffing on weekends and they had since made corrections by hiring an RN dedicated to the weekends. He stated he would have to follow up with the DON to see what happened. He stated the risk of not having RN coverage on the weekend was that it was a requirement for the residents. Review of the facility's policy on RN Coverage, undated, revealed Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week.

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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. 45055 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. The facility failed to ensure food in the facility's refrigerator, was labeled and dated. The facility failed to ensure food in the freezer was not exposed from air-borne contaminants. The facility failed to ensure the ice machine, located in the facility's kitchen, was thoroughly cleaned. The facility failed to ensure the trash can in the kitchen area was covered. The facility failed to ensure the tea dispenser was covered after being prepared. The facility failed to ensure the ice chest located in the dining area was clean and sanitized. The facility failed to ensure the Dietary Manager wore a head covering, while in the kitchen preparing food. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on 01/24/24 from 09:10 AM to 09:21 AM in the facility's only kitchen reflected: Observation of the ice machine, in the facility kitchen revealed the inside door hinges having dark reddish stains in the corner of the inside hinges. One large tea dispenser filled with tea, located in the kitchen area and near the entry into the kitchen, was uncovered and exposed to air-borne contaminants. One large trash container, midway filled with trash had no lid on it and was exposed for air-borne contaminants. One large bag of bread sticks in the walk-in refrigerator was not labeled or dated. One package of pie crust, located in the walk-in refrigerator was not dated and no visible expiration date was observed. One gallon container of Dill Pickle Relish, located in the walk-in refrigerator dated 6-12 and no visible expiration date was observed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One gallon container of Italian dressing, located in the walk-in refrigerator, was dated 1-11 or 11-1 and there was no visible expiration date. One large bag of French toast sticks, located in the walk-in freezer, was not sealed, undated, and was exposed to air-borne contaminants. One large bag of bread sticks in the walk-in freezer was not labeled or dated. One large yellow bin containing rice was observe have brownish stains along the inside of the bin. One blue and white 30-gallon cooler, filled with ice has black dirt stains along the inside of the contained and along the hinges of the cooler. In an observation and interview on 01/24/24 at 09:10 AM with the Dietary Manager, she was observed working in the facility's only kitchen with no hair covering for her long-braided hair. She stated she was busy and had forgotten to put on a hair net. She stated the risk of not wearing a hair net could result in hair falling into the food and contaminating it. In an interview on 01/25/24 at 1:10 PM with the Dietary Manager, she stated she was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. She was shown all of the concerns observed in the kitchen and she stated she had trained staff to date items with the month date and year, but she had to remind her staff to include the month date and year. She stated it was her mistake not wearing a head covering when she was observed on 01/24/24 without a head covering while preparing food for lunch. She stated she spoke with staff about ensuring the tea is covered once it was prepared. She stated she was the one that cleaned out the rice bin, which she cleans at least once a month. She stated she also cleaned the ice machine and she tried to clean it at least once a month. She stated she empties the ice then clean it. She stated she would reclean the inside again. She stated the risk of all of these concerns observed in the kitchen could result in resident getting sick. In an interview on 01/25/24 at 4:30 PM with the Administrator, he stated he was made aware of the concerns observed in the kitchen and he stated he would expect the Dietary Manager to ensure that the kitchen followed all guidelines, including ensuring the Dietary Manager wearing a hair net in the kitchen. He stated the risk of all the concern not being addressed could result in food contamination. Record Review of the Facility's policy on Food Storage and Supplies dated 2012, revealed All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened. It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illnesses. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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	675560	A. Building B. Wing	01/26/2024

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interviews and record reviews the facility failed to ensure medical records were accurately documented for 1 of 3 residents (Resident #2) reviewed for notification of changes. The facility inaccurately documented that the family of Resident #2 was notified following a fall. This failure could place the residents at risk for not having accurate records. Findings include: Record review of Resident #2's face sheet dated 01/26/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Relevant diagnosis included repeated falls, and muscle wasting and atrophy (decrease in muscle tissue). Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 10 (cognitively intact). The assessment also indicated the resident had an active diagnosis for repeated falls. Record review of Resident #2's Comprehensive Care Plan dated 12/05/23 reflected the resident was care planned for repeated falls, with the last fall occurring on 01/18/24, and an intervention including to follow the facility's policy on fall protocol and contacting responsible party. Record review of a progress notes on 01/18/24 for Resident #2 reflected the following: Note Text: Physical therapist informed this nurse that resident was on the floor in her room. Resident stated, I was sitting in my wheelchair, I reached down to grab one of my bags off the floor and fell out of the wheelchair and hit my head. Observed resident laying on the floor in her room with two therapists in her room with her. Observed hematoma to right side of resident forehead. Resident alert and responding appropriately, complaining of head pain. Instructed resident not to try and get up and instructed therapists to stay with resident. This nurse quickly went to nurses station to call the doctot and notified him of fall, residents pain and hematoma. New order received from doctor to send resident to the hospital via 911 to evaluate and treat. This nurse immediately called 911. Resident left via stretcher in stable condition at 1:26 PM. Resident's family notified of fall, transfer to the hospital, and clinical situation. Doctor notified. PCC updated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/26/24 at 09:05 AM with Resident #2's Responsible party, she stated she had not received a call from the facility notifying her of the resident's fall on 01/18/24 and was sent to the emergency room , until at least two hours after the incident occurred. She stated once she had received the call from LPN S, the resident had already been discharged from the emergency room and had returned to the facility. She stated she had asked why she was just being notified and she stated the nurse stated he had attempted to contact her but there was a weird sound on the phone when he dialed the number. She stated the nurse told her that he was going to make another attempt but had gotten distracted by another fall that had occurred in the facility during the same time, so she never got around to attempting to contact her again until at least two hours after the incident had occurred. In an interview on 01/25/24 at 09:45 Am with LPN S, he stated he was the nurse on duty when Resident #2 had an unwitnessed fall. He had initially stated he had notified the Responsible party of the incident when the incident had occurred. He was advised that the Responsible party stated she had not received a call until two hours later and he stated he did make four attempts to contact her but was getting a busy tone. He stated he had gotten busy on the floor with other falls and had not gotten around to contacting the Responsible party until hours later. He stated the risk of the resident's responsible party not being contacted was not a good thing for the family because they need to be notified immediately. In an interview on 01/25/24 at 10:25 AM with the DON, she was advised of Resident #2's Responsible party not being contacted about the resident's fall on 01/18/24 until at least two hours later. She stated LPN S had advised her that he had tried to contact the Responsible party but was unable to do so. She was advised that LPN S had documented in PCC that he had contacted the responsible party when this was not correct. The DON was observed reviewing the notes in PCC made by the LPN S and she stated that the statements initially made by the nurse was incorrect and should have been documented that an attempt was made. She stated she had in serviced the nurse of the proper documentation when there was no contact made and making timelier attempts if contact was not made with the Responsible party. She stated the risk of the responsible party not being notified in a timely manner could result in the responsible party receiving notification from the hospital instead of the facility, which is never good. Review of the facility's policy on Fall Management, dated 01/2022, reflected When a resident sustains a fall, the attending physician and the resident representative shall be notified of the fall and the resident's status.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 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 1 of 1 facility, reviewed for infection control. The facility DON (Infection Preventionist) failed to ensure: Residents who had the flu had appropriate signage on their door and PPE for use outside their door. Facility staff were utilizing appropriate PPE when caring for residents in isolation rooms. Facility staff notified the families of flu negative roommates that they were at risk of being infected with the flu. Flu negative residents were cohorted in the same room as flu positive residents. Flu negative roommates were offered the prophylactic treatment for the flu. An IJ was identified on 01/24/24. The IJ template was provided to the facility on [DATE] at 4:45PM. While the IJ was removed on 01/26/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm because all staff had not been trained on the POR. These failures could place residents at risk for the spread of infection through cross-contamination of pathogens and illness which could result in a decline in health and well-being or even death. Findings included: Record review of Flu Positive Residents, dated 01/24/24, and received from the DON, revealed 10 residents had the flu: o Resident #1 (Roommate - Resident #25 was flu negative) o Resident #41 (Roommate - Resident #31 was flu negative) o Resident #2 (No roommate) o Resident #55 (Roommate - Resident #42 was flu negative) o Resident #64 (Roommate - Resident #39 was flu negative) o Resident #12 (Roommate - Resident #49 was flu negative) o Resident #3 (No roommate) o Resident #46 (Roommate - Resident #4 was flu negative) (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Resident #24 (No roommate) o Resident #70 (Roommate - Resident #57 was flu negative) 1. Review of Resident #1's MDS admission assessment, dated 01/08/24, reflected she was an [AGE] year-old female admitted on [DATE]. Her cognitive status was severely impaired. Her diagnoses included non-Alzheimer's disease. 2. Review of Resident #41's MDS quarterly assessment, dated 01/08/23, reflected she was a [AGE] year-old female admitted on [DATE]. Her cognitive status was intact. Her diagnoses included non-Alzheimer's disease. 3. Review of Resident #2's MDS quarterly assessment, dated 10/25/23, reflected she was an [AGE] year-old female admitted on [DATE]. The resident was rarely understood. Her diagnoses included non-Alzheimer's disease. 4. Review of Resident 55's MDS quarterly assessment, dated 12/14/23, reflected he was a [AGE] year-old male admitted on [DATE]. His cognitive status was intact. His diagnoses included post-traumatic stress disorder. 5. Review of Resident 64's MDS quarterly assessment, dated 01/04/24, reflected she was an [AGE] year-old female admitted on [DATE]. Her cognitive status was severely impaired. Her diagnoses included Alzheimer's disease. 6. Review of Resident #12's MDS quarterly assessment, dated 10/15/23, reflected she was an [AGE] year-old female admitted on [DATE]. The resident was rarely understood. Her diagnoses included non-Alzheimer's disease. 7. Review of Resident #3's MDS admission assessment, dated 01/18/24, reflected she was an [AGE] year-old female admitted on [DATE]. Her cognitive status was moderately impaired. Her diagnoses included non-Alzheimer's disease. 8. Review of Resident #46's MDS quarterly assessment, dated 12/27/23, reflected he was a [AGE] year-old male admitted on [DATE]. His cognitive status was not assessed. His diagnoses included heart failure. 9. Review of Resident #24's MDS quarterly assessment, dated 01/04/24, reflected she was a [AGE] year-old female admitted on [DATE]. Her cognitive status was not assessed. Her diagnoses included stroke. 10. Review of Resident #70's MDS quarterly assessment, dated 12/15/23, reflected he was a [AGE] year-old male admitted on [DATE]. His cognitive status was severely impaired. His diagnoses included non-Alzheimer's disease. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on 01/24/24 at 10:47 AM of Resident #49's room revealed the resident was lying in B bed. The door was open, a sign to see the nurse was posted, and a bin with PPE was outside the door. Resident #49 requested water and CNA A entered the resident's room wearing a mask only. CNA A picked up the water bottle and gave the resident a drink. CNA A left the room. CNA A said the resident was in isolation and she got busy and forgot to wear all of her PPE into the room. She said it was important to wear PPE so that the infection did not spread. Neither resident had the curtain drawn in the room to separate them. Resident #49's flu positive roommate was not wearing a mask. An interview on 01/24/24 at 3:00 PM with the family of Resident #49 revealed they were never notified that the resident was in an isolation room with a resident that had the flu. The family member said they would not want Resident #49 to remain in the room. The family member said the facility did not contact them about administering medication prophylactically to treat for possible flu. An observation on 01/24/24 at 10:40 AM with Resident #46 revealed there was no signage on his door and there was no PPE outside of his room. The resident was interviewed by the Surveyor and said he felt ill. He was sitting up in bed with a congested cough. Resident #46 had a roommate (flu negative) who was lying in his bed. Resident #46 was not wearing a mask. An observation and interviews on 01/24/24 between 12:36 PM - 12:40 PM revealed staff shut Resident #46's door. Staff placed signage on the door and a PPE bin outside of the door. LVN C was standing next to her med cart outside of Resident #46's door. LVN C said Resident #46 was supposed to be in isolation because he had the flu. LVN C said she did not know why the resident did not already have signage on the door and PPE outside of the door prior to 12:36 PM. The DON walked to Resident #46's door. The DON said the resident was supposed to be in isolation because he had the flu. The DON said Resident #46's roommate did not have the flu, but there were no rooms to move him to and his family did not want him to move. An observation on 01/24/24 at 1:16 PM revealed Resident #3 had his door open. He was in his room seated in his wheelchair. There was a sign outside the room which reflected, All proper PPE must be worn upon entering. There was no PPE cart outside the room. It was not clear if the resident was in isolation or not. An interview on 01/24/24 at 1:29 PM with LVN D revealed she did not know for sure if Resident #3 had the flu . LVN D said the resident was being treated with Tamiflu (flu medication). LVN D said if the resident had the flu then there needed to be PPE outside their door because the resident would be contagious. An observation and interview with the DON on 01/24/24 at 1:47 PM revealed Resident #3 was supposed to be in isolation. The resident's door was still open. The DON said that staff must have taken the PPE cart instead of refilling it . An interview on 01/25/24 at 02:38 PM with the ADON revealed 10 residents had the flu according to the 24-hour report. She said an additional resident had been sent to the hospital for low oxygen saturation. The ADON said she would identify which residents were in isolation because they would have PPE outside of their door. The ADON said facility staff needed to wear a gown, gloves, face shield, and N95 mask to provide care to a resident with the flu. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews on 01/24/24 at 2:29 PM and on 01/25/24 at 3:03 PM with the DON revealed the flu outbreak started on 01/17/24 when some of the residents first showed signs and symptoms of the flu. She said flu tests were sent to the lab, but results were not received until 01/21/24. The DON said some residents started Tamiflu and some did not. She said staff were educated to wear PPE. The DON said residents and staff were not tested unless they were symptomatic. She said the facility was following the CDC guidelines for managing the flu infection and the health department had been contacted. The DON said she did not know why families of roommates of flu positive residents were not contacted by the charge nurse and she started contacting families on 01/24/24 . The DON said she did not know why staff were not changing their masks when exiting an isolation room. She said staff were supposed to wear PPE in isolations rooms which included an N95 mask, goggles/face shield, gown, and gloves . She said she saw staff were not wearing PPE appropriately and she was in-servicing them. She said 10 residents and 2 staff had the flu. She said it important to wear PPE and keep flu positive residents cohorted to prevent cross contamination. The DON said the infection spread partially because Resident #70 was ill but would walk through the halls of the facilit y. The DON said facility staff would encourage the resident to stay in her room. The DON said she did not know how many of the flu positive residents received the flu vaccine or which of their roommates received the vaccine. She said staff knew which residents had the flu because of shift-to-shift report and the signs on the door and PPE bins outside of the door. Review of the website: https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm on 01/24/24 reflected: Preventing transmission of influenza viruses and other infectious agents within healthcare settings, including in long-term care facilities, requires a multi-faceted approach that includes the following: Influenza Vaccination Influenza Testing Infection Prevention and Control Measures Antiviral Treatment Antiviral Chemoprophylaxis . Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Droplet Precautions should be implemented for residents with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a resident is in a healthcare facility. Examples of Droplet Precautions include: Placing ill residents in a private room. If a private room is not available, place (cohort) residents suspected of having influenza residents with one another. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Wear a facemask (e.g., surgical or procedure mask) upon entering the resident's room. Remove the facemask when leaving the resident's room and dispose of the facemask in a waste container. Communicate information about patients with suspected, probable, or confirmed influenza to appropriate healthcare personnel . exposed residents on units or wards with influenza cases in the long-term care facility (currently impacted wards) should receive antiviral chemoprophylaxis as soon as an influenza outbreak is determined . When at least 2 patients are ill within 72 hours of each other and at least one resident has laboratory-confirmed influenza, the facility should promptly initiate antiviral chemoprophylaxis with oral oseltamivir to all non-ill residents living on the same unit as the resident with laboratory-confirmed influenza (outbreak affected units), regardless of whether they received influenza vaccination during the current season. Antiviral chemoprophylaxis is meant for residents who are not exhibiting influenza-like illness but who may be exposed or who may have been exposed to an ill person with influenza, to prevent transmission . Review of the facility policy and procedure, IPCP Standard and Transmission-Based Precautions, dated October 2022, reflected: .4. Droplet Precautions (TBP) are used for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking (e.g. influenza). See CDC Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions for other conditions and infections in which droplet precautions are indicated. a. Implement source control by placing a mask on the patient. b. Ensure appropriate patient placement in a single room if possible. In long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives. c. Use personal protective equipment (PPE) appropriately. Don mask (and eye protection if indicated) upon entry into the patient room or patient space. d. Limit transport and movement of patients outside of the room to medically-necessary purposes. If transport or movement outside of the room is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette . 6. Implementation: a. The facility will implement a system to alert staff, residents, and visitors that a resident is on TBP. i. Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. Cough etiquette signs were posted on entrance doors and hallways on 1/24/24. 9. Train the trainer in-servicing was given to the DON/Infection Preventionist, ADON, Rehab Director and RN Cluster Partners by the Clinical Resource. The training includes masking, donning/doffing PPE, droplet precautions and discontinuation of precautions, procedures for outbreak including identifying respiratory illness, disinfection and handwashing all based on CDC guidance for influenza. This was completed 1/24/24 prior to start of training for all other staff. 10. Training and competency on donning and doffing PPE, handwashing, droplet precautions and discontinuation of precautions, and outbreak procedures including identifying respiratory illness and disinfecting practices will be completed with all staff by 1/25/24. This training was initiated on 01/24/24 will be completed on 1/25/24 with all staff prior to the start of their next shift. The training includes masking, donning/doffing PPE, droplet precautions and discontinuation of precautions, procedures for outbreak/disinfection and handwashing all based on CDC guidance and will be provided by the DON, ADON, Clinical Resource, Cluster Partners, Rehab Director, and Executive Director and completed by 1/25/24. Train the trainer in-service was given by the Clinical Resource RN and was completed with DON, ADON, Cluster Partners, Rehab Director, and Executive Director on 1/24/24. 11. This training will be completed in-person by 1/25/24 with all staff prior to the start of their next shift. A member of management will be at the facility at each change of shift to ensure all get trained prior to going to work on the floor. Staff will not be allowed to work unless they have completed the training and competency checks. This training will also be included in the new hire orientation and will be included for agency staff/PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received their training and competency. 12. An ad hoc meeting regarding items in the IJ template will be completed on 01/24/2024. Attendees will include the DON/Infection Preventionist, Medical Director, ADON, Clinical Resource, Executive Director and will include the plan of removal items and interventions. 13. The DON, ADON, or Clinical Resource RN will verify staff competency with 10 staff weekly using the PPE and handwashing competency checklists. This will be completed weekly after the initial training and competency began on 01/24/2024. 14. Influenza positive residents will be reviewed during weekly clinical meeting and the Medical Director will be consulted for any recommendations or suggestions as necessary. Meetings attendees to include but not limited to DON, ADON, Rehab Director, and Executive Director. The DON and Executive Director will be responsible for ensuring this meeting is held weekly and influenza positive residents are reviewed. This meeting will begin on 01/24/2024. 15. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x4 weeks beginning 1/25/24 or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. Monitoring of the Plan of Removal reflected: (continued on next page)

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	01/26/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations on 01/26/24 between 9:00 AM - 4:00 PM revealed residents with the flu were in isolation and there was appropriate signage and PPE available outside of their doors. Resident #24 was observed leaving her room (isolation room) and entered the hall without wearing a mask. The ADON intervened and escorted the flu positive resident back to her room and shut her door. Staff donned and doffed PPE appropriately when entering and exiting isolation rooms. Interviews on 01/26/24 between 9:51 AM - 4:00 PM with 13 staff from all shifts, (CNA E, LVN F, LVN G, CNA H, CNA I, CNA J, ADON, CNA K, CNA L, MA M, CNA N, CNA O, and LVN P) revealed the staff were in-serviced on hand hygiene, donning and doffing PPE appropriately, identifying residents with flu symptoms and what to do with those residents. Facility staff were checked off on hand hygiene and donning and doffing PPE. Staff were able to correctly identify which residents had the flu and were in isolation. Staff said everyone was responsible for ensuring isolation rooms were correctly identified. Staff nurses said they were responsible for notifying the physician, family, facility staff, and administrative staff regarding residents with flu symptoms. Facility staff said if the flu positive resident had a roommate they would notify the family and physician to determine if they were to be treated prophylactically and if they were to remain in the room with the flu positive resident. Facility nurses said the physician had to be notified before a resident could be removed from isolation and the residents were supposed to be in isolation for 7 days. An interview with the DON on 01/26/24 at 03:34 PM revealed she had received a Train the Trainer in-service. She said she identified errors during the flu outbreak that included a delay in receiving lab results which led to a delay with when residents were placed in isolation. She said there was a rapid spread of the flu virus and that staff thought isolation ended after 5 days and were removing PPE bins before they were supposed to. The DON said that her role in the POR was to educate staff, monitor PPE use, monitor handwashing, and ensure that families were contacted. An interview with the Medical Director on 01/26/24 at 2:47 PM revealed he was contacted by facility staff regarding the Immediate Jeopardy. He said his role in the POR would be to ensure tracking was completed and that residents were prophylactically treated. He said he felt at that time the flu outbreak was under control. An interview with the Administrator on 01/26/24 at 3:48 PM revealed the issues he identified with the outbreak were that the facility did not respond correctly to ensure staff followed infection control protocols. He said his role in the POR was to educate staff and monitor to ensure the education was completed and followed through on. He said going forward a response plan would be implemented with each positive case and the issues would be discussed in QAPI meetings. He said he would ensure contact tracing and tracking of the anti-viral medication administration would be completed. The Administrator was informed the IJ was removed on 01/26/24 at 5:15 PM. While the IJ was removed the facility remained out of compliance at a scope of pattern and a severity level of no actual harm due to the facility's need to monitor the implementation and effectiveness of its POR.