STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675806	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurenwood Nursing and Rehabilitation	330 W Camp Wisdom Rd Duncanville, TX 75116

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to ensure the residents had a right to secure and confidential personal and medical records for one (Residents #1) of 6 residents reviewed for resident rights. The facility failed to ensure MA A did not leave the computer tablet unlocked on top of a medication cart which disclosed Residents #1's EMAR on 06/22/26 from 10:05 am to 10:06 am. This failure could place residents at risk of embarrassment, feelings of vulnerability, and a decline in health and psycho-social well-being. The findings included: An observation on 06/24/26 at 10:05 am, on the 500 hall, revealed an unattended medication cart with Resident #1's EMAR showing her medication profile. No one was around the medication cart or had walked by it during this time. An observation on 06/24/26 at 10:06 am, revealed MA A walking towards the 500 hall to the medication cart. He stated he had to get something and then said he went to the bathroom, He stated he was gone for one to two minutes and was sorry he made the mistake leaving the tablet open and walking away from it. He stated it was not a good idea to leave the computer tablet unlocked and showing Resident #1's information. He stated the computer tablet detailed Resident #1's private medical information and someone unauthorized could have walked by and viewed her documentation. He stated people such as visitors and residents could have viewed Resident #1's information. He stated he normally did not leave the computer tablets unlocked. He stated this was the one time he did, and would not do again. Record review of Resident #1's June [DATE] on 06/24/26 morning medications revealed, MA A administered: 300 mg Allopurinol 1 tablet 1 x D for gout, 2.5 mg Amlodipine 1 tablet 1 x D for HTN, 81 mg Aspirin 1 tablet 1 x D for prophylactic, 25 mcg 2 tablets 1 x D, 25 mcg Cholecalciferol 2 tablets 1x D for supplements, 15 mg Buspirone 1 tab every morning, 30 mg Duloxetine 1 capsule 2 x D, 300 mg Gabapentin 1 capsule 2 x D for nerve pain, 25 mg and Hydroxyzine pamoate 1 capsule 2 x D. During an interview on 06/24/26 at 2:14 pm, MA A stated he worked there for almost a year, and stated his last HIPAA compliance training was last month. He stated he had not spoken to management about leaving the computer tablet open with resident information. During an interview on 06/24/26 at 2:52, Medical Records B stated she believed the Administrator was responsible for HIPPA compliance at the facility, but was not sure. She stated the last HIPAA training was two weeks ago. During an interview on 06/24/26 at 3:43 pm, the DON stated they did a good job with HIPAA compliance. She stated she was aware of MA A leaving his computer screen up with resident information disclosed. She stated MA A was human and was not sure what called his attention away. She stated he had never done that before, and she would give him grace, because if the Lord gave her grace she was going to give it to him too. She stated MA A was very conscientious, but MA A said someone called him away from the medication cart. She stated that MA A apologized and she told him people made mistakes and she was not going to fire him. She stated she did HIPAA re-education for him to remember to turn off his tablet or take it with him. She stated leaving Resident #1's personal information out for anyone to see could have caused somebody else to get her medical information. She stated anyone walking by could do whatever they wanted with Resident #1's information. She stated she knew it was very important to comply with their HIPAA policy and said MA A was a good MA and she was not going to keep punishing him over it. She stated MA A had the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675806	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurenwood Nursing and Rehabilitation	330 W Camp Wisdom Rd Duncanville, TX 75116

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knowledge and understanding for his job.During an interview on 06/24/26 at 3:57 pm, the Administrator stated the facility was good with HIPAA compliance. She stated if they had any HIPAA issues, they would address them right then and there. She stated she was ultimately responsible for HIPAA compliance, and the DON and each staff member were also responsible. She stated any staff that dealt with the resident's health information was responsible for HIPAA compliance. She stated she was not aware of there being a HIPAA issue today (06/24/26) involving MA A leaving his computer tablet open with resident information disclosed. She stated she would make sure she addressed this issue right away. She said typically they did not have any HIPAA concerns. She stated her expectation was to make sure everybody was HIPAA complaint. Record review of MA A's Inservice Training Report dated 06/24/26 conducted by the DON revealed MA A signed this form acknowledging being educated on: HIPAA - Safeguarding resident information - Contents/Summary of Training session: Safeguarding resident information Policy and procedures. Record review of the facility's Guidelines for all nursing procedures dated December 2024 revealed, Purpose: To provide general guidelines for resident rights while caring for the resident. Preparation: Prior to having direct care responsibilities for residents, staff must have appropriate in-service training on resident rights, including:. e. Confidentiality of protected health information. General guidelines: f. Close the room entrance door and provide for the residents privacy. Record review of the facility's HIPAA Security Measures policy revised 09/19/26 revealed, Policy: It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and /or records that are in electronic format. Policy Explanation and Compliance Guidelines: 1.Facility leadership will ensure the implementation of policies and procedures to prevent, detect, contain, and correct any security violations. 4.The facility will implement policies and procedures to address security incidents, including identification and response to suspected or known incidents; mitigation, to the extent practicable, harmful effects of any security incidents; and documentation of security incidents and their outcomes.