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	06/04/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 3 of 6 residents (Resident #7, Resident #8, and Resident #77) reviewed for discharge planning. The facility failed to notify the residents or the residents' representative or POA of the transfer or discharge with the reasons for the move in writing in a language and manner they understand for Resident #7, Resident #8, and Resident #77.The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #7, Resident #8, and Resident #77. This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. A record review of Resident #7's face sheet, dated 06/03/2026, revealed a [AGE] year-old female admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Non-St Elevation Myocardial Infarction (type of heart attack caused by a partial or temporary blockage in a coronary artery), Cognitive Communication deficit (often caused by brain injury or neurological disease), Chronic Obstructive Pulmonary Disease (acute flare-up, worsening of symptoms, increased breathlessness, cough, or sputum production beyond normal daily variations), Acute Respiratory Failure with Hypoxia (when the respiratory system cannot adequately transfer oxygen into the bloodstream), and Paranoid Personality Disorder (a mental health condition of unwarranted distrust and suspicion of others).A record review of Resident #7's quarterly MDS assessment, dated 04/06/2026, reflected that Resident #7's BIMS score was 03/15, indicated severe cognitive impairment. Resident #7 required set-up or clean-up assistance (which meant staff set up or cleaned up) and she completed the activity.A record review of Resident #7's progress note, dated 12/09/2025, revealed that Resident #7 complained of chest pain and shortness of breath, an ambulance was called and Resident #7 was transferred to the hospital. There was no evidence that a transfer or discharge notice was provided to Resident #7 in writing or to the State LTC Ombudsman.A record review of Resident #7's progress note, dated 12/28/2025, revealed that Resident #7 had abnormal vital signs, altered mental status, and increased confusion. Resident #7 was transferred to the hospital for further evaluation and treatment. There was no evidence that a transfer or discharge notice was provided to Resident #7 in writing or to the State LTC Ombudsman.During an interview on 06/03/2026 at 11:28 a.m., Resident #7 stated she did not remember if she received a written letter when she was sent to the emergency room. She also stated she would have liked to receive a letter from the facility so she could give it to her family member.A record review of Resident #8's face sheet, dated 06/04/2026, revealed a [AGE] year-old female admitted to the facility on [DATE], she was her own responsible party. Her diagnoses included Chronic Obstructive Pulmonary Disease (acute flare-up, worsening of symptoms, increased breathlessness, cough, or sputum production beyond normal daily variations), Type 2 Diabetes Mellitus without complications (indicates the presence of high blood sugar but without established damage to nerves, eyes, kidneys, or 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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cardiovascular system), Morbid (severe) obesity due to excess calories (excessive fat accumulation), and Chronic Hypoxic Respiratory Failure (an ongoing condition where your lungs cannot transfer enough oxygen into the bloodstream).A record review of Resident #8's MDS assessment, dated 12/16/2025, reflected that Resident #8's BIMS score was 12/15, indicated moderate impairment in cognitive function. Resident #8 required mostly substantial to maximal assistance (which meant staff did more than half the effort) with care. A record review of Resident #8's progress notes, dated 12/16/2025, revealed that she had fallen earlier and complained of leg pain, was not willing to wait for the facility mobile x-ray, called 911, and was taken to the hospital. There was no evidence that a transfer or discharge notice was provided to Resident #8 in writing or to the State LTC Ombudsman. During an interview on 06/04/2026 at 1:13 p.m., Resident #8, stated she had never received a written letter when she was sent to the hospital. She explained that having the information provided in writing would have allowed her to review the details more carefully later.A record review of Resident #77's face sheet, dated 06/04/2026, revealed a [AGE] year-old female admitted to the facility on [DATE], she was her own responsible party. Her diagnoses included Cognitive Communication Deficit (often caused by brain injury or neurological disease), Muscle Wasting (the shrinking of muscle tissue caused by disuse), Hypokalemia (lower-than-normal potassium levels in the blood), and Diaphragmatic Hernia (a hole or weakness in your diaphragm).A record review of Resident #77's admission MDS assessment, dated 03/28/2026, reflected that Resident #77's BIMS score was 11/15, indicated moderate impairment in cognitive function. Resident #77 required mostly setup or clean-up assistance (which meant staff set up or cleaned up) and she completed the activity.A record review of Resident #77's progress notes, dated 04/02/2026, revealed she had a planned discharge home. There was no evidence that a transfer or discharge notice was provided to the State LTC Ombudsman.During an interview on 06/04/2026 at 10:28 a.m., the Social Worker revealed that she had not provided written notification to the residents or their representatives regarding the transfer or discharge, including the reason for the transfer or discharge. She also stated that the only list she sent to the State LTC Ombudsman was 30-day notices. The Social Worker said if residents or their representatives received a transfer or discharge letter it would help them understand what happened or they could give it to their doctor for better understanding of why they were sent to the hospital.During an interview on 06/04/2026 at 11:25 a.m., the DON revealed that the nursing staff only provided a transfer form to the hospital, not a written transfer or discharge letter, she also added she did not send a list of discharged residents to the State LTC Ombudsman. She was asked to explain the potential impact on residents if they did not receive a discharge letter; she did not provide a response. During an interview on 06/04/2026 at 2:43 p.m., the Facility LTC Ombudsman revealed she was not provided with the facility's monthly list of discharged residents. She reported that throughout the year, she had received the names of only two discharged residents.A record review of the facility's discharge policy Discharging the Resident, dated 12/2025, revealed it did not contain any requirements requiring written notification to be provided to the resident or the resident's representative regarding discharge.According to eCFR S483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and(iii) Include in the notice the items described in paragraph (c)(5) of this section.S483.15(c)(4) Timing of the notice.(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged .(ii) Notice must be made as soon as practicable before transfer or discharge when-(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of this section;(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or(E) A resident has not resided in the facility for 30 days.S483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:(i) The reason for transfer or discharge;(ii) The effective date of transfer or discharge;(iii) The location to which the resident is transferred or discharged ;(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's 1 of 1 kitchen reviewed for food safety reviewed for food safety. The facility failed to ensure that only disposable paper towels were disposed of in the garbage receptacle at handwashing sink #1.The facility failed to ensure that stored canned goods had uncompromised seals and were free from dents.These failures could place residents at risk for food-borne illness, cross contamination, and infection.During an observation on 06/03/2026 at 11:22 a.m., of the #1 handwashing sink's garbage receptacle the following was revealed: #1 handwashing sinks garbage receptacles contained items other than disposable paper towels, including used gloves, and plastic wrapping.During an observation on 06/03/2026 at 11:43 a.m., of the dry storage room the following was revealed:1 can of fruit cocktail 6 lbs. 5 oz., written received date 04/16/2026, no best by date, with a dent on the top seal and bottom seal.1 can of fruit cocktail 6 lbs. 5 oz., written received date 05/12/2026, no best by date, with a dent on the top seal and bottom seal.1 can of fruit cocktail 6 lbs. 5 oz., no written received date, no best by date, with a dent on the side of the can. 1 can of fruit cocktail 6 lbs. 5 oz., written received date 05/27/2026, no best by date, with a dent on the bottom seal.1 can of crushed pineapple 6 lbs. 7 oz., written received date 05/26/2026, with a dent on the bottom seal.1 can of vegetarian beans 7 lbs. 5 oz., written received date 06/02/2026, with a dent on the side of the can.During an interview on 06/03/2026 at 11:59 a.m., the DM stated that the date written on all canned goods was the date the facility received the item. She stated the Dietary Aides were responsible for stocking the shelves in the dry storage area and ensuring products were properly labeled. She stated a dent was considered any noticeable damage or puncture that could be easily seen during a visual inspection. During an interview on 06/03/2026 at 12:08 p.m., the DA said she was responsible for writing the date on all canned goods and the date was when the facility received the items. She explained that when stocking the canned goods, if she noticed a dent she would remove the can from the storage area and place it in the DM's office. In a record review of the facility's Food Safety and Sanitation policy, dated 2023, revealed: .3. Food Purchasing. e. Bulging or leaking cans, cans with severe dents on the seam or broken containers of food will not be used.4. Food Storage.Canned and dry foods without expiration dates should be used within six months of delivery or according to the manufacturer's guidelines.In a record review of the U.S. FDA Food Code 2022 reflected: Section 6-301.20 Disposable Towels, Waste Receptacle. Waste Receptacles at handwashing sinks are required for the collection of disposable towels so that the paper waste will be contained, will not contact food directly or indirectly, and will not become an attractant for insects or rodents.In a record review of the U.S. FDA Food Code 2022 reflected: Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and 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 three (Residents #4, #19, and #42) of 5 residents reviewed for infection control. The facility failed to ensure Resident #4 was not exposed to Resident #19 (roommate) who was treated for MRSA infection. The facility failed to ensure CNA A changed gloves and performed hand hygiene during incontinence care for Resident #42. This failure could place residents at risk of infection. Findings included: 1. Record review of Resident #4's Quarterly MDS Assessment, dated 03/11/26, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her cognitive skills for daily decision making were severely impaired. Her diagnoses included stroke and respiratory failure. The resident had an indwelling catheter, feeding tube, and a tracheostomy. Record review of Resident #4's Comprehensive Care Plans, dated 02/02/26, reflected:Resident had a terminal prognosis related to chronic respiratory failure.Facility interventions included:Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. 2. Record review of Resident #19's Annual MDS Assessment, dated 03/02/26, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS score was 8, which indicated her cognitive skills were moderately impaired. Her diagnoses included heart failure and non-Alzheimer's disease. The resident required supervision for toileting hygiene. Record review of Resident #19's Comprehensive Care Plans, dated May 2026, reflected there was not a care plan for isolation or MRSA. Record review of Resident #19's Lab Summary, collected 05/18/26, reflected:Urine Culture: greater than 75,000 CFU/ML of MRSA (type of bacteria that many antibiotics cannot treat) isolated. Record review of Resident #19's Order Summary Report, dated 05/23/26, reflected:Strict isolation related to MRSA. Contact isolation. Resident would receive all services including but not limited to meals, activities, therapy, treatments and nursing services in their room. Record review of Resident #19's Progress Notes reflected:06/04/26 10:43 AMError in documentation. (reference date/time: 05/23/26 1:06 PM) Note states ESBL (enzymes from bacteria that are difficult to treat) and should state MRSA.Author: RN B 05/23/26 1:06 PMResident has a new order for Vancomycin 1 gram IV daily for 10 days due to ESBL infection. Resident placed on contact isolation precautions.Author: RN B Record review of Resident #19's Comprehensive Care Plans, dated 06/03/26, reflected:ADL self-care performance deficit related to weakness.Facility interventions included:Encourage resident to participate to the fullest extent possible with each interaction. There was not a care plan for MRSA in the urine. In an observation on 6/02/26 at 11:05 AM, Residents #19 and #4 were observed in their room together. There was a contact isolation sign posted on the door. PPE was present. Resident #19 was in bed. Resident #4 was in her bed and was non-verbal. Resident #4 had a tracheostomy, feeding tube, and a catheter. In an interview on 06/03/26 at 2:07 PM, LVN C and LVN D revealed they were infection control nurses. They said Resident #19 was in contact isolation for MRSA in the urine. They said Resident #4 did not have an infection. They said it was safe for the residents to be in the same room together because Resident #19 used the toilet and Resident #4 had a catheter. They said they did not know what the facility policy said about cohorting residents in the same room when one resident had MRSA. In an interview on 06/03/26 at 2:46 PM, the DON said Resident #19 did not have an active urinary tract infection of MRSA, but the facility did place a PICC line in Resident #19 to administer vancomycin to treat it. The DON said Resident #19 did not need to be in strict isolation. The DON said for Resident #19 to have an active infection, the MRSA level in her urine culture would have to be <100,000 CFU/ML. In an interview on 06/03/26 at 3:40 PM, FNP revealed Resident #19 was tested for a urinary infection because she was not feeling well and had nausea. She was treated for MRSA in the urine, but she did not meet the definition of having an active infection because her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MRSA level was only <75,000 CFU/ML. The FNP said staff should wash their hands and wear gloves when caring for Resident #19. In a follow-up interview on 06/04/26 at 10:29 AM, the DON said Resident #4 was on enhanced barrier precautions because she had in-dwelling devices and a tracheostomy. The DON said Resident #4 was not immunocompromised (impaired immune system) and was not at risk for developing a MRSA infection from Resident #19. The DON said Resident #19 and Resident #4 could be co-horted together in the same room because Resident #4 had a catheter and was cared for by nurses, not CNAs. The DON said the nurses changed the resident briefs, not the CNAs. In an interview on 06/04/26 12:42 PM, LVN D said the CNAs were responsible for providing brief changes for Resident #4. In an interview on 06/04/26 at 1:19 PM, Hospice RN said Resident #4 was on Hospice and was immunocompromised. She said Hospice was not made aware that Resident #19 was being treated for MRSA and should not have been in a room with Resident #4. In an interview on 06/04/26 at 3:05 PM, Physician revealed Resident #4 was at risk for developing infections because she had indwelling devices. He said Resident #19 was colonized (the bacteria is carried in the blood but is not causing an active infection) with MRSA and did not have an active MRSA infection in the urine. He said he did not know why Resident #4 was kept in the room with Resident #19 and he was going to go and assess each resident and draw more labs on Resident #19. He said the decision to keep them in a room together needed to be done in accordance with policy and procedure. Record review of the facility's policy and procedure, Multidrug-Resistant Organisms, dated December 2025, reflected: .Room Placement .4. A resident with a multidrug-resistant organism may need to be separated from a roommate who has any of the following: a device such as an indwelling urinary catheter, gastrostomy feeding tube, or intravenous access line; a pressure ulcer or other open skin wound including a postoperative wound; or significant immunosuppression (due to malignancy, chemotherapy, etc.).5. The resident need not be moved from his/her room until after screening is done and the need for Contact Precautions is determined.6. Depending on the situation, placement may include the following:a. Placement in a room with someone else who is colonized or infected with the same organism, but does not have any other infection (cohorting);b. Placement with someone who does not have invasive devices or wounds;c. Placement in a private room, if possible.7. A resident who is infected or colonized with a multidrug-resistant organism will be permitted to participate in group meals and activities if draining wounds are covered, bodily fluids are contained, and he/she observes good hygiene practices. 3. Record review of Resident #42's Quarterly MDS Assessment, dated 03/22/26, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. His BIMS score was 13, which indicated his cognitive skills were intact. The resident had an in-dwelling catheter and was always incontinent of bowel movement. His diagnoses included stroke and respiratory failure. The resident was dependent on staff for toileting hygiene. Record review of Resident #42's Comprehensive Care Plan, dated 09/11/23, reflected:ADL self-care performance deficit related to decreased mobility.Facility interventions included: Dependent on staff for toilet use In an observation on 06/03/26 at 11:35 AM of incontinence care for Resident #42, CNA A folded down the resident's brief, cleaned the penis and scrotum, cleaned the buttocks, and did not change gloves or perform hand hygiene. CNA A applied barrier cream, placed a clean brief, and straightened the sheets with her soiled gloves. In an interview on 06/03/26 at 12:05 PM, CNA A said she was trained months ago to perform hand hygiene after changing gloves. CNA said she messed up this time and failure to perform hand hygiene could lead to contamination, germs, and infection. In an interview on 06/04/2026 at 10:29 AM, the DON said hand hygiene was supposed to be performed after glove changes and training was completed with staff. The DON said monitoring was in place and management observed staff for hand hygiene. The DON said residents were at risk for the spread of infection if hand hygiene was not performed. Record review of the facility's policy, Hand-Washing/Hand Hygiene, revised December 2025, reflected: This facility considers hand hygiene the primary means to prevent the spread of infections.7. Use an alcohol-based hand rub; or, alternatively, soap (antimicrobial or non-antimicrobial) and water forthe following situations.:m. After removing gloves.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for one (Residents #12) of 8 residents reviewed for PASSR. The facility failed to refer Resident #12, who had mental illness, to the state designated service for review. This failure could place residents at risk of missed PASSR services.Findings included: Record review of Resident #12's Quarterly MDS Assessment, dated 05/08/26, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS score was 8, which reflected her cognitive skills for daily decision making were moderately impaired. Her diagnoses included bipolar disorder and schizophrenia. She did not have dementia. The MDS did not include PASSR status. Record review of Resident #12's Comprehensive Care Plans, dated 05/05/26, reflected:Resident had unspecified psychosis, schizoaffective disorder, and bipolar disorder. The resident could see and hear people in her room trying to rape her. Facility interventions included:Give medications as ordered and evaluate with psychological care. Record review of Resident #12's PASSR Level-I screening, dated 12/08/25, reflected the resident did not have mental illness and did not have dementia. In an observation on 06/02/26 at 11:25 AM, Resident #12 was sleeping and not available for interview. In an interview on 06/04/26 at 2:45 PM, the MDS Coordinator said she received Resident #12's PASSR Level-I screening and did not submit a new one. She said she was not supposed to correct the PASSR Level-I screening and did not know the effect it could have on the resident if it was incorrect. She said she did not know who was responsible for overseeing her work. In an interview on 06/04/26 at 3:40 PM, the DON revealed PASSR was data entry and she would look at the PASSR Level-1 screenings that were received by the facility to ensure they were put in SIMPLE correctly. The DON said she did not know the process to follow if the PASSR Level-I screening received was inaccurate. The DON said the resident could be at risk for missed services if the PASSR Level-I screening was incorrect. Review of the facility's policy and procedure, PASSR Requirements and Level I and Level II, dated December 2025, reflected: .2. Review the Level 1 screen, at least quarterly, and assure it is filed in the medical record and accurately reflects the patient's/resident's current status.3. Ensure that the appropriate state designated agency is contacted for any resident/patient requiring a Level II screen either on preadmission, annually, or upon learning of an SMI/ID diagnosis that was previously unknown or undetermined.