

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675820	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/01/2025
NAME OF PROVIDER OR SUPPLIER  The Lennwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  8017 W Virginia Dr Dallas, TX 75237	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35747</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 6 residents reviewed for pharmacy services.</p> <p>The facility failed to ensure LVN A properly received inventory of Resident #1's Acetaminophen-Codeine #3 (controlled medication) from the pharmacy, resulting in 26 missing tablets.</p> <p>The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 10/07/24 and ended on 10/17/24. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure placed residents at risk for unrelieved pain due to their medication not being readily available.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 03/01/25, reflected she was an [AGE] year-old female, who most recently admitted to the facility on [DATE], with diagnoses including transient cerebral ischemic attack (a temporary disruption of blood flow to the brain, causing stroke-like symptoms that resolve completely within a short period) and peripheral vascular disease (a condition that affects the blood vessels outside of the heart and brain), and rheumatoid arthritis (a long-term autoimmune disease that causes painful inflammation in the joints).</p> <p>Review of Resident #1's Physician's Orders, dated 03/01/25, reflected she was prescribed Acetaminophen-Codeine Oral Tablet 300-30MG (Acetaminophen with Codeine, also referred to as Tylenol #3) orally up to four times per day as needed (for pain). The start date of this medication was 09/12/24.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Provider Investigation Report, dated 10/11/24, reflected during the 10:00PM (10/07/24) to 6:00AM (10/08/24) shift, LVN A signed for a delivery of medications from the pharmacy that contained a blister pack (a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) of Resident #1's prescription for Acetaminophen-Codeine #3 (26 tablets). During the following shift (6:00AM to 2:00PM) on 10/08/24, the medication was identified as missing from the medication cart. Although LVN A signed for the medication during the previous shift, she could not recall receiving the medication. LVN A was suspended pending the outcome of the investigation, and she was sent for a drug screen (results indicated she was positive for marijuana). Resident #1's Responsible Party and physician were notified of the incident. The police department and the pharmacy were notified, as well. The facility conducted an audit of all medication carts with no noted discrepancies. The pharmacy performed an audit to determine if there was a discrepancy in delivery with no noted discrepancies. Facility staff were in-serviced on the facility's controlled substance policy which included receiving, storing, and handling narcotic medications. Facility staff were also in-serviced on the facility's drug use policy. Staff were interviewed to ensure competency was achieved from the in-services. LVN A's employment with the facility was terminated. The facility filed a complaint with the Texas Board of Nursing for drug diversion and a positive THC drug screen.</p> <p>Review of a Manifest Form, dated 10/07/24, reflected LVN A signed the form, indicating she had received Resident #1's prescription medication of Acetaminophen-Codeine #3 (26 tablets).</p> <p>Review of the facility's in-service logs, dated from 10/11/24 to 10/17/24, reflected facility staff were in-serviced on procedures for pharmacy services (including receiving medications), controlled substances, and a drug-free workplace.</p> <p>Review of the personnel file for LVN A, completed on 03/01/25, reflected her employment with the facility was terminated effective 10/16/24.</p> <p>Observations of three separate medication carts on 03/01/25 from 10:12AM to 11:30AM, including a review of narcotic logs and count sheets, reflected no evidence of a current drug diversion. It appeared as though facility staff were following the facility's policies and procedures to prevent a drug diversion. These observations were completed with RN B, LVN C, and MA D.</p> <p>During interviews with multiple staff members (RN B, LVN C, MA D, MA E, and RN F) on 03/01/25 from 10:12AM to 11:30AM, they each stated they had been in-serviced on pharmacy services. They were knowledgeable of the facility's policies and procedures related to acquiring, receiving, dispensing, labeling, storing, and administering medications. They were able to verbalize the facility's policies and procedures related to the prevention of drug diversion, including what procedures to take when narcotics were received from the pharmacy as well as the procedure for counting medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 03/01/25 at 12:00PM, she stated Resident #1's prescription medication of Acetaminophen-Codeine #3 (26 tablets) was identified as missing on 10/08/24, during the 6:00AM to 2:00PM shift. The Administrator stated the facility's investigation reflected that LVN A signed for a delivery of the medication during the previous overnight shift (10:00PM to 6:00AM, from 10/07/24 to 10/08/24). LVN A stated although she signed for the medication, she could not recall whether or not she actually saw the medication. LVN A was suspended pending the outcome of the investigation. She was sent for a drug screen, which indicated she was positive for marijuana. The Administrator stated Resident #1's Responsible Party and physician were notified of the incident. The police department and the pharmacy were notified, as well. The facility conducted an audit of all medication carts with no noted discrepancies. The pharmacy performed an audit to determine if there was a discrepancy in delivery with no noted discrepancies. The Administrator reported facility staff were in-serviced on the controlled substance policy which included receiving, storing, and handling narcotic medications. Facility staff were also in-serviced on the facility's drug use policy. Staff were interviewed to ensure competency was achieved from the in-services. LVN A's employment with the facility was terminated, effective 10/16/24. The facility filed a complaint with the Texas Board of Nursing for drug diversion and a positive THC drug screen. The Administrator stated Resident #1 did not miss any of her assigned doses, nor did she sustain any adverse effects due to the incident. The facility ordered and paid for a new prescription of Acetaminophen-Codeine #3. The Administrator stated the risk of a drug diversion included residents not receiving their prescribed medications and potentially experiencing pain as a result, as well as the possibility of an impaired staff member.</p> <p>On 03/01/25 at 3:47PM, the surveyor attempted to contact LVN A via telephone. The surveyor left a voice message requesting a return telephone call.</p> <p>Review of the facility's Controlled Substances Policy, dated 12/2024, reflected, .Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record .</p>		