STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675820	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lennwood Nursing and Rehabilitation	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)
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. Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 (300 Hall) out of 1 hallways reviewed for accidents and hazards. 1. The facility failed to ensure that 1 of 1 mechanical lift on the 300 Hall was locked, secured and stored in a secure designated area when not in use. 2. CNA B did not remove the unlocked and unsecured mechanical lift parked on the hallway of the 300 Hall in between residents' rooms. This failure could place residents, visitors and staff at risk of falls and/or injuries. Findings Included: An observation on 06/16/26 at 11:16 AM revealed one unlocked and unsecured mechanical lift parked on the hallway on the 300 Hall in between residents rooms. There were not any residents observed in the hallway during the observation. An observation on 06/16/26 at 11:32 AM revealed one unlocked and unsecured mechanical lift parked on the hallway on the 300 Hall in between resident's rooms. There were not any residents observed in the hallway during the observation. An observation on 06/16/26 at 11:55 AM revealed CNA B entering and exiting residents' rooms on the 300 Hall. An observation on 06/16/26 at 12:03 PM revealed one unlocked and unsecured mechanical lift parked on the hallway on the 300 Hall in between residents rooms. There were not any residents observed in the hallway during the observation. In an interview on 06/16/26 at 12:07 PM with CNA B, she stated that she had been employed at the facility for 7 months. CNA B stated on 06/16/26, she was assigned to the 300 Hall. She stated that she was unaware there was one mechanical lift parked in the hallway of the 300 Hall was unlocked and unsecured. CNA B stated during her employment at the facility she had taken in-service trainings on mechanical lift usage, safety and storage. CNA B stated that she could not recall when she had previously taken in-service trainings on mechanical lift usage, safety, and storage. CNA B stated that her previous in-service trainings stated mechanical lifts were to be always locked when they were not in use and placed in a storage area and not on the hallways. CNA B stated the facility did not have a designated area for mechanical lift storage, but the staff will place the mechanical lifts in unoccupied resident rooms on each hall. CNA B stated she typically did not check the parked mechanical lifts to verify if they were locked and secured. CNA B stated the mechanical lift that was observed on 06/16/26 on the hallway of the 300 Hall was overlooked because she had been assisting a family member with a resident in the resident's room. CNA B stated that harm could be caused to anyone when a parked mechanical lift was on the hallway unlocked, unsecured and not stored. CNA B stated when a parked mechanical lift was on the hallwy unlocked and unsecured it may cause anyone to have accidents and falls. She stated that someone could be harmed by having a serious fall with injuries, such as a head injury when a mechanical lift was unlocked and unsecured. CNA B stated she knew the damage an unlocked mechanical lift could cause because in the past, she bumped against the mechanical lift and hit her foot on the mechanical lift and broke her toe, which caused her some pain and discomfort. An email was sent to ADON A on 06/16/26 at 12:48 PM, requested the facility's policy on accidents and hazards, mechanical lifts, and mechanical lift safety and storage. In an interview on 06/16/26 at 2:06 PM with LVN C, she stated that she had been employed at the facility for 13 years. LVN C stated on 06//16/26 she was assigned to the 300 Hall. She stated that she was unaware on 06/16/26 there (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was an unlocked and unsecured mechanical lift parked on the 300 Hall in the hallway. LVN C stated that she had taken in-service trainings on mechanical lift safety and storage. LVN C stated that she did not remember when she had previously taken in-service trainings on mechanical lift usage and safety. LVN C stated on 06/16/26 she and other staff completed an in-service training on mechanical lift safety and storage. LVN C stated mechanical lifts should always be locked and secured when they were not in use. LVN C stated mechanical lifts should never be placed on the hallway when not in use. LVN C stated mechanical lifts should be placed in a secure area, such as an unoccupied resident room when not in use. LVN C stated she would now check the mechanical lifts every time she passed them to ensure that they were secure and always locked. LVN C stated that if she observed any staff members store the mechanical lift in the hallway and direct them place the mechanical lift in an unoccupied resident room. LVN C stated she would also direct the staff member to ensure that the parked mechanical lift was locked and secured prior to leaving the area. LVN C stated if a mechanical lift was unlocked, there was a risk of the mechanical lift moving, rolling and someone tripping on the mechanical lift. She stated that another risk of having an unlocked and unsecured mechanical lift on the hall was that someone can grab the mechanical lift and may have a trip and/or a fall. LVN C stated that someone could be harmed by an unlocked mechanical lift in the hallway and may fall and receive injuries such as broken bones, fractures, and skin tears. In an interview on 06/16/26 at 3:11 PM with ADON A, she stated that she had been employed at the facility for 2 days. ADON A stated that she was unaware that the mechanical lift parked on the hallway of the 300 Hall was unlocked and unsecured during three observations on 06/16/26. ADON A stated that her expectation was that all mechanical lifts in the building were to be locked when they were not in use. ADON A stated that all staff have been educated and trained via in-service trainings on the proper usage and safety of mechanical lifts, which included always being locked, secured and stored in a safe place. ADON A stated that she did not know when the staff received their last in-service training on mechanical lift usage, safety and storage. ADON A stated that she will reeducate staff on all shifts with ongoing in-service trainings on mechanical lift safety and storage. ADON A stated she reeducated staff with an in-service training 06/16/26. ADON A stated the in-service training for staff included reeducation on performing routine checks of the mechanical lifts in the building. ADON A stated there were risks to anyone to be injured due to an unlocked and unsecured mechanical lift on the hallways. ADON A stated if anyone touched an unlocked and unsecured mechanical lift, there was a potential for someone to lean against the mechanical lift causing it to roll and also a fall. ADON A stated that there was potential for harm to anyone who attempted to lift themselves with the unlocked and unsecured mechanical lift, which could cause injuries, such as broken bones, fractures, including broken hips, and head injuries. ADON A stated that the facility did not have a policy for mechanical lifts relating to mechanical lift safety and storage. The Administrator was unavailable for an interview on 06/16/26 due to being on Leave. Record Review on 06/16/26 at 12:30 PM revealed ADON A educated staff with an In-Service Training for Mechanical Lifts and Storage. Record Review of facility's policy for Using a Mechanical Lifting Machine, dated December 2025 did not provide any information regarding accidents and hazards relating to mechanical lift safety and storage. Record Review of facility's policy for Accidents and Supervision, dated July 2017 and reviewed and revised December 2025 reflected, Policy:The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes:Identifying hazard(s) and risk(s)Evaluating and analyzing hazard(s) and risk(s)Implementing interventions to reduce hazard(s) and risk(s)Monitoring for effectiveness and modifying interventions when necessaryDefinitions:Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident.Environment refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.Hazards refers to elements of the resident environment that have the potential to cause injury or illness.Risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.Supervision/Adequate Supervision refers to intervention and means of mitigating risk of an accident.Policy Explanation and Compliance Guidelines:The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident.All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident.The facility should make a reasonable effort to identify the hazards and risk factors for each resident.Various sources provide information about hazards and risks in the resident environment.These sources may include, but are not limited to:quality assessment and assurance (QAA) activities ii. environmental rounds. vii. individual observation.This information is to be documented and communicated across all disciplines. 2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff b. Assigning responsibility c. Providing training as needed d. Documenting interventions (e.g., plans of action developed by the Quality Assurance Committee or care plans for the individual resident) e. Ensuring that the interventions are put into action. f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice. g. Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully. h. Facility-based interventions may include, but are not limited to: i. educating staff ii. repairing the device/equipment iii. developing or revising policies and procedures i. Resident-directed approaches may include: i. implementing specific interventions as part of the plan of care ii. supervising staff and residents, etc. iii. facility records document the implementation of these interventions. 5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.