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	08/29/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater when the facility had a medication error rate of 29% based on 9 errors of 31 opportunities, which involved 2 of 4 residents (Resident #67 and # 56) observed during medication administration. -The facility failed to ensure Resident #67's extended release (ER) medications were not crushed. - LVN A failed to follow physician orders for water flushes after medication administration given via the G-Tube (a tube into the stomach that delivers formula for nutrition and medication) for Resident #56. - LVN A failed to follow facility policy by crushing all medications (tablets) together during observation on medication administration on Resident #56. - LVN A failed to follow physician order for checking Resident #56's residual and placement before medication administration through the G-tube. These failures could place residents at risk of unwanted side effects and not receiving therapeutic dosage of medications. Findings include: 1.Review of Resident #67's face sheet reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, major depressive disorder, hypertension, obesity, dysphagia (difficult with swallowing) and asthma. Review of Resident #67's Quarterly MDS assessment, dated 07/12/24, reflected a BIMS score of 12 indicating resident had mild cognitive impairment. Resident #67 required minimal assistance with activities of daily living. Review of Resident #67's physician orders reflected the order for Potassium Chloride ER Tablet Extended Release 20MEQ Give 1 tablet by mouth one time a day for low Potassium, order date 05/13/24, and Isosorbide Mononitrate ER Oral Tablet Extended (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
	675820	A. Building B. Wing	08/29/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Release 24 Hour 30 MG (Isosorbide Mononitrate) Give 1 tablet by mouth one time a day for chest pain, order date 09/16/23. Observation on 08/27/24 at 09:37 AM revealed MA B administering to Resident #67; gabapentin 300 mg 1 tablet baclofen 20 mg 1 tablet amlodipine 10 mg 1 tablet potassium cl ER 20 meq 1 tablet (do not crush) losartan potassium 50 mg 2 tablets carvedilol 25 mg 1 tablet baclofen 5 mg 1 tablet isosorbide ER 30 mg (do not crush) tramadol hcl 50 mg, hydralazine 25 mg - half tablet clopidogrel 75 mg 1 tablet fluoxetine hlc 20 mg tylenol 325 mg and aspirin 81 mg low dose. MA B crushed all the medications together and mixed with pudding and administered the medications to the resident. In an interview on 08/27/24 at 09:58 AM with the MA B stated she was not aware but know she realized she was not supposed to crush the medications because they were extended-release medications. MA B stated crushing medications that were not supposed to be crushed might lead to the medication not being effective and resident taking more medication than required that could lead to negative effects. 2.Record review of Resident #56's face sheet dated 08/29/24 reflected a [AGE] year-old female with and admitted [DATE] and a re-admitted [DATE]. The resident had a diagnosis of gastrostomy status. Record review of Resident #56's annual MDS assessment, dated 07/31/24, reflected Resident #56 had BIMS score of 03 which indicated she was severely cognitively impaired. Resident #56 received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Resident was on hospice services. (continued on next page)

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	08/29/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #56's Physician orders report dated 07/31/24 reflected, .NPO and/or TUBE FEEDING diet NPO texture, ordered 08/07/22. Enteral Feed Order every shift Auscultate for Tube Placement before feeding and medication administration Q Shift and PRN, order date 10/16/23. Enteral Feed Order every shift Check Residual prior to feeding if greater than 150cc return contents and HOLD feeding and notify MD, order date 10/16/23. Enteral Feed Order every shift Flush PEG Tube with 30cc water before and after medication administration, order date 10/16/23. Record review of Resident #56's care plan with a revision date of 03/13/23 reflected, Focus, Tube feeding Jevity 1.2 @70cc/hr X 22 hrs/day, Water flushes q6hr @ 200cc r/t Dysphagia, goal .(Resident #56) will be free of aspiration through the review date. Interventions, .Check for tube placement and gastric contents/residual volume per facility protocol and record. Observation on 08/27/24 at 09:45 AM revealed LVN A administering medication via the G-tube to Resident #56. LVN A prepared the following medications: *Norco 5-325 mg 1 tablet, *Vitamin C 500 mg 1 tablet, *Ferrous sulfate 7.5 cc, *Gabapentin 100 mg 1 tablet, *Multi - vitamin 1 tablet, *Senna 1 tablet, and *Pepcid 40 mg 1 tablet. LVN A crushed all the tablets together and mixed with water in a cup. LVN A then proceed to the resident's room. Resident #56 was in bed and formula was infusing, and LVN A paused the feeding. LVN then tried to flush the G-tube several times because it seemed clogged, after flushing by pushing water with the syringe. LVN A did not check for placement or residual, LVN A then administered the medications that were mixed together and then administered Ferrous sulfate which was in liquid form. LVN A then connected Resident #56 back to the formula without flushing the tubing after medication administration. (continued on next page)

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	08/29/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/27/24 at 11:06 AM with LVN A she stated, initially she stated she was supposed to crush the medications together cocktail, but when she checked the orders there was no orders to cocktail the medications. LVN A stated she was not supposed to mix the medications together because they could be medication interactions with the medications. LVN A stated she was not aware of the facility policy on G-tube medication administration. Regarding flushing in between medications and after medication administration, LVN A stated she was not aware she was supposed to flush the G-tube because the G-tube was being automatically flushed by the feeding pump when the formula was infusing. LVN A stated she was supposed to flush to prevent the G-tube from clogging or medication interactions during medication administration. LVN A stated she forgot to check for placement and residual during medication administration. LVN A stated she was supposed to check for placement and residual, to make sure the G-tube placement was right and check for residual to make sure the resident did not have too much in her stomach that could lead to vomiting thus aspiration. LVN A stated she had worked in the facility for about one month and she had not completed a check off on G-tube medication administration. In an interview on 08/28/24 at 01:02 PM with the ADON revealed she had been in the facility for about 3 months. The ADON stated MA B was supposed to follow physician orders, and if a medication indicated not to be crushed, she was not supposed to crush the medication. The ADON stated if the resident was taking their medications crushed and they had extended-release medications, the staff was supposed to call the residents primary care provider to get an order for liquid medications. MA B was not supposed to crush the extended-release medications because it defeats the purpose of being extended and the resident could absorb larger dose of medication than intended. ADON stated during G-tube medication administration LVN A was supposed to administer each medication separately and flush after each medication, also flush after medication administration to prevent medication administration. The ADON stated LVN A was supposed to check for placement and residual per physician order and facility policy. The ADON stated, LVN A was supposed to be aware the amount in the stomach to prevent nausea and vomiting which could lead to aspiration. Facility policy, reviewed December 2023 titled Administering Medications Through the Enteral Tubing reflected, The purpose of this procedure is to provide guidelines for the safe administration of medications through and enteral tubing.General Guidelines.3. Do not mix medications together prior to administering through an enteral tubing. Administer each medication separately. 18. Confirm placement of the feeding tube. 20. Check gastric residual volume to assess to tolerance of enteral feeding.26. If administering more than one medication, flush with 15 ml of (or prescribed amount) warm or room temperature water between medications. Review of the facility policy reviewed December 2023, and titled Administering Oral Medications reflected, Purpose. The purpose of this procedure is to provide guidelines for the safe administration of oral medications 6. Check the label of the medication and conform the medication name and the dose with the MAR.

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	08/29/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interviews and record reviews, the facility failed to establish and maintain an infection 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 (Resident #10) of 3 residents observed infection control in that: MA C failed to follow infection control requirements while performing peri care for Resident #10. These failures could affect residents who receive peri care could result in cross contamination of germs and could result in an infection or hospitalization . The findings were: Record Review of Resident #10's face sheet dated 08/29/24 revealed she had an original admission on 08/03/22 and a re-admission on 05/03/23, with diagnoses of: muscle waiting and atrophy, anxiety, hypertension, dementia, heart failure and lack of coordination. Record Review of Resident #10's quarterly MDS assessment dated [DATE] revealed Resident #10 had a BIMS score of 9 indication mild cognitive impairment. Resident # 10 required maximum assistance with activities of daily living, and she was always incontinent of bowel and bladder. Observation on 08/27/24 at 12:36 PM revealed MA C providing incontinent care to Resident #10. MA C did not complete hand hygiene or change gloves after cleaning the resident. With the same gloves MA C applied the clean brief, barrier cream and touched the resident's linens. In an interview on 08/27/24 at 12:52 PM with MA C she stated she was a medication aide and she had not provided direct care or incontinent care to any resident in the facility. MA C stated she had not been in-serviced or been checked off on incontinent care, she stated she was not aware she was supposed to change gloves and complete hand hygiene after cleaning the resident. In an interview 08/28/24 on 12:55 PM with the ADON revealed she had been in the facility for about 3 months. The ADON stated the staff was supposed to change gloves and complete hand hygiene after cleaning the resident to prevent cross contamination. The ADON stated she was not aware if MA C had been checked off on incontinent care of in-serviced on infection control. In an interview on 08/29/24 at 11:42 AM LVN D revealed she was the infection preventionist. LVN D stated MA C was supposed to complete hand hygiene and change gloves after cleaning the resident to prevent cross contamination thus infection control. LVN D stated the ADON was responsible to complete infection control in-service and kept the records. LVN D stated she was not aware if MA C was trained on incontinent care or in-serviced on infection control. Review of the facility policy revised 12/2023, titled Hand Hygiene (Center for Disease Control and Prevention) reflected, Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.b. The use of gloves does not replace hand washing. Wash hands after removing gloves.