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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident rights to a comfortable, homelike environment, with accommodation of needs for 6 of 12 residents (Resident #43, Resident #60, Resident #39, Resident #62, Resident #63, Resident#56) reviewed for residents' rights.1.The facility failed to ensure the temperature in Resident #60's room was maintained at a safe and comfortable range of 71 to 81 degrees on 9/23/25. The room temperature was 82 degrees Fahrenheit.2.The facility failed on 09/23/2025 to ensure the call light system was accessible to a resident, the call light was lying on the floor in the shared residents' toilets located inside the residents' rooms on 9/23/25 for Resident #43, Resident # 60, Resident #39, and Resident #62.3. The facility failed to ensure Resident #63's and Resident #56's call light was within reach on 09/23/25. This failure could place residents at risk of an uncomfortable environment ,not having a means of directly contacting caregivers in an emergency situation or when they needed support for daily living and diminish their quality of life. 1)Record review of Resident #60's Quarterly MDS, dated [DATE] reflected an [AGE] year-old male who was admitted to the facility on [DATE], and readmitted on [DATE]. Resident #60 had diagnoses of cancer (when abnormal cells grow out of control and spread to other areas of your body), muscle weakness, and lack of coordination. Resident #60 had a BIMS score of 10, which indicated moderate cognition impairment. Record review of Resident #60's care plan dated 09/04/25 reflected, focus: [Resident#60] rights will be respected and maintained through the review date. Goal: Resident rights will be respected and maintained through the review date. Intervention/Tasks: Dignity and respect: I will have the right to: *live in safe, decent, and clean conditions *be free from abuse, neglect, and exploitation *be treated with dignity. An observation on 09/23/25 at 10:51 AM, with Resident #60 revealed he was lying in bed wearing a hospital gown, his face was damp with sweat. Resident #60 stated it was hot in his room, because the air conditioning (AC) unit under the window was not working. When asked how long the AC unit in his room was not working, he replied for the last month. He stated he reported it to the aides taking care of him but was unable to recall a name. Interview and observation on 09/23/25 at 4:00 PM, the Maintenance Director checked the temperature in Resident #60's room with a digital thermometer, the temperature was 82 degrees Fahrenheit. The Maintenance Director stated the room temperatures was supposed to be between 71 to 81 degrees Fahrenheit, or for this building to a comfortable level for the residents. The Maintenance Director attempted to turn the AC unit on and was unable. the Maintenance Director unplugged the AC unit, tested the power outlet, and stated there was no power in it. The Maintenance Director stated he will go and fix it. The Maintenance Director left the room, and came back, he plugged the AC unit and turned it on, and it started working. The Maintenance Director stated he was from another facility and was covering for the main Maintenance Director who was sick. He stated he was not aware of the AC unit not working in Resident #60's room. He stated the direct care staff should report the issue to the Maintenance Department to fix it. He did not answer the question about if there if was risk to the resident. In an interview on 09/25/25 at 12:23 PM, the DON stated he was not aware of the AC unit not functioning in Resident #60's room. He stated normally when they have (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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that situation, they would move the resident to a different room or bring a fan until the AC unit was fixed or move the resident until the AC got fixed and move the resident back to his/her room. The DON stated the risk to residents could be skin breakdown from sweating, uncomfortable environments, and delayed in recovery from illnesses. In an interview on 09/26/25 at 5:56 PM, the Administrator stated her expectations was for all the AC units to be in working conditions in the residents' rooms. She stated the resident should be moved to another room with a working AC unit and get his/her AC unit repaired. She stated the staff was supposed to notify the Maintenance Director and enter the order on the TELS (Electronic maintenance record system) . She stated risk to residents overheating and discomfort. 2)Observation on 09/23/25 at 10:50 AM, revealed resident's shared toilet call light pull string was intertwined on the grab bar for Resident #43. Observation on 09/23/25 at 11:22 AM, revealed resident's shared toilet call light pull string was short and about two feet from the floor for Resident #60. Observation on 09/23/25 at 11:33 AM, revealed resident's shared toilet call light pull string short and about two feet from the floor for Resident #39 and Resident #62. Interview and observation on 09/23/25 at 4:00 PM, the Maintenance Director looked at the call light outlets in the shared residents' toilets located inside the residents' rooms, and stated the call light strings was short, too high and the strings needed to be within the reach of a resident who was on the floor. The Maintenance Director stated he would fix them right away. The Maintenance Director stated the risk to residents was the residents could fall and not get help. 3)Record review of Resident #63's Quarterly MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of stroke, partial paralysis of left non dominant side, and severe cognitive impairment (BIMS score of 5). Record review of Resident #63's care plan reflected he was at risk of falls due to increased weakness and interventions included .be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. dated initiated 07/08/24. In an interview and observation on 09/23/25 at 10:07 AM, Resident #63 was lying in bed and his call light was not within reach, he stated he was not sure where his call light was. Observation revealed his call light was on his chair underneath gift bags and birthday decorations. Resident #63 stated he needed his call light to call for assistance. In an observation and interview on 09/23/25 at 10:12 AM, CNA F found Resident #63's call light on his chair underneath personal items and stated that Resident #63's call light should have been within reach on his bed and was not sure why it was not placed next to him. She stated residents not having their call light within reach put them at risk of not being able to call for help. In an interview on 09/23/25 at 2:15 PM, LVN E stated that Resident #63's call light should always be within reach so he could call for assistance. She stated residents without their call light within reach placed them at risk for falls or not getting assistance that they needed. Record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected Resident #56 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Sepsis, Hypertension, diabetes and stroke. Resident #56 had a BIMS of 12 indicating she was moderately cognitively impaired. Resident #56 required substantial/maximal assistance with ADLs of transfers and positioning. Review of Resident #56's comprehensive care plan last revised on 05/14/25 reflected Resident #56 was at risk for falls related to [stroke] with left sided weakness. Intervention included Be sure [Resident #56] call light within reach and encourage me to use it for assistance as needed. [Resident #56] need prompt response to all requests for assistance. In an observation and interview on 09/23/2025 at 10:50 AM, revealed Resident #56 sitting in her electric wheelchair. Resident #56's call light device was on the floor next to bed about 3 feet away from electric wheelchair. Resident #56 stated she could not reach the call light and would like it within reach. Observation and interview on 09/23/25 at 10:54 AM, CNA N revealed the call light was not within reach of Resident #56 and moved the call light within reach of Resident #56 by attaching it to her clothing while she was sitting in the electric wheelchair. He stated Resident #56 was dependent on staff for transfers and her call light should be within reach. CNA N stated earlier when he got her up the call light was within reach he thought,. he (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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident #56 was able to use her call light. In an interview on 09/29/25 at 12:20 PM, the DON revealed his expectation was that call lights was always within reach of a resident. He stated that not having a call light within a resident's reach placed residents at risk of not being able to call for help. In an interview on 09/26/25 at 5:56 PM, the Administrator revealed her expectation was the call light string in the residents' bathrooms to be long enough for the resident in the floor to be able to reach. She further stated it was the responsibility of the Maintenance Director, nurses, and all the staff to make sure residents' call lights was easily accessible to the residents. She stated the risk to residents injury, and delayed response for care and needs. Record review of the facility policy titled Call Lights: Accessibility and Timely Response dated 12/01/2024 reflected The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. 5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed. 6. The staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director . Record review of the facility policy titled Safe and HomeLike Environment dated 12/2024, reflected Policy: In accordance with residents' rights, the facility will provide a safe, comfortable and home like environment.Definitions. [Comfortable and safe temperature levels] means that the ambient temperature should be in a relatively narrow range that minimizes residents; susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents. 7. The facility will maintain comfortable and safe temperature levels. a. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit.

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	12/11/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 2 of 2 (Resident #34, and Resident #45) residents reviewed for range of motion. The facility failed to implement interventions to prevent further decline of Resident #34 and Resident #45's contractures to their left hands on 09/23/25. This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. 1-Record review of Resident #34's Quarterly MDS, dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE], and readmitted on [DATE]. Resident #34 had diagnoses of hypertension (elevated blood pressure), cerebrovascular accident (It is a serious medical condition that occurs when the brain is damaged due to a lack of blood flow, either from a blocked blood vessel or a ruptured one), and Hemiplegia (paralysis that affects only one side of your body) or Hemiparesis (one-sided muscle weakness) affecting left nondominant side. Resident #34 had a BIMS score of 14, which indicated intact cognition. Further review revealed MDS section GG0115, Functional Limitation in Range of Motion was coded 1 for upper and lower extremities, indicating Impairment on one side. Record review of Resident #34's care plan dated 07/29/25 reflected, focus: [Resident #34] has Hemiplegia/Hemiparesis r/t CVA. Goal: [Resident #34] will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis through review date. Intervention/tasks: PT, OT, ST evaluate and treat as ordered. Record review of Resident #34's CNAs task list dated 09/24/25 did not indicate splint placement or range of motion to be provided to Resident #34's left hand. Record review of Resident #34's order summary, dated 09/23/25, reflected no physician order for left hand splint or range of motion. Record review of Resident #34's OT evaluation and Plan of treatment dated 08/13/24 revealed Range of motion .LUE ROM=impaired. Assessment Summary- Clinical impressions: resident presents with a significant decline in the ability to participate with ADL's secondary to generalized weakness, impaired balance, mobility, decreased activity tolerance, and ADLs. Skilled justification: reason for skilled services: Resident required OT service to. decreased risk for falls and perform UB ADLs with increased (Independence) and safety. Risk factors: due to .physical mobility impairments and associated functional deficits, the resident is at risk for further decline in function and falls. Focus of POT: skilled intervention focus=Restoration, compensation. In an observation and interview on 09/23/25 at 11:10 AM, Resident #34 was observed lying in bed, left hand was contracted, and the resident was not able to open his hand on command, and there was not a contracture management device in place. Resident #34 stated he had a stroke and was not able to use his left hand. He stated he never had a splint or any kind of support for his left hand. In an interview and observation on 09/23/25 at 01:55 p.m., CNA G gently opened Resident #34's left hand revealing his nails to be approximately 0.8 cm in length extending from the tip of his fingers. Inspection of his palm did not reveal any skin breakdown. She stated she had not been instructed on any splint placement or the use of the carrot splint for the resident. She stated she was not sure if the resident was in restorative care or not. She stated it was not on their task list for them to apply any splint or any range of motion exercises. In an interview on 09/25/25 at 09:27 AM, the Physical Therapy Director stated Resident #34 was not using therapy currently. She stated Resident #34 was on OT services from 07/15/24 through 11/07/24 and no splint was ordered for his left hand at that time, because it was not needed for functional ability and skin integrity. When asked if there was any risk to Resident #34, she replied the splint was for the resident's function, and Resident #34 did not have any functional impairment, because the contraction was affecting his non dominant hand, and there was no skin breakdown reported. She further stated until this day, she did not see any need for the splint for Resident #34. 2-Record review of Resident #45's Quarterly MDS, dated [DATE] reflected a (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	12/11/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[AGE] year-old male who was admitted to the facility on [DATE]. Resident #45 had diagnoses of hypertension (elevated blood pressure), cerebrovascular accident (It is a serious medical condition that occurs when the brain is damaged due to a lack of blood flow, either from a blocked blood vessel or a ruptured one) , weakness, lack of coordination, and Hemiplegia (paralysis that affects only one side of your body) or Hemiparesis (one-sided muscle weakness) affecting left nondominant side. Resident #45 had a BIMS score of 08, which indicated moderate cognition impairment. Further review revealed MDS section GG0115. Functional Limitation in Range of Motion was coded 1 for upper and lower extremities, indicating Impairment on one side. Record review of Resident #45's care plan dated 08/07/25 reflected, focus: [Resident #45] have impaired physical mobility related to contracture(s) to. Goal: [Resident #45] will remain free of complications related to from my contracture(s) through review date. Intervention/Tasks: Refer resident to therapy to be evaluated for therapy intervention. Splints may be applied per physician orders. There was no document in the care plan of Resident#45 refusing the splint for his contracted left hand. Record review of Resident #45's CNAs task list dated 09/24/25 did not indicate splint placement or range of motion to be provided to Resident #45's left hand. Record review of Resident #45's order summary, dated 09/23/25, reflected a physician order dated 04/18/25 and still active Resident to have splint on LUE for 8 hours per day. Monitor for s/s of redness, edema or skin break down one time a day for contracture management and remove per schedule. Record review of Resident #45's OT evaluation and Plan of treatment dated 08/13/24 revealed Range of motion .LUE ROM=impaired. Assessment Summary- Clinical impressions: resident presents with a significant decline in the ability to participate with ADL's secondary to generalized weakness, impaired balance, mobility, decreased activity tolerance, and ADLs. Skilled justification: reason for skilled services: Resident required OT service to increase independence with ADLs, maximize independence with ADLs, increase function activity tolerance, facilitate sitting tolerance and postural control, provision of modalities and strengthening and increase safety awareness . Risk factors: due to .physical mobility impairments and associated functional deficits, the resident is at risk for. further decline in function, increased dependency upon caregivers . Focus of POT: skilled intervention focus=Restoration. In an observation and interview on 09/25/25 at 09:44 AM, Resident #45 was observed up in wheelchair in the hallway. Resident #45's left hand was contracted, and the resident was not able to open his hand on command, and there was not a contracture management device in place. Resident #45 stated he had a stroke and was not able to use his left arm and hand. He stated he never had a splint or any kind of support for his left hand. In an interview and observation on 09/25/25 at 09:57 AM, CNA H gently opened Resident #45's left hand revealing his nails to be approximately 0.6 cm in length extending from the tips of his fingers. Inspection of his palm did not reveal any skin breakdown. She stated she had not been instructed on any splint placement or the use of the carrot splint for the resident. She stated she was not sure if the resident was in restorative care or not. She stated it was not on their task list for them to apply any splint or any range of motion exercises. In an interview on 09/25/25 at 09:59 AM, LVN I stated there was no splint device in Resident #45's room, and she did know if he ever got one from the OT department. She stated the physical therapy department was responsible for putting the order for the splint and supplying one for the resident. She stated the nurses and CNAs was responsible for applying and removed the splints for the residents following the doctor's order. She stated the risk to the resident further decline in mobility and skin breakdown leading to infection development. In an interview on 09/25/2025 10:22 AM, the Physical Therapy Director stated her department put an order for the Resident left hand's splint in the system, and it was the responsibility of the nurses to apply the splint for the Resident. When asked if she gave Resident#45 a splint, she replied she put the order in the system for the splint, and she did not have any document of given the splint to Resident#45. In an interview on 09/25/25 at 12:23 PM, the DON stated they had all residents screened by therapy upon admission and at any time there was a functional decline. He stated they do not have a restorative program, but Range of motion and splinting can be carried out by the nursing staff and the CNAs once therapy (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	12/11/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	determines the need. He stated he had been informed about Resident #45's refusing his splint. He stated therapy sets up the plan for what restorative needs the resident will require and communicate with the MDS nurse. He stated anytime the resident was refusing any service the CNAs had to let the Charge Nurse and himself know. He stated the interventions needed to be care planned. He stated failing to implement interventions for residents with limited Range of motion could lead to worsening of a resident's contractures, decline in function, skin breakdown, and wound by the nails digging in the hand's palm and pain from that pressure. In an interview on 09/26/25 at 5:56 PM, the Administrator stated her expectations were for the Therapy department to assess and to give a splinting device to residents in need to prevent further contraction. She stated the Therapy Department should collaborate with nursing staff, and the nurses to follow up for the management of the device. She stated the risk to residents injury or further damage to muscle, ligament, and pain. Review of the facility's policy titled, Prevention of Decline in Range of Motion, dated July 2017, reflected, The facility in collaboration with the medical director, director of nurses and appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care. a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion.b. The facility will provide treatment and care .this includes but not limited to .ii. Appropriate equipment (braces or splint) .

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	12/11/2025

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 (Resident #6, #14, #30) of 7 residents reviewed for accidents and hazards.1. The facility failed to ensure Resident #14 had a wanderguard and the placement and functioning of the device was monitored and documented in his medical record. 2. The Administrator and DON failed to implement a system to ensure residents (Resident #6, #14, and #30) at risk for wandering/elopement were monitored and documented in the resident's treatment administration record and that staff were following current physician orders for wanderguard placement. These failures could place the residents at risk for elopement and serious harm. Findings included:1. Review of Resident #14's face sheet undated reflected Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Hypothyroidism (condition in which thyroid gland does not make enough thyroid hormones to meet your body's needs), hypertension (high blood pressure) and age-related cognitive decline (the gradual decline in cognitive abilities that occurs as people age).Review of Resident #14's quarterly MDS assessment dated [DATE] reflected Resident #14 had a BIMS of 8 indicating he was moderately cognitively impaired. Resident #14 was partial/moderate to substantial/maximal assistance with ADLs. Review of Resident #14's initial elopement assessment dated [DATE] reflected Resident #14 was at risk for elopement. It was not complete with the following questions blank: 6. Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home etc.) 7. Does the Resident wander aimlessly or non-goal-directed (i.e. confused, moves with purpose, may enter others' rooms and explore others' belongings). The assessment was incomplete including the goals, interventions and clinical suggestions.Review of Resident #14's comprehensive care plan last revised 08/11/25 reflected Resident #14 had impaired cognitive function/dementia or impaired thought processes [related to] Dementia. The care plan did not reflect Resident #14's elopement risk, wandering behavior and did not reflect Resident #14's order for wanderguard placement for resident safety.Review of Resident #14's progress notes for 08/01/25 to 09/22/25 reflected the following:-Dated 07/31/25 nursing skilled evaluation by LVN K reflected Level of cognitive impairment: Moderate impairment (memory loss).Mood and Behavior: Resident wanders at night.-Dated 08/01/25 at 11:00 PM Nurse note by LVN K reflected Patient had to be redirected several times going in and out of room's and rambling in drawer's.-Dated 08/02/25 nursing skilled evaluation completed by RN A reflected Safety Note: Resident is a wanderer and is a high risk for elopement. Wander guard worn.-Dated 08/03/25 nursing skilled evaluation completed by RN A reflected under Safety concerns - note: High risk for elopement; wears a wander guard.-Dated 08/04/25 nursing skilled evaluation completed by RN A reflected Resident #14 had severe impairment and safety note: wanders.-Dated 08/05/25 nursing skilled evaluation completed by RN A reflected Resident #14 had safety concerns: wanders.Dated 08/31/25 at 9:16 PM nursing note by RN A reflected Resident removed wander guard from his leg and placed it on his dinner tray. Resident placed on 24 hour report and oncoming shift notified.Review of Resident #14's elopement assessment dated [DATE] reflected Resident #14 was at risk for elopement due to resident wanders aimlessly or non-goal-directed and Resident #14 was a recent admit not accepting the situation. The assessment was incomplete including the goals, interventions and clinical suggestions.Review of Resident #14's consolidated physician orders dated 09/23/25 reflected Resident #14 had a current order dated 09/04/25 of WANDERGUARDS: CHECK FOR PLACEMENT ANDPROPER WORKING FUNCTION EVERY SHIFT Placement: right ankle Expiration date: 2/15/2026.Review of Resident #14's September 2025 MAR/TAR reflected Resident #14 had no monitoring documentation every shift for wanderguard (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	12/11/2025

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 - Some	placement and proper working functioning for wanderguard.Review of Resident #14's Kardex reviewed on 09/23/25 reflected no elopement or wandering risk under safety.Observation on 09/23/25 at 2:28 PM revealed Resident #14 was in the therapy room. Physical Therapist Assistant V checked both legs including ankles and Interview with Physical Therapist Assistant V revealed she could not locate a wanderguard on him.Observation on 09/23/2025 at 2:36 PM revealed Resident #14 was in the therapy room. LVN L checked both of Resident #14's legs including ankles finding no wanderguard placement on Resident #14 and Interview with LVN L revealed there was not a wanderguard on Resident #14. Interview on 09/23/25 at 2:39 PM with LVN L revealed he had completed orientation last week and yesterday was his first day working with residents. He stated to know if the residents were an elopement risk and had a wander guard at the start of the shift the nurses check the elopement risk binder for the list of the current residents with elopement risk, and that they have to check if the residents were wearing the wander guard. LVN L stated he did not know Resident #14 was supposed to wear a wander guard.2. Record review of Resident #6's face sheet dated 09/23/2025 reflected she was a [AGE] year old female with an admission date of 05/16/2025. Diagnoses included Encephalopathy (a state where brain function is disordered, damaged, or malfunctions, leading to an altered mental state), Schizoaffective disorder (a chronic mental health condition, Type 2 diabetes mellitus with diabetic neuropathy, unspecified (elevated blood sugar levels and nerve damage).Record review of Resident #6's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #6 used a wheelchair for ambulation, and she needed supervision with chair/bed to chair transfers and to walk 50 feet with two turns.Record review of Resident #6's care plan with a revision date of 06/03/2025 reflected she needed 24-hour supervision, she used antidepressant medication related to bipolar disorder, review date 07/24/2025 reflected Resident #6 was a risk for elopement. Goal: Resident #6's safety will be maintained through the review date. Interventions: Distract Resident #6 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book resident prefers.Record review of Resident #6's Kardex dated 09/23/2025 reflected no information Resident #6 was an elopement risk.Record review of Resident #6's physician order summary dated 09/23/2025 reflected Resident #6 had an order for wander guard from 09/04/2025: Check for placement and proper working function every shift. Placement: Right ankle, Expiration date: 02/15/2026, every shift.Record review of Resident #6's TAR dated 09/24/2025 reflected no information regarding the wander guard monitoring for any shift, for the month of September 2025.Observation and interview of Resident #6 on 09/23/2025 at 12:54 PM in her room revealed resident was sitting in her bed. Resident #6 stated she wore a wander guard, she could not remember if the staff were monitoring her wanderguard. Observed a wander guard on her right ankle.3. Record review of Resident #30' s face sheet dated 09/23/2025 reflected she was a [AGE] year-old female with an original admission date of 02/15/2021. Diagnoses included unspecified dementia (memory loss), delusional disorder (false beliefs based on incorrect interpretation of reality), type two diabetes mellitus (elevated blood sugar levels).Record review of Resident #30's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 7 which indicated severe cognitive impairment. Resident #30 used wheelchairs for ambulation, needed moderate assistance with chair/bed to chair transfers and substantial assistance with walking. Record review of Resident #30's care plan with a revision date of 11/29/2021 reflected she was at risk to wander. Goal: Resident #30's safety will be maintained through the review date. Interventions: distract Resident #30 from wandering behaviors by offering pleasant diversions, structured activities, food, conversations, television, book.provide with wander guard. Record review of Resident #30's Kardex dated 09/23/2025 reflected no information that Resident #30 was an elopement risk.Record review of Resident #30's physician order summary dated 09/23/2025 reflected Resident #30 had an order for wander guard from 09/23/2025 with the same start date: Check for placement and proper working function every shift. Placement: Left ankle, Expiration date: 02/15/2026, every shift for safety measures.Record review of Resident #30's TAR dated 09/24/2025 reflected no information (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	12/11/2025

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 - Some	regarding the wander guard monitoring for any shift, for the month of September 2025.Observation and interview of Resident #30 on 09/23/2025 at 01:43 PM in the hallway revealed resident was wheeling her wheelchair by herself. Resident #30 stated she was going to the other side of the building. Observed a wander guard on her left ankle, she could not remember if staff were monitoring her wanderguard. In an interview on 09/23/25 at 4:32 PM with CNA M revealed she had worked at the facility for about 6 months and worked all the halls. She stated that the only way she knew a resident was a wander/elopement risk was if staff told her or if she saw a resident wore a wanderguard bracelet. She stated the kardex reflected what a resident needed. She stated Resident #6 did not wander but had a wanderguard. She stated Resident #14 used to have a wanderguard and he mostly stayed in his room. She stated Resident #30 wandered around the facility but did not try to exit. CNA M stated residents who were at risk of elopement would say things like they want to leave or want to go home or actively try to leave the building or was were always going towards the doors saying they want to leave. She stated she received in-services on elopements and responding immediately to alarms and to notify the nurse, DON, and the Administrator if a resident eloped. In an interview on 09/23/25 at 5:37 PM with CNA B she stated She stated she was not sure if a resident's risk of wandering/elopement or wearing of a wanderguard showed up on the kardex. In an observation with CNA B of the Kardex revealed there was no indication of Residents #6, #14, or #30 risk of wandering/elopement or wanderguard status. She stated she thought the kardex reflected the elopement risk of the residents and whether they wore a wanderguard and was not able to find the information. She stated there was also a book at the nurses station that had the picture and information of residents at risk of wandering/elopement. In an interview on 09/25/25 at 10:26 AM with the DON, he stated the current orders for wanderguards are based on residents elopement assessment showing he or she is an elopement risk. He stated Resident #14 was a current wander/elopement risk and should have a wanderguard. He stated if the wanderguard was not on a resident who was at risk for wandering/elopement the resident could go out the door and it would not alarm to inform staff. He reviewed Residents # 6, #14, and #30 physician orders and TAR and stated a check box had not been checked to move the order to the TAR. In an interview on 09/23/25 at 5:55 PM with the Administrator, she stated there were no extra wanderguards at the facility that could be used for testing the wanderguard system. She stated when they discovered Resident #14 was missing his wanderguard the facility acquired a wanderguard from a sister facility. She stated the Interim Maintenance Director was covering from another facility while their Maintenance Director was in the hospital. She stated she did not know if the Maintenance Director had documentation of monitoring and testing of the wanderguard system. In an interview on 09/24/25 at 10:26 AM with the DON he stated He stated all residents' wanderguards were tested and all were working. He stated his expectation was for nurses with residents with wanderguards to stay aware of where those residents are located during their shift. Every nurse's station had a binder with a list and picture of which residents were at risk of wandering/elopement. He stated resident wanderguards were tested frequently with residents being brought up to the door to ensure the alarm sounds and there was an activation device will show if the system was working. He stated he was not sure where the activation device currently was located. He stated it was important to ensure the physician orders to monitor and check placement of wandergaurds were in the TAR because it informed nurses who were was at risk of wandering/elopement and ensured the nurses were checking the wanderguard for working order and placement. He stated the Maintenance Director and a nurse check the wanderguard system at least 3 times a week by taking a resident up to the front door and ensured the alarm activated. In an interview on 09/24/25 at 10:59 AM with the ADON she stated it was her 4th day working at the facility and was trained regarding elopements and wandering residents by the DON and the Human Resources Director and was told the facility did not accept residents who eloped. She was unable to name any residents who were a current elopement/wandering risk. She stated residents were at risk of wandering or elopement when they had diagnoses such as dementia, were confused or (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	12/11/2025

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 - Some	not orientated, had UTIs or infections. In an interview on 09/24/25 at 11:09 AM with the [NAME] President of Clinical Operations she stated orders are typically entered into the resident's electronic chart by the floor nurse and then it automatically updates the TAR for nurses and the Point of Care (POC) for CNAs. She stated it was important monitoring of wanderguards were was completed as ordered because it ensured resident safety of those at risk of wandering/elopement. She stated there was a task tab needed to be clicked in the resident record to move the order or area of concern into the resident's care plan and kardex. She stated it was important residents at risk of wandering/elopement and wanderguards were care planned with interventions so nurses and other facility staff were aware of those at high risk or sought exits and kept an closer eye on them. In an interview on 09/24/25 at 1:46 AM with the Administrator she stated She stated the MDS Coordinator reviewed and updated the care plans for all residents. She stated she expected any resident with a wanderguard had it care planned and in the kardex so staff were aware and it was seen and documented across the board for all staff. She stated all door alarms and the wanderguard were checked by a contracted company and were found to be in working order by the company and the Maintenance Director. She stated the Maintenance Director checked the wanderguard system frequently and was currently in the hospital and she was not aware of any documentation of his checking of the wanderguard system and would look for it and the documentation from the contracted company regarding door alarms. She stated the Interim Maintenance Director would be covering the facility while the Maintenance Director was out. She stated the DON was responsible for ensuring nurses monitored and documented the placement, working order, and expiration date of wanderguards. She stated it was important for nurses documented monitoring in the resident electronic record because it ensured staff were checking the device.Record review of the facility's elopement policy, titled Elopement-Overview, dated reviewed December 2024, reflected: The facility elopement definition is as follows: Elopement occurs when a Resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.Record review of the facility's accidents and hazard policy titled Safety and Supervision of Residents, dated reviewed December 2024, reflected: .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Individualized, Resident-Centered Approach to Safety1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.4. Implementing interventions to reduce accident risks and hazards shall include the following:a. Communicating specific interventions to all relevant staff;b. Assigning responsibility for carrying out interventions;c. Providing training, as necessary;d. Ensuring that interventions are implemented; ande. Documenting interventions.5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; andd. Evaluating the effectiveness of new or revised interventions.Record review of the facility's elopement facility practices, titled Elopement-Facility Practices, dated reviewed December 2024, reflected: The facility team will assess the environment to identify potential risks associated with elopement. Facility interventions will be developed and implemented to reduce the risk of elopement and/or hazards associated with elopement. Guidelinesl. Assess the security of potential internal environmental risk factors including, but not limited to, the following: Elevators Exit Doors Screens Stairwells Windows2. Maintain door alarms and wander control systems in proper working order. (Refer to the Prevention Maintenance Program in the Maintenance Manual.).5. Maintain a current protected list of names and photographs of resident/patients identified at risk for elopement. Assure picture contains the following information:a. (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	12/11/2025

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 - Some	Nameb. Descriptionc. Heightd. Weighte. Agef. Pertinent medical informationg. Lot# of Electronic Bracelet if applicableh. Expiration date of Electronic Bracelet' if applicable6. Monitor whereabouts of the at-risk resident/patient during rounds.7. Validate, through observation, the resident/patient is wearing electronic device every shift as indicated & document on the TAR.8. Validate daily that the electronic device is properly functioning & document on the TAR.Record review of the facility's wandering residents policy, titled Wandering, Resident, dated reviewed December 2024, reflected: The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.Policy Interpretation and Implementation4. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 5. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering.6. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a monitoring plan will be included.5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall:a. Examine the resident for injuries;b. Contact the Attending Physician and report findings and conditions of the resident;c. Notify the resident's legal representative (sponsor);d. Notify search teams that the resident has been located; e. Complete and file an incident report; andf. Document relevant information in the resident's medical record.Record review of the facility's elopement prevention policy, titled Elopement Prevention, dated reviewed December 2024, reflected: The facility recognizes that elopement prevention is an interdisciplinary process that must include the cognitively impaired resident/patient and family. The facility will implement individualized interventions & strive to prevent elopement.Guidelines2. Complete admission data collection 3. Review and evaluate risk factor data.4. Determine if the resident/patient is at risk for elopement.5. Include resident/patient and family in development of the Plan of Care.6. Present at the next scheduled Interdisciplinary Plan of Care (IPOC) &/or Standards of Care meeting.7. Develop individualized interventions which may include, but are not limited to, the following: Electronic monitoring/alarm systems Environmental modifications Protected list of names and photographs of those at risk for elopement. Psychosocial interventions Regular rounds Resident/patient and family education Staff interventions Structured group activities8. Communicate risk and interventions with the resident/patient and family and provide education as needed.9. Discuss interdisciplinary interventions with the resident/patient and family and provide education as needed.10. Provide staff training as needed.11. Review and revise Plan of Care as needed.Record review of the facility's elopement management policy, titled Elopement Management, dated reviewed December 2024, reflected: The interdisciplinary team will re-evaluate cognitively &/or psychologically impaired residents/patients who have attempted, unsuccessfully or successfully, to leave the facility without staff knowledge. With the assistance of the resident/patient and family, individualized interventions will be developed and initiated to manage the elopement behavior. Guidelines.8. Review and revise individualized interventions that may prevent further elopement attempts. 10. Communicate interventions to staff and provide training as needed. 11. Evaluate and document effectiveness of revised interdisciplinary interventions.12. Review and Revise Plan of Care needed.Help shape the future of iQIES. Click Here to participate in iQIES HCD Research or email us at iqies_hcd@cms.hhs.gov.

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	12/11/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for 1 of 6 residents (Resident #53) reviewed for storage of medications.The facility failed to ensure Resident #53's Econazole Nitrate Cream (treatment for skin infection) labeled topical ointment, was secured, and not left at the bedside.This deficient practice could place residents at risk for loss of biologicals, overuse of medication, and not receiving the therapeutic benefit of the medication. Findings included:Record review of Resident #53's admission MDS, dated [DATE] reflected an [AGE] year-old male who was admitted to the facility on [DATE], and readmitted on [DATE]. Resident #53 had diagnoses of hypertension (Elevated blood pressure), and Alzheimer's Disease (a progressive brain disorder that causes memory loss, cognitive decline, and behavioral changes). Resident #53 had a BIMS score of 00, which indicated severe cognitive impairment. Record review of Resident #53's order summary, dated 09/23/25, reflected no physician order for Econazole Nitrate Cream, 1%. Observation of 09/23/25 at 01:53 PM revealed, Resident #53 was not in the room, and there was a box of Econazole Nitrate Cream, 1% with a non-facility's pharmacy label indicating apply topically to the affected area twice daily, and a faded date that read [./29/2025] During an interview and observation on 09/23/25 at 2:26 PM, LVN L looked at the medication box and stated, he did not notice the ointment box on the nightstand in Resident #53's room. He stated maybe Resident #53's family member brought it from home. He stated the medication should not be left at the bedside, because it could be used by someone for whom it was not intended. He further stated a confused resident in the facility could eat it, too, and have an adverse reaction to the medication, like an upset stomach. During an interview on 09/25/25 at 12:23 PM, the DON stated he tried to educate residents' family members to let the nurses know if they bring medication from home, so the nurses will get an authorization for use of the medication from the facility primary physician. He stated the nurse for Resident #53 was supposed to take the medication ointment from the resident's room and notify the family, notify the primary physician and see if the primary physician wanted to incorporate the medication ointment in Resident #53's medication regimen, and the facility pharmacy could be able to deliver the medication, because the one found at bedside looked like it was from an outside pharmacy. The DON stated the risk to residents could be taking medication that was contraindicated for them and could react with other medications that they are taking. The DON stated another resident could use ointment medication as a toothpaste or lotion. During an interview on 09/26/25 at 5:56 PM, the Administrator stated there should not be any medications at the bedside, and all the residents' medications should be kept in the medication cart. She stated the risk to residents could be injury, and adverse events if they take too much medication. Review of the facility policy titled Medication Storage dated December/2024 reflected Policy. Medications. are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall only be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication.14. Outdated., discontinued or deteriorated medications.are immediately removed from stock, disposed.

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	12/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to meet the resident's highest practicable physical, mental, and psychosocial wellbeing for 6 (Residents #14, #8, #6, #29, #30 and #37) of 24 residents reviewed for care plans.1. The facility failed to develop a comprehensive care plan for Residents #8 and #14 who were at risk for elopement/wandering.2. The facility failed to develop a Kardex for Residents #6, #8, #14, #29, #30 and #37 at risk for elopement/wandering.These failures place residents at risk of not having their individualized needs meet, preventative measures and interventions in place to prevent elopements. Findings included:1. Review of Resident #14's face sheet undated reflected Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Hypothyroidism (condition in which thyroid gland does not make enough thyroid hormones to meet your body's needs), hypertension (high blood pressure) and age-related cognitive decline (the gradual decline in cognitive abilities that occurs as people age).Review of Resident #14's quarterly MDS assessment dated [DATE] reflected Resident #14 had a BIMS of 8 indicating he was moderately cognitively impaired. Resident #14 was partial/moderate to substantial/maximal assistance with ADLs. Review of Resident #14's initial elopement assessment dated [DATE] reflected Resident #14 was at risk for elopement. It was not complete with the following questions blank: 6. Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home etc.) 7. Does the Resident wander aimlessly or non-goal-directed (i.e. confused, moves with purpose, may enter others' rooms and explore others' belongings). The assessment was incomplete including the goals, interventions and clinical suggestions.Review of Resident #14's comprehensive care plan last revised 08/11/25 reflected Resident #14 had impaired cognitive function/dementia or impaired thought processes [related to] Dementia. The care plan did not reflect Resident #14's elopement risk, wandering behavior and did not reflect Resident #14's order for wanderguard (a wearable, electronic resident bracelet that alerts staff when a resident approaches a protected area, such as a door exit) placement for resident safety.Review of Resident #14's progress notes for 08/01/25 to 09/22/25 reflected the following:-Dated 07/31/25 nursing skilled evaluation by LVN K reflected Level of cognitive impairment: Moderate impairment (memory loss).Mood and Behavior: Resident wanders at night.-Dated 08/01/25 at 11:00 PM Nurse note by LVN K reflected Patient had to be redirected several times going in and out of room's and rambling in drawer's.-Dated 08/02/25 nursing skilled evaluation completed by RN A reflected Safety Note: Resident is a wanderer and is a high risk for elopement. Wander guard worn.-Dated 08/03/25 nursing skilled evaluation completed by RN A reflected under Safety concerns - note: High risk for elopement; wears a wander guard.-Dated 08/04/25 nursing skilled evaluation completed by RN A reflected Resident #14 had severe impairment and safety note: wanders.-Dated 08/05/25 nursing skilled evaluation completed by RN A reflected Resident #14 had safety concerns: wanders.Dated 08/31/25 at 9:16 PM nursing note by RN A reflected Resident removed wander guard from his leg and placed it on his dinner tray. Resident placed on 24 hour report and oncoming shift notified.Review of Resident #14's elopement assessment dated [DATE] reflected Resident #14 was at risk for elopement due to resident wanders aimlessly or non-goal-directed and Resident #14 was a recent admit not accepting the situation. The assessment was incomplete including the goals, interventions and clinical suggestions.Review of Resident #14's consolidated physician orders dated 09/23/25 reflected Resident #14 had a current order dated 09/04/25 of WANDERGUARDS: CHECK FOR PLACEMENT ANDPROPER WORKING FUNCTION EVERY (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	12/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SHIFT Placement: right ankle Expiration date: 2/15/2026.Review of Resident #14's Kardex (a summary of patient information for daily care) reviewed on 09/23/25 reflected no elopement or wandering risk under safety.2. Record review of Resident #8's Quarterly MDS dated [DATE], reflected he was an [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of dementia, had a BIMS score of 14 (intact cognition), and required limited assistance with ADLS. Record review of Resident #8's elopement evaluation, dated 7/24/25, reflected he was not at risk of elopement with and the sections for risk of elopement and clinical suggestions were blank. Review of Resident #8's elopement evaluation dated, 9/4/25, reflected he was at risk of elopement with and the sections for risk of elopement and clinical suggestions were blank. Record review of Resident #8's physician orders reflected an order, start dated 09/04/25: WANDERGUARD: CHECK FOR PLACEMENT ANDPROPER WORKING FUNCTION EVERY SHIFT. Placement: Right Ankle .Record review of Resident #8's psychiatry progress note, date of service 09/17/25, reflected Resident #8 was a poor historian, forgetful with a flat affect and past medical history of dementia, bipolar, psychotic disorder with delusions and had a cognitive communication deficit.Record review of Resident #8's comprehensive care plan last revised 09/08/25 reflected it did not include his wander guard and risk of elopement/wandering.Record review of Resident #8's Kardex did not reflect wander guard elopement/wandering status.3. Record review of Resident #6's face sheet dated 09/23/2025 reflected she was a [AGE] year old female with an admission date of 05/16/2025., Diagnoses included Encephalopathy (a state where brain function is disordered, damaged, or malfunctions, leading to an altered mental state), Schizoaffective disorder (a chronic mental health condition), Type 2 diabetes mellitus with diabetic neuropathy, unspecified (elevated blood sugar levels and nerve damage).Record review of Resident #6's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #6 used a wheelchair for ambulation, and she needed supervision with chair/bed to chair transfers and to walk 50 feet with two turns.Record review of Resident #6's care plan, with a revision date of 06/03/2025, reflected the need for 24-hour supervision and that she used antidepressant medication related to bipolar disorder: a later review on 07/24/2025 reflected Resident #6 was a risk for elopement. Goal: Resident #6's safety will be maintained through the review date. Interventions: Distract Resident #6 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book resident prefers.Record review of Resident #6's Kardex dated 09/23/2025 reflected no information Resident #6 was an elopement risk.Record review of Resident #6's physician order summary dated 09/23/2025 reflected Resident #6 had an order for wander guard from 09/04/2025: Check for placement and proper working function every shift. Placement: Right ankle, Expiration date: 02/15/2026, every shift.4. Review of Resident #29's quarterly MDS assessment dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of stroke affecting right side, hypertension (high blood pressure), diabetes (chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood glucose levels), aphasia (language disorder that affects person's ability to communicate effectively). Resident #29 was moderately impaired in daily decision making. Resident #29 had no wandering behavior during the lookback period. Resident #29 required supervision to partial/moderate assistance with ADLs.Record review of Resident #29's physician order dated 09/04/25 reflected an order, start dated 01/21/25: WANDERGUARD: CHECK FOR PLACEMENT AND PROPER WORKING FUNCTION EVERY SHIFT. Placement: Right Ankle .Observation and Interview on 09/23/2025 at 2:50 PM revealed Resident #29 was in his room and had a wanderguard on his left ankle. RN Q stated Resident #29 was confused, and did have wandering and exit seeking behavior at times. She stated she was responsible to check his wanderguard placement and functioning of the wanderguard each shift when she was his charge nurse.5. Record review of Resident #30's face sheet dated 09/23/2025 reflected she was a [AGE] year-old female with an original admission date of 02/15/2021. Diagnoses included unspecified dementia (memory loss), delusional disorder (false beliefs based on incorrect interpretation of (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	12/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reality), type two diabetes mellitus (elevated blood sugar levels).Record review of Resident #30's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 7 which indicated severe cognitive impairment. Resident #30 used wheelchairs for ambulation, and needed moderate assistance with chair/bed to chair transfers and substantial assistance with walking. Record review of Resident #30's care plan with a revision date of 11/29/2021 reflected she was at risk to wander. Goal: Resident #30's safety will be maintained through the review date. Interventions: distract Resident #30 from wandering behaviors by offering pleasant diversions, structured activities, food, conversations, television, book.provide with wander guard. Record review of Resident #30's Kardex dated 09/23/2025 reflected no information that Resident #30 was an elopement risk.Record review of Resident #30's physician order summary dated 09/23/2025 reflected Resident #30 had an order for wander guard from 09/23/2025 with the same start date: Check for placement and proper working function every shift. Placement: Left ankle, Expiration date: 02/15/2026, every shift for safety measures.6. Record review of Resident #37's Quarterly MDS, dated [DATE], reflected he was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of dementia (loss of cognition), major depressive disorder (persistently depressed mood or loss of interest), and severe cognitive impairment (BIMS score of 3). He required moderate assistance with ADLs, ambulated with a wheelchair, and used a wander/elopement alarm daily.Record review of Resident #37's care plan reflected he was an elopement risk/wanderer. Interventions included wanderguard to right ankle, to distract resident with pleasant or structured activities, dated initiated 01/21/25 and revised on 02/11/25. Record review of Resident #37's Kardex did not reflect wander guard elopement/wandering status.Review of Resident #37's elopement evaluation dated, 9/4/25, reflected he was at risk of elopement and the sections for risk of elopement and clinical suggestions were blank. Record review of Resident #37's physician orders reflected an order, start dated 01/21/25: WANDERGUARD: CHECK FOR PLACEMENT AND PROPER WORKING FUNCTION EVERY SHIFT. Placement: Right Ankle .In an interview on 09/23/25 at 4:32 PM with CNA M revealed she had worked at the facility for about 6 months and worked all the halls. She stated the kardex reflected what a resident needed. In an interview and observation on 09/23/25 at 5:37 PM with CNA B of Resident #8 or #37, or Resident #30's Kardex revealed there was no indication of their risk of wandering/elopement or wanderguard status. She stated she thought the kardex reflected the elopement risk of the resident and whether they wore a wanderguard and was not able to find the informationIn an interview on 09/24/25 at 11:09 AM with the [NAME] President of Clinical Operations she stated orders are typically entered into the resident's electronic chart by the floor nurse. She stated there was a task tab that needed to be clicked in the resident record to move the order or area of concern into the resident's care plan and kardex. She stated it was important that residents at risk of wandering/elopement were care planned with interventions so that nurses and other facility staff were aware of those at high risk or sought exits and kept a closer eye on them. In an interview on 09/24/25 at 1:46 PM with the Administrator revealed stated she and the MDS Coordinator reviewed and updated the care plans for all residents who were at risk for elopement/wandering. She stated that she expected any resident with a wanderguard had it care planned and in the kardex so that staff were aware and it was seen and documented across the board for all staff. In an interview on 09/24/25 at 1:50 PM with the MDS Coordinator stated she did not complete the care plans for residents at risk for elopement and did not input the physician orders for wanderguard placement on 09/04/25. She stated she did not update the Kardex but she thought the DON was responsible to update the Kardex for the CNAs to review for residents. She stated care plan/kardex must include at risk for elopement, observation for wandering behaviors wanderguard placement and verification of function, and monitoring for wanderguard function. She stated not having a resident's wanderguard placement, monitoring, or wandering/elopement risk care planned or in the kardex meant staff might not know they were at risk.In an interview on 09/26/25 at 5:44 PM with the Administrator she stated she was not aware that there were residents that did not have their wandering/elopement risk care planned there was also (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	12/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confusion over whose job duty it was to update resident kardex/care plan. She stated residents not having monitoring in place for wanderguards monitoring and placement placed them at risk of eloping and was a failure in their protocol. She stated residents not having a kardex or care plan that reflected their wanderguard placement, wander/elopement risk and interventions placed residents at risk because staff might not know their risk of wandering/elopement and they might elope.Record review of the facility's elopement policy, titled Elopement-Overview, dated reviewed December 2024, reflected: The facility elopement definition is as follows: Elopement occurs when a Resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.Record review of the facility's accidents and hazard policy titled Safety and Supervision of Residents, dated reviewed December 2024, reflected: .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Individualized, Resident-Centered Approach to Safety1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.4. Implementing interventions to reduce accident risks and hazards shall include the following:a. Communicating specific interventions to all relevant staff;b. Assigning responsibility for carrying out interventions;c. Providing training, as necessary;d. Ensuring that interventions are implemented; ande. Documenting interventions.5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; andd. Evaluating the effectiveness of new or revised interventions.Record review of the facility's wandering residents policy, titled Wandering, Resident, dated reviewed December 2024, reflected: The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.Policy Interpretation and Implementation1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering.3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a monitoring plan will be included.5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall:a. Examine the resident for injuries;b. Contact the Attending Physician and report findings and conditions of the resident;c. Notify the resident's legal representative (sponsor);d. Notify search teams that the resident has been located; e. Complete and file an incident report; andf. Document relevant information in the resident's medical record.Record review of the facility's elopement prevention policy, titled Elopement Prevention, dated reviewed December 2024, reflected: The facility recognizes that elopement prevention is an interdisciplinary process that must include the cognitively impaired resident/patient and family. The facility will implement individualized interventions & strive to prevent elopement.Guidelines1. Complete admission data collection 3. Review and evaluate risk factor data.4. Determine if the resident/patient is at risk for elopement.5. Include resident/patient and family in development of the Plan of Care.6. Present at the next scheduled Interdisciplinary Plan of Care (IPOC) &/or Standards of Care meeting.7. Develop individualized interventions which may include, but are not limited to, the following: Electronic monitoring/alarm systems Environmental modifications Protected list of names and photographs of those at risk for elopement. Psychosocial interventions Regular rounds Resident/patient and family education Staff interventions Structured group activities8. Communicate risk and interventions with the resident/patient and family and provide education as needed.9. Discuss interdisciplinary interventions with the resident/patient and family and provide education as needed.10. Provide staff training as needed.11. Review and revise Plan of Care as (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	12/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed.Review of facility's policy Care Plans, Comprehensive last revised December 2024 reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.7. The care planning process will: b. Include an assessment of the resident's strengths and needs.8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes. b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.g. Incorporate problem areas; h. Incorporate risk factors associated with identified problems.m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels.9. Area of concern that are identified through the resident assessment will be evaluated before interventions are added to the care plans.13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.

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	12/11/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 4 (Resident #37, Resident #34, Resident #45, and Resident #60) of 12 residents reviewed for personal care. The facility failed to ensure: 1- Resident #37's nails were trimmed and without jagged edges. 2- Resident #60's nails were trimmed and cleaned. 3- Resident#34's nails were trimmed and cleaned. 4- Resident#45's nails was trimmed and without jagged edges. This failure could place residents who require staff assistance at risk of dermatitis (inflammation of the skin), infections, and low self-esteem.1-Record review of Resident #37's care plan reflected he was at risk of impairment to his skin's integrity due to decreased mobility and incontinence, interventions included to avoid scratching and keep fingernails short, dated initiated 10/04/25. An observation and interview on 09/23/25 at 10:20 AM, Resident #37 was lying in bed with nails that was long and jagged on both hands. Resident #37 stated his nails was too long and raggedy. He stated he was not sure why they was not trimmed and would like them trimmed. In an interview on 09/23/25 at 10:32 AM, LVN E stated she was just about to trim Resident #37's nails. Observation of Resident #37's nails at that time, LVN E stated that his nails was long and jagged in areas. LVN E stated that she usually trimmed Resident #37's nails once a week and she had not been to work in over a week and stated she was going to trim them now . 2-Record review of Resident #60's Quarterly MDS, dated [DATE] reflected an [AGE] year-old male who was admitted to the facility on [DATE], and readmitted [DATE]. Resident #60 had diagnoses of cancer (when abnormal cells grow out of control and spread to other areas of your body), muscle weakness, and lack of coordination. Resident #60 had a BIMS score of 10, which indicated moderate cognition impairment. Further review revealed personal hygiene he was coded as supervision or touching assistance. Record review of Resident #60's care plan dated 09/04/25 reflected, focus: [Resident#60] have an ADL Self Care Performance Deficit r/t increased weakness. Goal: [Resident #60] will maintain current level of function in.Personal Hygiene. through the review date. Intervention/Tasks: [Resident #60] require (1) staff participation with personal hygiene and oral care. An observation and interview on 09/23/25 at 10:51 AM, Resident #60 was lying in bed, his fingernails on both hands was long approximately 0.7 cm from the tips of his fingers, and dirty with black matter underneath. Resident #60 stated his nails was too long and he would like them to be cleaned and trimmed. In an interview and observation on 09/23/25 at 12:08 PM, CNA G looked to Resident #60's fingernails and stated they needed to be cleaned and trimmed, because they looked dirty, long, and jagged. CNA G stated CNAs and Nurses was responsible for nail care. She stated that Nurses was responsible for nail care for diabetic residents. She stated nail care for residents was done as needed. She added the risk to residents for not trimming or cleaning nails decreased skin integrity and risk of infections. 3-Record review of Resident #34's Quarterly MDS, dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE], and readmitted on [DATE]. Resident #34 had diagnoses of hypertension (elevated blood pressure), cerebrovascular accident (It is a serious medical condition that occurs when the brain is damaged due to a lack of blood flow, either from a blocked blood vessel or a ruptured one), and Hemiplegia (paralysis that affects only one side of your body) or Hemiparesis (one-sided muscle weakness) affecting left nondominant side. Resident #34 had a BIMS score of 14, which indicated intact cognition. Further review revealed personal hygiene he was coded as partial/moderate assistance. Record review of Resident #34's care plan dated 07/29/25 reflected, focus: [Resident #34] have an ADL Self Care Performance Deficit. Goal: [Resident #34] will improve current level of function through the review date.Intervention/Tasks: [Resident #34] require (1) staff participation with personal hygiene and oral care. In an observation and interview on 09/23/25 at 11:10 AM, Resident #34 was observed lying in bed, fingernails on both hands was long approximately 0.8 cm in length from the tips of his fingers, (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	12/11/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	jagged and dirty with black substance underneath. Resident #34 stated he would like his fingernails cleaned and trimmed. In an interview and observation on 09/23/25 at 12:11 PM, CNA G looked to Resident #34's fingernails and stated they needed to be cleaned and trimmed, she said they looked dirty, long, and jagged. CNA G stated CNAs and Nurses was responsible for nail care. She stated that Nurses was responsible for nail care for diabetic residents. She stated nail care for residents was as needed. She added the risk to residents for not trimming or cleaning nails decreased skin integrity and risk of infections. 4-Record review of Resident #45's Quarterly MDS, dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #45 had diagnoses of hypertension (elevated blood pressure), cerebrovascular accident (It is a serious medical condition that occurs when the brain is damaged due to a lack of blood flow, either from a blocked blood vessel or a ruptured one), weakness, lack of coordination, and Hemiplegia (paralysis that affects only one side of your body) or Hemiparesis (one-sided muscle weakness) affecting left nondominant side. Resident #45 had a BIMS score of 08, which indicated moderate cognition impairment. Further review revealed personal hygiene he was coded as supervision or touching assistance. Record review of Resident #45's care plan dated 08/07/25 reflected, focus: [Resident #45] have an ADL Self Care Performance Deficit r/t increased weakness. Goal: [Resident #45] will maintain current level of function in. Personal hygiene through the review date. Intervention/Tasks: [Resident #45] require (1) staff participation with personal hygiene and oral care. In an observation and interview on 09/25/25 at 09:44 AM, Resident #45 was observed up in his wheelchair in the hallway. Resident #45's left hand was contracted with fingernails long approximately 0.6 cm in length from the tips of his fingers. Resident #45 left hand four fingers (4th, 3rd, 2nd and 5th) was drawn up in fist and resting against the hand palm. Resident #45 right hand thumb fingernail was long approximately 0.6 cm in length from the tips of his finger, and jagged. Resident #45's right hand other fingers (4th, 3rd, 2nd and 5th) was trimmed to the tips of his fingers. Resident #45 stated, he was able to trim his hand right four fingernails, but was unable to trim his right-hand thumb, and his left-hand fingernails. Resident #45 was not able to state how he was able to trim some of his fingernails, and he liked his fingernails trimmed. In an interview and observation on 09/25/25 at 09:57 AM, CNA H looked to Resident #45's fingernails and stated they needed to be trimmed, they looked long, and jagged. CNA H stated CNAs and Nurses was responsible for nail care. She stated that Nurses was responsible for nail care for diabetic residents. She stated nail care for residents was done as needed. She added the risk to resident for not trimming or cleaning nails was decreased skin integrity and risk of infections. In an interview on 09/25/25 at 09:59 AM, LVN I revealed, CNAs was responsible for resident nail care, unless the resident had diagnoses of Diabetes, then Nurses was responsible for trimming resident nails. She stated dirty, long fingernails can expose the residents to the risk of developing infections or skin tears. LVN I further stated that although CNAs was responsible for nail care, it was ultimately the responsibility of the charge nurse to ensure residents' fingernails was always cleaned and trimmed. In an interview on 09/25/25 at 12:20 PM, the DON revealed there was no expectation on frequency of nail trimming for residents because each person's nails grew at a different rate. He stated that he expected staff to ensure residents nails was kept low and clean. He stated the risk to a resident by not having trimmed, clean, or smooth nails could be skin tears or infections. In an interview on 09/26/25 at 5:56 PM, the Administrator stated residents' fingernails should be cleaned and trimmed to the resident's likening. She stated it was the responsibility of CNAs and nurses to make sure residents' fingernails was kept clean and trimmed. She stated the risk to residents was injuries and development of infection. Record review of facility policy titled Providing Nail Care dated 12/2024 reflected The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. 3. Routing cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care to include trimming and filing, will be provided on a regular schedule. nail care will be provided between scheduled occasion as the needs arises. a. Nails should be kept smooth to avoid skin injury .

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	12/11/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, 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 of 2 (300-400-600-Hall cart) medication carts reviewed for pharmacy services. The facility failed to ensure expired medication, was removed from the 300-400-600-Hall medication cart. This failure could place residents at risk of receiving an expired medication, not reaching the intended therapeutic dose, and/or contamination from expired supplies.Findings included:Observation on 09/23/25 at 09:21 AM of the 300-400-600-Hall medication cart revealed:-Two boxes of Latanoprost Ophthalmic Solution 0.005 % (Glaucoma) with open date of 08/09/25-One box of Dorzolamide hcl 2% (Glaucoma) with open date of 08/09/2025.-One box Timolol maleate 0.5% (glaucoma) with open date of 08/09/2025. -Two boxes of Artificial tears with open date of 08/13/25. During an interview on 09/23/25 at 10:23 AM, LVN I stated all the nurses was responsible for checking for expired medications/supplies in the medication carts at the start of their shift. She stated the expectation was for the solution or liquid medication to be discarded 28 days after opening, unless otherwise specified by the ordering doctor or pharmacy. She stated if a resident was to take expired medication, then the medication strength could be altered, and it could negatively affect the resident. When asked the last time the medications was given to the residents, she replied, she did not administer the eye drops, the eye drops was given by the evening nurses. During an interview on 09/25/25 at 12:23 PM, the DON stated all the nurses was responsible for checking their medication cart at the start of the shift for expired supplies and medications. He stated the solution/liquid medication should be labeled with the date it was opened and discarded no later than 28 days after that date. The DON stated the risk to residents, the medications strength could be ineffective after the expiration date or becomes contaminated, and lead to infection development. During an interview on 09/26/25 at 5:56 PM, the Administrator stated, she expected frequent auditing of the medication carts by the nurses to make sure there was no discharged residents' medication, and no expired medication in the carts. She stated the risk to residents, the medication dose may not be effective and should be used by the manufacturers expiration date. Review of the facility policy titled Medication Storage dated December/2024 reflected Policy. Medications. are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.14. Outdated., discontinued or deteriorated medications.are immediately removed from stock, disposed of accordingly.

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	12/11/2025

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** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 of 4 residents (Resident #43) observed for infection control. CNA M failed to perform hand hygiene and change gloves while providing incontinence care to Resident # 43. This failure could place residents at risk for infection.Findings included:Record review of Resident #43's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE], and readmitted [DATE] with the diagnoses of hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), and cerebrovascular accident (occurs when blood flow to the brain is interrupted, leading to brain damage). Resident #43 had a BIMS score of 06, which indicated severe cognition impairment. Further review revealed urinary continence/ bowel continence were coded as frequently incontinent. Record review of Resident #43's care plan dated 08/11/25 reflected, focus: [Resident #43] have an ADL Self Care Performance Deficit r/t CVA Goal: [Resident #43] will maintain current level of function in.toilet use.Personal Hygiene. through the review date. Intervention/Tasks: [Resident #43] require extensive assistance of 1 staff participation to use toilet. Observation on 09/25/25 at 1:31 PM, reflected CNA M provided incontinent care to Resident #43. CNA M entered Resident #43's room washed hands, put on clean gloves and explained to the resident that she was to provide incontinent care. CNA M positioned the resident and unfastened her brief, then proceeded to clean the resident. Resident#43's brief was soaked with urine. CNA M cleaned Resident #43 front area, removed gloves, and put on clean gloves without performing any hand hygiene. CNA M helped Resident #43 turned to her left side. When CNA M completed cleaning Resident #43's buttocks area, she pushed the dirty brief under the resident, without any hand hygiene or change of gloves, CNA M proceeded to apply the clean brief. After CNA M applied the clean brief, she removed the dirty brief that was at the left side of the Resident #43 and placed it in the trash can. CNA M removed gloves, covered the resident, positioned the resident, and moved the bedside table closer to the resident. After care, CNA M completed hand hygiene and exited the room. In an interview on 09/25/25 at 1:40 PM, CNA M stated she was to complete hand hygiene before and after care and after taking off Resident #43's dirty brief. CNA M stated she was supposed to change her gloves with hand hygiene after she cleaned the resident before applying the clean brief. CNA M stated she was supposed to sanitize her hands each time she removed the dirty gloves before putting on the clean gloves. CNA M stated she was to complete hand hygiene for infection control[PH1] . In an interview on 09/25/25 at 2:40 PM, the DON stated infection control was important during care. The DON stated during care the staff was to use the hand sanitizer or wash hands if they were physically soiled. The DON stated the staff was expected to complete hand hygiene before care and after care, he also stated during incontinent care the staff was supposed to change gloves and use hand sanitizer when taking off the dirty brief before applying the clean. The DON stated hand hygiene was to be completed for infection control[PH2] . Review of the facility policy dated 12/24 and titled Hand-Washing/Hand Hygiene reflected, The facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. h. Before moving from a contaminated body site to a clean body site during resident care. This applies to all staff working in all locations within the facility.a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of gloves use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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	12/11/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a comfortable, homelike environment, with safe temperature levels within a range of 71 to 81 degrees Fahrenheit for 1 of 6 residents (Resident #60) observed for environmental concerns. The facility failed to ensure the temperature in Resident #60's room was maintained at a safe and comfortable range on 9/23/25. The room temperature was 82 degrees Fahrenheit. This failure could place residents at risk of an uncomfortable environment and diminish their quality of life.Findings included: Record review of Resident #60's Quarterly MDS, dated [DATE] reflected an [AGE] year-old male who was admitted to the facility on [DATE], and readmitted on [DATE]. Resident #60 had diagnoses of cancer (when abnormal cells grow out of control and spread to other areas of your body), muscle weakness, and lack of coordination. Resident #60 had a BIMS score of 10, which indicated moderate cognition impairment. Record review of Resident #60's care plan dated 09/04/25 reflected, focus: [Resident#60] rights will be respected and maintained through the review date. Goal: Resident rights will be respected and maintained through the review date. Intervention/Tasks: Dignity and respect: I will have the right to: *live in safe, decent, and clean conditions *be free from abuse, neglect, and exploitation *be treated with dignity. An observation on 09/23/25 at 10:51 AM, with Resident #60 revealed he was lying in bed wearing a hospital gown, his face was damp with sweat. Resident #60 stated it was hot in his room, because the air conditioning (AC) unit under the window was not working. When asked how long the AC unit in his room was not working, he replied for the last month. He stated he reported it to the aides taking care of him but was unable to recall a name. Interview and observation on 09/23/25 at 4:00 PM, the Maintenance Director checked the temperature in Resident #60's room with a digital thermometer, the temperature was 82 degrees Fahrenheit. The Maintenance Director stated the room temperatures was supposed to be between 71 to 81 degrees Fahrenheit, or for this building to a comfortable level for the residents. The Maintenance Director attempted to turn the AC unit on and was unable. the Maintenance Director unplugged the AC unit, tested the power outlet, and stated there was no power in it. The Maintenance Director stated he will go and fix it. The Maintenance Director left the room, and came back, he plugged the AC unit and turned it on, and it started working. The Maintenance Director stated he was from another facility and was covering for the main Maintenance Director who was sick. He stated he was not aware of the AC unit not working in Resident #60's room. He stated the direct care staff should report the issue to the Maintenance Department to fix it. He did not answer the question about if there if was risk to the resident. In an interview on 09/25/25 at 12:23 PM, the DON stated he was not aware of the AC unit not functioning in Resident #60's room. He stated normally when they have that situation, they would move the resident to a different room or bring a fan until the AC unit was fixed or move the resident until the AC got fixed and move the resident back to his/her room. The DON stated the risk to residents could be skin breakdown from sweating, uncomfortable environments, and delayed in recovery from illnesses. In an interview on 09/26/25 at 5:56 PM, the Administrator stated her expectations was for all the AC units to be in working conditions in the residents' rooms. She stated the resident should be moved to another room with a working AC unit and get his/her AC unit repaired. She stated the staff was supposed to notify the Maintenance Director and enter the order on the TELS (Electronic maintenance record system) . She stated risk to residents overheating and discomfort. Record review of the facility policy titled Safe and HomeLike Environment dated 12/2024, reflected Policy: In accordance with residents' rights, the facility will provide a safe, comfortable and home like environment.Definitions. [Comfortable and safe temperature levels] means that the ambient temperature should be in a relatively narrow range that minimizes residents; susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents. 7. The facility (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	12/11/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will maintain comfortable and safe temperature levels. a. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit.