STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676276	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewest Rehabilitation and Skilled Care	2450 Bickers St Dallas, TX 75212

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents, establish policies and procedures to investigate any such allegations for two (Residents #1 and #2) of eleven residents reviewed for abuse. 1. The facility failed to implement and follow their abuse, neglect, and exploitation policy to ensure Resident #1 was safe from abuse when CNA A reported that Resident #3 was observed touching Resident #1's shoulder area of her body on 08/22/2024. 2. The facility failed to implement and follow their abuse, neglect, and exploitation policy to ensure Resident #2 was safe from abuse when CNA B reported that Resident #4 was observed using his cane to hit Resident #2 over the head on 08/19/24 or 08/20/2024. These failures could place all residents at risk for abuse and psychosocial harm. Findings include: (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Abuse, Neglect and Exploitation revised 01/08/2023, reflected, All reports of resident abuse .are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .2. The facility administrator is the Abuse Prevention Coordinator in the facility and is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . V.1. If resident abuse . is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. b. The local/state ombudsman. c. The resident's representative. d. Adult protective services .; e. Law enforcement officials. f. The resident's attending physician; and g. The facility medical director. 6. Upon receiving any allegations of abuse, the administrator is responsible for determining what actions (if any) are needed for the protection of residents . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse . In an interview with the Regional Nurse and Administrator on 08/29/2024 at 8:59 AM, the Administrator stated she was the abuse coordinator, and all allegations of abuse or suspected abuse came to her. She stated her role as the abuse coordinator was to follow the facility's abuse policy and investigate all allegations or suspicions of abuse to ensure resident safety. She said staff were trained in the facility's abuse and neglect policies regularly and the last abuse in-services was on 08/28/2024 at a staff meeting. She stated she was not aware of any resident hitting another resident with a cane or any resident touching another resident inappropriately. She stated incidents like that should be recorded for her follow up. The Regional Nurse said she had not knowledge of the incidents either. She said she was covering for the DON since she went on leave yesterday. 1. Record review of Resident #1's Face Sheet dated 08/29/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: Hypertension (high blood pressure), hyperlipidemia (high cholesterol), atherosclerotic heart disease of native coronary artery without angina pectoris (hardening of the arteries), unspecified dementia without behavioral disturbance (confusion or mild cognitive impairment), and Alzheimer's disease (brain disorder that causes memory loss, thinking problems and behavior changes). Record review of Resident #1's Initial MDS Assessment, dated 08/29/2024, reflected it was started and not completed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan dated 08/12/2024, reflected, Problem: [Resident #1] has impaired cognitive function and impaired thought processes AEB: Short Term memory deficit, Long Term memory deficit, Impaired ability to understand others, Impaired ability to make daily decisions. [Resident #1] requires assistance to perform functional abilities d/t cognitive decline d/t Alzheimer's dementia. Interventions: substantial assistance with toileting, bathing, dressing and transfers. Supervision for eating and hygiene. Record review of Resident #1's Progress Notes, dated 08/22/2024 at 6:21 PM and signed by LVN C, reflected, [Resident #1] refused to eat dinner. Asked what she would prefer as alternative but stated that was going to eat in her apartment. [RP] called and notified, spoke to resident, NP made aware. Healthy shake provided. On 08/22/2024 at 7:06 PM and signed by LVN C, reflected, [MD] in the facility, notified of poor meal intake. Stated may prescribe appetite stimulant. There was no documentation of incident, assessment, or notifications regarding CNA A's observation that Resident #3 touched Resident #1 in the shoulder area of her body. Record review of Resident #3's Face Sheet dated 08/29/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: Encephalopathy (damage or disease that affects the brain), Type 2 diabetes (affects hot the body uses sugar as fuel), acute kidney failure (kidneys stop working), end stage renal disease (kidneys not working affectively), and major depressive disorder (persistent feeling of sadness and loss of interest). Record review of Resident #3's Quarterly MDS Assessment, dated 08/20/2024, reflected, a BIMS score of 15, which indicated no cognitive impairment. He used a manual wheelchair to ambulate. He was independent of toileting, hygiene, bathing and transfers. No verbal or physical behaviors directed toward others were indicated. Record review of Resident #3's Care Plan dated 05/24/2024, reflected, Problem: [Resident #3] is at Risk for altered mood state related to history of PTSD and depression. Intervention: Psychiatry and/or psychology to follow and treat as indicated. Problem: Behavior Problem: [Resident #3] has a (sic) unwanted behaviors AEB exposing self to staff. Interventions: If behavior occurs in public place, attempt to remove resident. Record review of Resident #3's Progress Notes for August 2024, reflected no documentation of incident, assessment, or notifications regarding CNA A's observation that Resident #3 touched Resident #1 in the shoulder area of her body. An interview and observation on 08/29/2024 at 9:25 AM, with Resident #1 revealed, she felt safe in the facility and denied anyone in the facility touched her inappropriately. She could not recall an interaction with Resident #3. She said if anyone touched her in a bad way, she would punch them and tell the nurses. Resident #1 was observed standing beside her bed, arranging the bedding during interview. When asked if she should be standing on her own or required assistance, she said she could walk on her own. She answered questions coherently and sat in her wheelchair when staff entered the room and reminded her to sit in her wheelchair. In an interview on 08/29/2024 at 4:45 PM, Resident #3 denied touching any resident inappropriately. He said he did not know Resident #1 and did not want to answer any more questions. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 10:52 AM, CNA A stated she saw Resident #3 in the television area, in his wheelchair, behind Resident #1 on the evening of 08/22/2024. She said Resident #1 was in her wheelchair and Resident #3 was whispering in her ear and rubbing her shoulder. CNA A said she did not intervene becasue Resident #4 did not touch Resident #1's breast area but she felt uncomfortable about seeing it because Resident #3 had some history of making inappropriate comments to staff. She denied Resident #3 made comments to her. She said she was not sure if Resident #1 was uncomfotable and did not ask her. She said she let LVN C know, and he told her he saw it too. She said LVN C went to see what was going on. She said she did not speak to Resident #1 or Resident #3 about it. She said she did not hear anything more about it that evening. CNA A said she told LVN D, and the Administrator what she saw, the next morning. CNA A said when she told the Administrator, the Administrator said, she would take care of it. CNA A said she knew the abuse policy and reported what she had seen. She said it did not seem like anyone addressed it. In an interview on 08/29/2024 at 11:06 AM, LVN D said CNA A told her she saw Resident #3 rub Resident #1's shoulder the evening before and it made CNA A her feel uncomfortable. She said CNA A told her that she told LVN C when it happened. LVN D said CNA A showed her how Resident #3 touched Resident #1 and she told her to talk to the DON. LVN D said she did not tell the Administrator but did tell the DON and ADON I. She stated Resident #1 did have an issue, in June or July 2024, with dialysis center nurses. LVN D said Resident #1 was asked to leave the dialysis center when he exposed himself to the nurses there. In a telephone interview on 08/29/2024 at 12:05 PM, LVN C stated he was at the nurses' station in the evening of 08/22/2024 when CNA A told him Resident #3 was rubbing Resident #1's shoulder while he was behind her in the television area. He said when he looked up, he saw the two Residents talking, Resident #3 had his hand on the handles of Resident #1's wheelchair. He said he did not have the same concern about Resident #3 and #1's interaction and did not think it was sexually suggestive at all. He said he did not see what CNA A reported to him. He said he did not inform the Administrator / Abuse Coordinator about the incident but should have so they could follow up appropriately. He said he did not follow the facility's Abuse Policy. LVN C stated the MD came in to see Resident #1 a few minutes after and he informed the MD of Resident #1's confusion and not eating but did not tell the MD about the incident CNA A reported to him. LVN C said Resident #3 did have an incident at the dialysis center where he exposed himself to the nurses. He said when that occurred, they changed his medication and there had not been any incidents since. 2. Record review of Resident #2's Face Sheet dated 08/29/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: chronic kidney disease (gradual loss of kidney function), major depressive disorder (persistent feeling of sadness and loss of interest), and unspecified dementia, severe, with other behavior disorder (loss of cognitive functioning, thinking, remembering, reasoning to an extent it interferes with daily living). Record review of Resident #2's Quarterly MDS Assessment, dated 07/29/2024, reflected a BIMS score of 99 which indicated he was unable to complete the assessment. Staff assessment of mental status indicated short- and long-term memory problems. Cognitive skills for daily decision making indicated moderately impaired. He required moderate assistance for hygiene, toileting, bathing and transfers. No verbal or physical behaviors directed toward others were indicated. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Care Plan dated 01/26/2024 - Present, reflected, Problem: [Resident #2] has delirium or an acute confusional episodes, aggressive behaviors, AEB new behaviors that are different from my usual functioning r/t: hx of MDD, schizophrenia. Interventions: Redirect and provide gentle reality orientation as required. Reorient to person, place, time, situation as required. Problem: [Resident #2] has impaired cognitive function and impaired thought processes AEB: impaired ability to understand others, impaired ability to make daily decisions. Problem: [Resident #1] extensive assistance for requires assistance to perform functional abilities in Self Care and Mobility AEB weakness, decrease in ADL's, uses w/c for mobility. Record review of Resident #2's Progress Notes for August 2024, reflected no documentation of incident, assessment, or notifications regarding CNA B's observation of Resident #2 hit on the head with a cane by Resident #4. Record review of Resident #4's Face Sheet dated 08/29/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: unspecified parkinsonism (disease that impacts movement), dementia, moderate, with agitation (loss of cognitive functioning, thinking, remembering, reasoning to an extent it interferes with daily living), type 2 diabetes (affects hot the body uses sugar as fuel), chronic kidney disease (gradual loss of kidney function). Record review of Resident #4's Quarterly MDS Assessment, dated 08/08/2024, reflected a BIMS score 9 which indicated moderate cognitive impairment. Behavior indicated verbal behavior symptoms directed toward others and often refused care. Functional abilities included set up assistance for eating, hygiene, toileting and bathing. He was independent for transfers. He required moderate assistance for hygiene, toileting, bathing and transfers. No verbal or physical behaviors directed toward others were indicated. Record review of Resident #4's Care Plan dated 10/05/2024 - Present, reflected, Problem: [Resident #4] has an ADL self-care performance deficit r/t impaired balance, uses w/c for mobility, and walks with w/c for stability. Intervention: [Resident #4] is able to: walk with a cane. Problem: Risk of altered mood state, [Resident #4] will get mad at staff and refuse services and tell them to get out of his room. Problem: [Resident #4] has been physically aggressive with staff. Intervention: Monitor/document/report PRN any s/sx of resident posing danger to self and others. Problem: [Resident #4] hoards items in their room and will become upset when others attempts to remove items from the room. [Resident #4] hoards specific items meal tickets and places on air condition, boxes with papers at bedside. Intervention: If [resident #4] becomes confrontational or upset allow them time to calm down and explain in a kind compassionate manner why we need to clean the room. Record review of Resident #4's Progress Notes for August 2024, reflected no documentation of incident, assessment, or notifications regarding CNA B's observation that Resident #2 was hit on the head with a cane by Resident #4. An interview and observation on 08/29/2024 at 9:44 AM, with Resident #2, revealed he did not know if anyone hit him with a cane. This surveyor asked him if he was afraid of anyone, Resident #2 seemed to understand the question but did not answer. He was observed in bed, no marks or bruises were observed on the visible parts of his body (arms or head). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation on 08/29/2024 at 10:10 AM, with Resident #4, revealed, he denied hitting anyone with his cane when they came into his room. He said he used his wheelchair to get around the facility but always pushed it. He said he did use a cane to walk when in his room. Resident #4 was observed sitting on his bed. His cane was hooked on the handle of the wheelchair at the end of his bed. A pile of meal tickets was observed on the window ledge. Resident #4 said he collected them and did not like anyone toughing his things. In an interview on 08/29/2024 at 11:57 AM, CNA B stated about a week ago, she heard a lot of yelling come from Resident #4's room, she said she went to the room where she saw Resident #4 hitting Resident #2 on the head with his cane. She said she got between the Residents and then took Resident #2 out of the room. She said other staff came to the hall and took Resident #2 back to his Hall. She said she did not know who the other staff were. She said she did not see any blood on Resident #2's head. She said she reported what she saw to the ADONs, the Administrator, and wrote a statement before leaving her shift for the day. In an interview on 08/29/24 at 1:07 PM, LVN E stated she was getting report from the day shift nurse when they heard yelling from the hall. She said she looked down the hall and saw an aide coming out of the room pushing Resident #2 in his wheelchair. She stated she went to the room and CNA B told her Resident #4 was hitting Resident #2. She said the Administrator and DON were also in the hall. She stated she did not do an incident report because her visual assessment did not reveal any injury on either resident. She said she did not see any blood. She said she did not hear anything further about the incident. In a telephone interview on 08/29/2024 at 1:30 PM, Resident #2's family member said he had no knowledge of Resident #2 being hit or in any altercation at the facility. In an interview on 08/29/2024 at 2:43 PM, LVN F stated on either 08/19/2024 or 08/20/2024 she heard a commotion and when she looked, Resident #2 was being pushed in his wheelchair out of Resident #4's hall. She said she was told Resident #2 had wondered into Resident #4's room. She said she did not see any incident and did not see or speak to CNA B about it. She stated no one told her Resident #4 hit Resident #2. She said she thought it was just a verbal altercation. In an interview on 08/29/2024 at 5:49 PM, LVN G stated she was at the nurses' station when she saw an aide pushing Resident #2 back to his hall. She stated she did not know what happened and was not told about the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 11:27 AM, with ADONs H and I, ADON I stated LVN C told her on the morning of 08/23/2024 that CNA A reported to LVN C that Resident #3 touched and rubbed Resident #1's the evening before on 08/22/2024. ADON H said she had no knowledge of the incident. ADON I said LVN D said the DON was aware and was going to follow up with CNA A. ADON I said she spoke to the DON who told her the Administrator already knew about the incident, so she did not report it to the Administrator / Abuse Coordinator. ADON I said she never followed up because she assumed the DON was handling it. ADON I said the incident should be addressed because Resident #3 was known to have made sexual comments to facility staff and was refused treatment at a dialysis center after exposing himself to the nurses there. She said they want to ensure the resident was safe and investigate the situation. ADON H and I said they did not know of any incident where Resident #4 hit Resident #2 on the head with his cane. ADON I said she was in her office when she heard yelling and went to the nurses station, she could not recall the day. She stated staff told her Resident #2 had wandered into Resident #4's room. She stated she did not see anything that occurred in the room but saw staff escort Resident #2, in his wheelchair, back to his hall. In a telephone interview on 08/29/2024 at 12:49 PM, the DON stated she was made aware of an incident where Resident #3 touched Resident #1 on her shoulder the next morning. She said she discussed it with the Administrator at their Stand-up Meeting, to determine what to do. She said she did not recall the day it occurred. She said she spoke to Resident #1, and she denied she was touched in an inappropriate way. She said Resident #3 also denied the incident. She said she expected to be notified of the situation when it occurred so she could ensure residents were safe until she was able to gather more information. She said she would not expect an incident report to be done because there was no harm but did expect some type of documentation in the progress notes. She said she did get statement from CNA A and said the Administrator would have it. The DON said she was informed that Resident #2 was at the entry of Resident #4's room and Resident #4 was yelling at him to leave, sometime last week. She said she was in the facility when it occurred did not speak to CNA B about what she saw. She said the Administrator was also aware of the incident because she came out of her office when we heard the yelling. She said she did not know if either resident was harmed and did not know of any physical altercation between the two residents. She said she would expect the residents be assessed and the assessment be documented. She said she did not implement the facility's Abuse Policy to ensure safety, assess for harm or investigate either incident because she did not feel that abuse occurred. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 1:53 PM, the Administrator stated she heard yelling in the hall and came out of her office to see what was going on. She said she observed staff taking Resident #2 to his hall from Resident #4's hall. She said staff told her Resident #4 threatened Resident #2 but there was no physical contact. She said she did not talk to CNA B, who separated the residents, or interview anyone about the incident. She said an incident report would not be required since there was no physical contact. When asked how she knew if there was or was not physical contact if she did not interview CNA B, she said she would not know. When asked how she kept the resindets safe from abuse, she said the information she had was not physical so the resindets were safe from abuse. The Administrator said CNA A did tell her that Resident #3 touched Resident #1 on the shoulder but not he breast area. She said CNA A said this occurred the evening before it was reported to her. The Administrator said both CNA A and LVN C did not call her about the incident immediately. She said she did speak to Resident #1 on 08/23/24 and she denied being touched inappropriately. The Administrator said Resident #3 denied the incident as well. She said she did not feel abuse occurred, so she did not document any of it. When asked about statements from CNA A and CNA B, she denied having and statements from staff regarding the incidents. She said her role as the abuse coordinator was to follow the facility's abuse prevention policy and investigate all allegations of abuse or suspected abuse. She said she did not feel either of these incidents constituted abuse and therefore did not investigate them. She said staff should have informed her immediately so she could assess the information for resident safety. In an interview on 08/24/2024 at 1:59 PM, the Regional Nurse stated she expected all allegations of abuse or suspected abuse to be investigated. She said any suspected abuse should be reported to the Abuse Coordinator immediately. She said it was important to follow the policy to ensure all residents were kept safe while any suspected abuse allegation was investigated. She said the DON and Administrator did not follow the facility's Abuse Policy because there was no investigation and no documentation of an investigation on file or that any incident occurred or that residents were assessed. Record review of the facility's incident report log reflected no incidents logged on 08/22/2024 that involved Residents #1 or #3. There were no incidents logged on in August 2024 that involved Residents #2 or #4. Record review of the facility's in-service record reflected and in-service titled, Abuse and Neglect, dated 08/28/2024 was administered by ADON H. Staff signatures included CNAs A and B, and LVNs C, D, and E.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress for two (Residents #1 and #2) of eleven residents reviewed for abuse. 1. The facility failed to investigate the alleged or suspected abuse of Resident #1 to ensure all resident's safety, when CNA A reported that Resident #3 was observed touching Resident #1's shoulder area of her body. 2. The facility failed to investigate the alleged or suspected abuse of Resident #2 to ensure all resident's safety, when CNA B reported that Resident #4 was observed using his cane to hit Resident #2 over the head. These failures could place all residents at risk for abuse and psychosocial harm. Findings include: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Abuse, Neglect and Exploitation revised 01/08/2023, reflected, All reports of resident abuse . are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .VI. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse . or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: I. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. 7. All allegations are thoroughly investigated. The administrator initiates investigations. 8. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. 9. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. a. Any evidence that may be needed for a criminal investigation is sealed, labeled, and prevented from tampering or destruction. 10. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation. 11. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility 13. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents. d. interviews the person(s) reporting the incident. e. interviews any witnesses to the incident. f. interviews the resident (as medically appropriate) or the resident's representative. g. interviews the resident's attending physician as needed to determine the resident's condition. h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. i. interviews the resident's roommate, family members, and visitors. j. interviews other residents to whom the accused employee provides care or services. k. reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly . In an interview with the Regional Nurse and Administrator on 08/29/2024 at 8:59 AM, the Administrator stated she was the abuse coordinator, and all allegations of abuse or suspected abuse came to her. She stated her role as the abuse coordinator was to follow the facility's abuse policy and investigate all allegations or suspicions of abuse to ensure resident safety. She said staff were trained in the facility's abuse and neglect policies regularly and the last abuse in-services was on 08/28/2024 at a staff meeting. She stated she was not aware of any resident hitting another resident with a cane or any resident touching another resident inappropriately. She stated incidents like that should be recorded for her follow up. The Regional Nurse said she had not knowledge of the incidents either. She said she was covering for the DON since she went on leave yesterday. 1. Record review of Resident #1's Face Sheet dated 08/29/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: Hypertension (high blood pressure), hyperlipidemia (high cholesterol), atherosclerotic heart disease of native coronary artery without angina pectoris (hardening of the arteries), unspecified dementia without behavioral disturbance (confusion or mild cognitive impairment), and Alzheimer's disease (brain disorder that causes memory loss, thinking problems and behavior changes). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676276	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewest Rehabilitation and Skilled Care	2450 Bickers St Dallas, TX 75212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Initial MDS Assessment, dated 08/29/2024, reflected it was started and not completed. Record review of Resident #1's Care Plan dated 08/12/2024, reflected, Problem: [Resident #1] has impaired cognitive function and impaired thought processes AEB: Short Term memory deficit, Long Term memory deficit, Impaired ability to understand others, Impaired ability to make daily decisions. [Resident #1] requires assistance to perform functional abilities d/t cognitive decline d/t Alzheimer's dementia. Interventions: substantial assistance with toileting, bathing, dressing and transfers. Supervision for eating and hygiene. Record review of Resident #1's Progress Notes, dated 08/22/2024 at 6:21 PM and signed by LVN C, reflected, [Resident #1] refused to eat dinner. Asked what she would prefer as alternative but stated that was going to eat in her apartment. [RP] called and notified, spoke to resident, NP made aware. Healthy shake provided. On 08/22/2024 at 7:06 PM and signed by LVN C, reflected, [MD] in the facility, notified of poor meal intake. Stated may prescribe appetite stimulant. There was no documentation of incident, assessment, or notifications regarding CNA A's observation that Resident #3 touched Resident #1 in the shoulder area of her body. Record review of Resident #3's Face Sheet dated 08/29/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: Encephalopathy (damage or disease that affects the brain), Type 2 diabetes (affects hot the body uses sugar as fuel), acute kidney failure (kidneys stop working), end stage renal disease (kidneys not working affectively), and major depressive disorder (persistent feeling of sadness and loss of interest). Record review of Resident #3's Quarterly MDS Assessment, dated 08/20/2024, reflected, a BIMS score of 15, which indicated no cognitive impairment. He used a manual wheelchair to ambulate. He was independent of toileting, hygiene, bathing and transfers. No verbal or physical behaviors directed toward others were indicated. Record review of Resident #3's Care Plan dated 05/24/2024, reflected, Problem: [Resident #3] is at Risk for altered mood state related to history of PTSD and depression. Intervention: Psychiatry and/or psychology to follow and treat as indicated. Problem: Behavior Problem: [Resident #3] has a (sic) unwanted behaviors AEB exposing self to staff. Interventions: If behavior occurs in public place, attempt to remove resident. Record review of Resident #3's Progress Notes for August 2024, reflected no documentation of incident, assessment, or notifications regarding CNA A's observation that Resident #3 touched Resident #1 in the shoulder area of her body. An interview and observation on 08/29/2024 at 9:25 AM, with Resident #1 revealed, she felt safe in the facility and denied anyone in the facility touched her inappropriately. She could not recall an interaction with Resident #3. She said if anyone touched her in a bad way, she would punch them and tell the nurses. Resident #1 was observed standing beside her bed, arranging the bedding during interview. When asked if she should be standing on her own or required assistance, she said she could walk on her own. She answered questions coherently and sat in her wheelchair when staff entered the room and reminded her to sit in her wheelchair. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 4:45 PM, Resident #3 denied touching any resident inappropriately. He said he did not know Resident #1 and did not want to answer any more questions. In an interview on 08/29/2024 at 10:52 AM, CNA A stated she saw Resident #3 in the television area, in his wheelchair, behind Resident #1 on the evening of 08/22/2024. She said Resident #1 was in her wheelchair and Resident #3 was whispering in her ear and rubbing her shoulder. CNA A said she did not intervene becasue Resident #4 did not touch Resident #1's breast area but she felt uncomfortable about seeing it because Resident #3 had some history of making inappropriate comments to staff. She denied Resident #3 made comments to her. She said she was not sure if Resident #1 was uncomfotable and did not ask her. She said she let LVN C know, and he told her he saw it too. She said LVN C went to see what was going on. She said she did not speak to Resident #1 or Resident #3 about it. She said she did not hear anything more about it that evening. CNA A said she told LVN D, and the Administrator what she saw, the next morning. CNA A said when she told the Administrator, the Administrator said, she would take care of it. CNA A said she knew the abuse policy and reported what she had seen. She said it did not seem like anyone addressed it. In an interview on 08/29/2024 at 11:06 AM, LVN D said CNA A told her she saw Resident #3 rub Resident #1's shoulder the evening before and it made CNA A her feel uncomfortable. She said CNA A told her that she told LVN C when it happened. LVN D said CNA A showed her how Resident #3 touched Resident #1 and she told her to talk to the DON. LVN D said she did not tell the Administrator but did tell the DON and ADON I. She stated Resident #1 did have an issue, in June or July 2024, with dialysis center nurses. LVN D said Resident #1 was asked to leave the dialysis center when he exposed himself to the nurses there. In a telephone interview on 08/29/2024 at 12:05 PM, LVN C stated he was at the nurses' station in the evening of 08/22/2024 when CNA A told him Resident #3 was rubbing Resident #1's shoulder while he was behind her in the television area. He said when he looked up, he saw the two Residents talking, Resident #3 had his hand on the handles of Resident #1's wheelchair. He said he did not have the same concern about Resident #3 and #1's interaction and did not think it was sexually suggestive at all. He said he did not see what CNA A reported to him. He said he did not inform the Administrator / Abuse Coordinator about the incident but should have so they could follow up appropriately. He said he did not follow the facility's Abuse Policy. LVN C stated the MD came in to see Resident #1 a few minutes after and he informed the MD of Resident #1's confusion and not eating but did not tell the MD about the incident CNA A reported to him. LVN C said Resident #3 did have an incident at the dialysis center where he exposed himself to the nurses. He said when that occurred, they changed his medication and there had not been any incidents since. 2. Record review of Resident #2's Face Sheet dated 08/29/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: chronic kidney disease (gradual loss of kidney function), major depressive disorder (persistent feeling of sadness and loss of interest), and unspecified dementia, severe, with other behavior disorder (loss of cognitive functioning, thinking, remembering, reasoning to an extent it interferes with daily living). Record review of Resident #2's Quarterly MDS Assessment, dated 07/29/2024, reflected a BIMS score of 99 which indicated he was unable to complete the assessment. Staff assessment of mental status indicated short- and long-term memory problems. Cognitive skills for daily decision making indicated moderately impaired. He required moderate assistance for hygiene, toileting, bathing and transfers. No verbal or physical behaviors directed toward others were indicated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Care Plan dated 01/26/2024 - Present, reflected, Problem: [Resident #2] has delirium or an acute confusional episodes, aggressive behaviors, AEB new behaviors that are different from my usual functioning r/t: hx of MDD, schizophrenia. Interventions: Redirect and provide gentle reality orientation as required. Reorient to person, place, time, situation as required. Problem: [Resident #2] has impaired cognitive function and impaired thought processes AEB: impaired ability to understand others, impaired ability to make daily decisions. Problem: [Resident #1] extensive assistance for requires assistance to perform functional abilities in Self Care and Mobility AEB weakness, decrease in ADL's, uses w/c for mobility. Record review of Resident #2's Progress Notes for August 2024, reflected no documentation of incident, assessment, or notifications regarding CNA B's observation of Resident #2 hit on the head with a cane by Resident #4. Record review of Resident #4's Face Sheet dated 08/29/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: unspecified parkinsonism (disease that impacts movement), dementia, moderate, with agitation (loss of cognitive functioning, thinking, remembering, reasoning to an extent it interferes with daily living), type 2 diabetes (affects hot the body uses sugar as fuel), chronic kidney disease (gradual loss of kidney function). Record review of Resident #4's Quarterly MDS Assessment, dated 08/08/2024, reflected a BIMS score 9 which indicated moderate cognitive impairment. Behavior indicated verbal behavior symptoms directed toward others and often refused care. Functional abilities included set up assistance for eating, hygiene, toileting and bathing. He was independent for transfers. He required moderate assistance for hygiene, toileting, bathing and transfers. No verbal or physical behaviors directed toward others were indicated. Record review of Resident #4's Care Plan dated 10/05/2024 - Present, reflected, Problem: [Resident #4] has an ADL self-care performance deficit r/t impaired balance, uses w/c for mobility, and walks with w/c for stability. Intervention: [Resident #4] is able to: walk with a cane. Problem: Risk of altered mood state, [Resident #4] will get mad at staff and refuse services and tell them to get out of his room. Problem: [Resident #4] has been physically aggressive with staff. Intervention: Monitor/document/report PRN any s/sx of resident posing danger to self and others. Problem: [Resident #4] hoards items in their room and will become upset when others attempts to remove items from the room. [Resident #4] hoards specific items meal tickets and places on air condition, boxes with papers at bedside. Intervention: If [resident #4] becomes confrontational or upset allow them time to calm down and explain in a kind compassionate manner why we need to clean the room. Record review of Resident #4's Progress Notes for August 2024, reflected no documentation of incident, assessment, or notifications regarding CNA B's observation that Resident #2 was hit on the head with a cane by Resident #4. An interview and observation on 08/29/2024 at 9:44 AM, with Resident #2, revealed he did not know if anyone hit him with a cane. This surveyor asked him if he was afraid of anyone, Resident #2 seemed to understand the question but did not answer. He was observed in bed, no marks or bruises were observed on the visible parts of his body (arms or head). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation on 08/29/2024 at 10:10 AM, with Resident #4, revealed, he denied hitting anyone with his cane when they came into his room. He said he used his wheelchair to get around the facility but always pushed it. He said he did use a cane to walk when in his room. Resident #4 was observed sitting on his bed. His cane was hooked on the handle of the wheelchair at the end of his bed. A pile of meal tickets was observed on the window ledge. Resident #4 said he collected them and did not like anyone toughing his things. In an interview on 08/29/2024 at 11:57 AM, CNA B stated about a week ago, she heard a lot of yelling come from Resident #4's room, she said she went to the room where she saw Resident #4 hitting Resident #2 on the head with his cane. She said she got between the Residents and then took Resident #2 out of the room. She said other staff came to the hall and took Resident #2 back to his Hall. She said she did not know who the other staff were. She said she did not see any blood on Resident #2's head. She said she reported what she saw to the ADONs, the Administrator, and wrote a statement before leaving her shift for the day. In an interview on 08/29/24 at 1:07 PM, LVN E stated she was getting report from the day shift nurse when they heard yelling from the hall. She said she looked down the hall and saw an aide coming out of the room pushing Resident #2 in his wheelchair. She stated she went to the room and CNA B told her Resident #4 was hitting Resident #2. She said the Administrator and DON were also in the hall. She stated she did not do an incident report because her visual assessment did not reveal any injury on either resident. She said she did not see any blood. She said she did not hear anything further about the incident. In a telephone interview on 08/29/2024 at 1:30 PM, Resident #2's family member said he had no knowledge of Resident #2 being hit or in any altercation at the facility. In an interview on 08/29/2024 at 2:43 PM, LVN F stated on either 08/19/2024 or 08/20/2024 she heard a commotion and when she looked, Resident #2 was being pushed in his wheelchair out of Resident #4's hall. She said she was told Resident #2 had wondered into Resident #4's room. She said she did not see any incident and did not see or speak to CNA B about it. She stated no one told her Resident #4 hit Resident #2. She said she thought it was just a verbal altercation. In an interview on 08/29/2024 at 5:49 PM, LVN G stated she was at the nurses' station when she saw an aide pushing Resident #2 back to his hall. She stated she did not know what happened and was not told about the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 11:27 AM, with ADONs H and I, ADON I stated LVN C told her on the morning of 08/23/2024 that CNA A reported to LVN C that Resident #3 touched and rubbed Resident #1's the evening before on 08/22/2024. ADON H said she had no knowledge of the incident. ADON I said LVN D said the DON was aware and was going to follow up with CNA A. ADON I said she spoke to the DON who told her the Administrator already knew about the incident, so she did not report it to the Administrator / Abuse Coordinator. ADON I said she never followed up because she assumed the DON was handling it. ADON I said the incident should be addressed because Resident #3 was known to have made sexual comments to facility staff and was refused treatment at a dialysis center after exposing himself to the nurses there. She said they want to ensure the resident was safe and investigate the situation. ADON H and I said they did not know of any incident where Resident #4 hit Resident #2 on the head with his cane. ADON I said she was in her office when she heard yelling and went to the nurses station, she could not recall the day. She stated staff told her Resident #2 had wandered into Resident #4's room. She stated she did not see anything that occurred in the room but saw staff escort Resident #2, in his wheelchair, back to his hall. In a telephone interview on 08/29/2024 at 12:49 PM, the DON stated she was made aware of an incident where Resident #3 touched Resident #1 on her shoulder the next morning. She said she discussed it with the Administrator at their Stand-up Meeting, to determine what to do. She said she did not recall the day it occurred. She said she spoke to Resident #1, and she denied she was touched in an inappropriate way. She said Resident #3 also denied the incident. She said she expected to be notified of the situation when it occurred so she could ensure residents were safe until she was able to gather more information. She said she would not expect an incident report to be done because there was no harm but did expect some type of documentation in the progress notes. She said she did get statement from CNA A and said the Administrator would have it. The DON said she was informed that Resident #2 was at the entry of Resident #4's room and Resident #4 was yelling at him to leave, sometime last week. She said she was in the facility when it occurred did not speak to CNA B about what she saw. She said the Administrator was also aware of the incident because she came out of her office when we heard the yelling. She said she did not know if either resident was harmed and did not know of any physical altercation between the two residents. She said she would expect the residents be assessed and the assessment be documented. She said she did not implement the facility's Abuse Policy to ensure safety, assess for harm or investigate either incident because she did not feel that abuse occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 1:53 PM, the Administrator stated she heard yelling in the hall and came out of her office to see what was going on. She said she observed staff taking Resident #2 to his hall from Resident #4's hall. She said staff told her Resident #4 threatened Resident #2 but there was no physical contact. She said she did not talk to CNA B, who separated the residents, or interview anyone about the incident. She said an incident report would not be required since there was no physical contact. When asked how she knew if there was or was not physical contact if she did not interview CNA B, she said she would not know. When asked how she kept the resindets safe from abuse, she said the information she had was not physical so the resindets were safe from abuse. The Administrator said CNA A did tell her that Resident #3 touched Resident #1 on the shoulder but not he breast area. She said CNA A said this occurred the evening before it was reported to her. The Administrator said both CNA A and LVN C did not call her about the incident immediately. She said she did speak to Resident #1 on 08/23/24 and she denied being touched inappropriately. The Administrator said Resident #3 denied the incident as well. She said she did not feel abuse occurred, so she did not document any of it. When asked about statements from CNA A and CNA B, she denied having and statements from staff regarding the incidents. She said her role as the abuse coordinator was to follow the facility's abuse prevention policy and investigate all allegations of abuse or suspected abuse. She said she did not feel either of these incidents constituted abuse and therefore did not investigate them. She said staff should have informed her immediately so she could assess the information for resident safety. In an interview on 08/24/2024 at 1:59 PM, the Regional Nurse stated she expected all allegations of abuse or suspected abuse to be investigated. She said any suspected abuse should be reported to the Abuse Coordinator immediately. She said it was important to follow the policy to ensure all residents were kept safe while any suspected abuse allegation was investigated. She said the DON and Administrator did not follow the facility's Abuse Policy because there was no investigation and no documentation of an investigation on file or that any incident occurred or that residents were assessed. Record review of the facility's incident report log reflected no incidents logged on 08/22/2024 that involved Residents #1 or #3. There were no incidents logged on in August 2024 that involved Residents #2 or #4. Record review of the facility's in-service record reflected and in-service titled, Abuse and Neglect, dated 08/28/2024 was administered by ADON H. Staff signatures included CNAs A and B, and LVNs C, D, and E.