

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Lakewest Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49837</p> <p>Based on interview and record review, the facility failed to ensure residents were free from abuse for one (Resident #1) of four residents reviewed for abuse.</p> <p>The facility failed to protect Resident #1 from physical and verbal abuse by CMA C. On 09/18/24 at 7:30 PM, CMA C threw a pitcher of water at Resident #1 which caused him to get wet. CMA C also used profanity at Resident #1.</p> <p>The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 09/18/24 at 7:30 PM and ended on 09/30/24. The facility had corrected the noncompliance before the Incident investigation began on 02/24/25.</p> <p>This failure could place residents at risk for serious injury or harm.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 02/24/25, revealed Resident #1 was a [AGE] year-old male, with original admitted [DATE] with diagnoses that included: Aphasia , Dysarthria (difficult or unclear articulation of speech), Hemiplegia (paralysis of one side of the body), Bipolar disorder, Major depressive disorder, and Unsteadiness on feet.</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 15 (indicating intact cognition). The MDS reflected Resident #1 was independent for ADL for eating, toileting, personal and oral hygiene. Further review of the MDS assessment revealed Resident #1 did not exhibit any behaviors.</p> <p>Record review of Resident #1's care plan, dated on 09/25/24, reflected the following: Focus [Resident #1] required assistance to perform functional abilities in Self Care and Mobility AEB. Resident has unsafe or poor quality in functional range of motion upper or lower, right, and left extremities. Interventions: Provide the following Self Care assistance: Independent, Setup, Supervision/Touching, Partial/Moderate, Substantial/Maximal, Dependent. Provide the following Mobility Assistance: Independent, Setup, Supervision/Touching, Partial/Moderate, Substantial/Maximal, Dependent.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Provider Investigation Report (PIR) dated 09/18/24 reflected that, the facility self-reported an allegation of abuse by CMA C. The PIR reflected Resident #1 alleged that CMA C threw his water pitcher on him after he refused to take his medication. The document reflected that he stated when CMA C walked out his room, Resident #1 threw the water pitcher at CMA C and then got up. The documentation reflected CMA C turned around and threw water on Resident #1 that CMA C had in the cup she held. The documentation reflected Resident #1 tried to get at CMA C and slipped in the water. The documentation further reflected Resident #1 and CMA C exchanged words and staff came to get CMA C.</p> <p>In an attempted phone interview on 02/24/25 at 10:00 AM with Resident #1, Resident #1 did not answer, and his voicemail was not setup for a message to be left.</p> <p>In an interview on 02/24/25 at 10:41 AM with Resident #2, with a BIMS score of 15 (indicating intact cognition), revealed he heard commotion coming from across the hall. He stated he had a clear view of Resident #1's room. He stated he did not know why Resident #1 was mad but saw him throw a cup at CMA C. Resident #2 stated he heard Resident #1 using profanity towards CMA C Resident #2 stated he heard CMA C use profanity when she told Resident #1 to quit messing with her. He stated he did not hear CMA C call Resident #1 out his name. He stated Resident #1 and CMA C were hollering and screaming at each other; however, he could not make all out of what they said.</p> <p>In an interview on 02/24/25 at 11:28 AM, Resident #3, with a BIMS of 15 (indicating intact cognition), revealed he heard hollering coming from the hallway. He stated he was unable to make out they were saying, but he clearly heard Resident #1 hollering and arguing with CMA C. He stated he did not see the altercation between the two.</p> <p>In an interview on 02/24/25 at 11:58 AM, CNA A revealed she was outside with Resident #1 while he smoked. She stated she noticed his balance seemed off, so she escorted him to his room. She stated as she left the room, she encountered a FM, and they began to talk. She stated their backs were facing away from Resident #1's room. She stated they heard commotion and turned around. CNA A stated when she turned around, she saw CMA C pouring water into a cup. She stated CMA C then walked into Resident #1's room, dashed water and came back out. She stated she then heard Resident #1 using profanity at CMA C. CNA A stated she went into Resident #1 room and observed him sitting on the bed upset. She stated she observed a plastic cup and a little water on the floor. She stated she also observed that on Resident #1 was wet and so was his bed. CNA A stated Resident #1 told her that CMA C threw water on him. CNA A stated Resident #1 was upset and tried to get up and go after CMA C, saying he was going to get her. She stated she tried to calm him down and to get him to sit down, but he would not. She stated he was very unsteady on his feet. She stated she tried several times to get him to calm down, but she could not. She stated Resident #1 made his way out into the hallway, trying to go after CMA C. Resident #1 was telling CMA C that he was going to get her while calling her bad names. She stated CMA C was antagonizing Resident #1 saying come on, come on. She stated both Resident #1 and CMA C were both upset and screaming and hollering at each other. She stated she and the FM tried to keep Resident #1 and CMA C apart, but they kept going after each other. She stated she and the FM screamed for help and tried to place a med cart in between Resident #1 and CMA C, but Resident #1 continued to go after CMA C. She stated Resident #1 was very unsteady on his feet fell to the floor. She stated Resident #1 was able to get back up but continued to go after CMA C. CNA A stated at that time, more staff arrived and got the situation under control.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/24/25 at 12:30 PM, a FM revealed that she was in her son's room visiting him when she heard commotion. She stated the commotion was not friendly, but rather raised voice. She stated she heard screaming, hollering and profanity coming from the hallway. The FM stated she stepped outside the room and was able to see directly into Resident #1's room because it was across the hall from her son's room. The FM stated she saw a little cup/plastic cup and a little water on the floor of Resident #1's room. She stated she also saw CMA C pick up a water pitcher off the nurse's cart. She stated CMA C walked into the doorway of Resident #1's room and slung the pitcher of water at him. She stated she saw that he was wet as well as his hair. She stated Resident #1 got up and attempted to go after CMA C. She stated he was very unstable on his feet. She stated Resident #1 was using profanity at CMA C and kept saying he was going to knock her out. She stated CMA C was telling Resident #1 to come on, come on and antagonizing him. She stated the situation was very chaotic. She stated she and CNA A pushed the nurse's cart sideway to prevent Resident #1 from getting at CMA C. She stated she yelled and called out for help as she tried to keep Resident #1 from going after CMA C. The FM stated LVN E showed up and told CMA C to get her things and leave, but CMA C would not leave and continued to engage with Resident #1. She stated Resident #1 kept sliding and slid to the floor. She stated Resident #1 got up and continued going after CMA C. She stated CMA C eventually left and the situation calmed down. She stated staff addressed Resident #1 while she believed LVN E contacted the Administrator.</p> <p>In an interview on 02/24/25 with Resident #1 revealed CMA C chugged a pitcher of water on him when he was in his room, and it upset him. Resident #1 revealed that CMA C brought him a tray of food. He stated he told CMA C that he did not want to eat. He stated CMA C told him he was going to eat the food. He stated she then threw food at him and chugged a pitcher of water on him. He stated his shirt and bed was wet. He stated CMA C got mad and was using profanity at him. He stated he told her to leave his room. Resident #1 stated he could not remember anything else.</p> <p>In an interview on 02/24/25 at 1:11PM, CMA C revealed she had worked at the facility for a year and a half prior to Resident #'s admittance to the facility. She revealed that during Resident #1's time at the facility, he was angry and combative towards her and other staff. She initially stated that she did not remember the incident because she had put it behind her. She then stated she remembered handing Resident #1 his pills. She stated Resident #1 complained that his head hurt. She stated she asked him if he was going to take his medication, but he kept saying that he had a headache. She stated she told Resident #1 that she would let his nurse know, but Resident #1 was not happy with her response. She stated she asked him again if he was going to take his meds, and that was when he slapped the pills out her hand. She stated as she started to walk out the room, Resident #1 threw water on her. She stated she was soaking and wet. She stated as she continued out the room, Resident #1 came at her full force. She stated she headed to the med cart to get her purse and saw Resident #1 still coming at her. She stated she picked up her personal cup and held it as weapon to protect herself. She stated Resident #1 continued to come at her, so she kept the cup close to her. CMA C denied she threw anything at Resident #1. She stated she never threw anything at Resident #1 because she never even had time to take lid off to throw anything at him. CMA C stated she received a call from the Administrator about the incident. She stated she told the Administrator what happened and told the Administrator that she quit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/24/25 at 1:39 PM, LVN B revealed that she was sitting at the nurse's station with her back facing the four hundred halls. She stated she heard a FM yelling for someone to help her. She stated she turned around and saw a lot of people on hall one hundred. She stated she could not remember who all was on the hall, but that the scene was very chaotic. She stated she heard Resident #1 and CMA C using profanity and arguing, while approaching each other. She stated there were other staff in the hall trying to keep them apart. She stated as she ran down the hall, she told the other staff to get LVN E. She stated as she approached Resident #1 and CMA C, she screamed for CMA C to come back towards her as CMA C continued to approach Resident #1. She stated she told CMA C to go to the top of the hall and leave. She stated CMA C told her that she needed her keys and purse. LVN B stated she told CMA C to stay at the top of the hall and that she would get her keys and purse for her. She stated Resident #1 continued to use profanity and call CMA C foul names. LVN B stated the only thing that was wet on Resident #1 was his shirt. She stated CMA C did not appeared to be wet. She stated CMA C finally left and staff was able to calm Resident #1 down. LVN B stated she assessed Resident #1 for injuries, as well as took vitals and blood pressure. Resident #1 had no injuries.</p> <p>In an interview on 02/24/25 at 2:06 PM, CMA D revealed while he passed out meds on the four hundred halls, he heard screaming and yelling coming from the one hundred halls. He stated she saw nurses and aids managing the situation, so he continued to pass out his meds. He stated he intervened when he saw Resident #1 stand up, so he locked his cart and proceeded toward the one hundred halls. He stated he was able to get Resident #1 to sit down in his wheelchair and was able to calm him down. He stated once everyone had calm down, he went back to passing out his meds. He stated Resident #1 was screaming about something with his medicine. He stated Resident #1 had complained that he did not get a certain type of medicine and that he was upset about it. He stated he observed both Resident #1 and CMA C wet and observed a little water on the floor in the hallway. CMA D stated CMA C told him that Resident #1 knocked the cup out of her hand while she passed him his meds. He stated she did not reveal anything else to him. CMA D reported if that if a resident complained about wanting their pain meds, he would tell the nurse and then follow up with the resident to see if they received it.</p> <p>In an attempted telephone interview on 02/24/25 at 3:53 PM CNA F, left voice message and sent a text message for the staff to call back the writer.</p> <p>In a telephone interview on 02/24/25 at 4:01 PM, LVN E revealed responding to hall one hundred. She stated she did not witness the entire incident because she was in another area of the facility helping someone else. She stated from what she could recall, she observed Resident #1 and CMA C, as well as other staff on the hall. She stated there was screaming and yelling. She stated she could not remember who all was on the hall because the scene was chaotic. She stated when she spoke with Resident #1, he told her that CMA C threw water on him. She stated she observed both Resident #1 and CMA C's pants were wet. She stated she does not remember any other parts of their clothes being wet. She stated she does not recall all that was said, however, she remembered Resident #1 being the only one using profanity and arguing at that time. She stated Resident #1 was good most of the time; however, his temper would get the best of him. She stated Resident #1 was very volatile and would go off on someone.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 02/24/25 at 5:59 PM, the Administrator revealed that she was out of the office and did not have the information in front of her. She stated from what she could recall, a FM called and informed her about an altercation between Resident #1 and CMA C that had just happened. She stated a FM told her that she saw a cup on Resident #1's floor and saw CMA C enter the doorway of Resident #1 room and threw water on him. She stated she believed a FM said that one person threw water, and the other person threw water back. She stated the FM told her that Resident #1 and CMA C were yelling, screaming, and trying to get at each other. She stated the FM said that Resident #1 either slipped or fell on the water, while he continued to go after CMA C, but he was able to get back up. She stated the FM told her that she tried to put the nurse's cart in between Resident #1 and CMA C to keep them apart. She stated from what she could remember that it was over medication or Tylenol. She stated that both staff and the FM reported that CMA C used choice words toward Resident #1. The Administrator stated she spoke with Resident #1 the next day. She stated Resident #1 told her that CMA threw water on him, so he threw water back on her. She stated he said he may have overreacted. The Administrator stated that law enforcement (report# 24-1703571) was notified, and they came out; however, Resident #1 refused to talk to them. The Administrator stated that she spoke with CMA C about incident. She stated CMA C told her that Resident #1 used profanity and threw water on her while she had attempted to give him his meds. She stated she informed CMA C that she must walk away from tough situations and cool down. She stated before she could suspend CMA C, CMA C told her that she quit. The Administrator stated that at the conclusion of the investigation, the allegation of resident abuse by CMA C was confirmed and that it was evidence that CMA C was physically aggressive and abusive towards Resident #1. The Administrator stated she did not make a referral for CMA C due to her experience in the past when she attempted to refer another staff. She stated she could recall when she tried to refer an RN. She stated she had received an email from the state that said they would come out and conduct their own investigation and if a referral was needed, the state would make it. The Administrator stated that her expectation was for all staff to follow all abuse and neglect protocols and policies and maintain resident safety. She stated that her expectation was for staff to walk away from hostile situations and have someone else assist the resident if there are issues. The Administrator stated that in-service training for abuse, neglect, and resident rights was conducted for all staff members following the incident.</p> <p>Interviews on 02/24/25 with staff members (CNA A, LVN B, CMA D, LVN E and CNA G) revealed the facility had conducted abuse and neglect in-services on a routine basis and as needed. They all revealed that they received in-service resulting from the incident. The above-mentioned staff members were able to verbalize abuse and different forms of abuse and neglect. They also stated that any incidence of alleged abuse and neglect or any abuse and neglect witnessed would be reported to the facility abuse coordinator immediately. They also verbalized that they had the abuse coordinators name and contact number to report any abuse.</p> <p>Record review of CMA C personnel file revealed CMA C was hired on 06/22/23 and resigned from employment on 9/18/24. The facility had conducted Texas Department of Public Safety Criminal History verification and Employee Misconduct Registry Employability status check without any concerns. Record review of CMA C personnel file also revealed CMA C had completed abuse, neglect, and exploitation training on 7/11/24.</p> <p>Record Review of abuse and neglect in-services conducted by the facility on 09/19/24 and 09/30/24, revealed that all facility staff was trained on abuse and neglect, resident rights, abuse, neglect, and exploitation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled, Abuse, Neglect, and Exploitation revised on 01/08/2023, reflected, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written polices and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.</p> <p>The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 09/18/24 7:30 PM and ended on 09/30/24. The facility had corrected the noncompliance before the Incident investigation began. The facility's staff were reeducated regarding Abuse and Neglect on 09/19/24 through 09/30/24.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399</p> <p>Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was implemented so the facility was free of pests and rodents for the facility's one of four halls (Hall 100) reviewed for pest control.</p> <p>The facility failed to keep an effective pest control program to ensure the residents' rooms of resident room [ROOM NUMBER] and 115 including bathrooms were free of roaches and water bugs.</p> <p>This failure could place residents at risk for reduced quality of life and poor sanitary environment.</p> <p>Findings included:</p> <p>Interview on 02/24/25 at 2:42 PM with Resident #5 (room [ROOM NUMBER]) revealed she had roaches in her room in her bathroom at night constantly. She stated it bothered her to have the roaches in her room.</p> <p>Interview on 02/24/25 at 2:44 PM with Housekeeper I revealed she had seen roaches and water bugs in resident rooms including bathrooms and closets. Housekeeper I stated she had seen roaches in room [ROOM NUMBER]'s closet before and needed to clean room [ROOM NUMBER]'s closet.</p> <p>Interview and observation on 02/24/25 at 2:46 PM with Resident #6 (room [ROOM NUMBER]) revealed he saw roaches in his bedroom coming from the floorboard where there was an opening in the floorboard. He stated he had seen roaches in his bedroom [ROOM NUMBER] nights ago. He stated the facility was aware of it, and he had told facility staff about it but, did not know if pest control was treating the facility for roaches. Observation of the corner of floorboard revealed floorboard coming off with a 1-inch opening.</p> <p>Observation on 02/24/25 at 2:49 PM in resident room [ROOM NUMBER]'s bathroom revealed 2 live reddish brown bugs with a small head with long antennas. One was on the wall to the right of door entrance, and the other was right near the shower curtain on the shower floor. There were 2 brownish/black bugs with a big head in resident room [ROOM NUMBER]'s bathroom. One was on the ground to the left of the commode and the other was on the far shower wall.</p> <p>Interviews with Housekeeper I and CNA H on 02/24/25 at 2:50PM revealed both stated these bugs in resident room [ROOM NUMBER]'s bathroom were roaches and water bugs which came from the drains. They stated facility was aware of the bugs on hall 100 and it was an ongoing issue.</p> <p>Interview on 02/24/25 at 2:51 PM with Housekeeper I revealed the Maintenance Director had an app to put in maintenance or pest control requests. She was not aware of the facility having a pest control book. She stated facility and maintenance were aware of the ongoing issues with bugs</p> <p>Interview on 02/24/25 at 3:07 PM with Maintenance Director revealed he was aware of roaches and water bugs found in Hall 100 resident rooms. He stated the bugs came from the drains and Pest Control Company J had come today, leaving glue traps in all resident rooms on Hall 100.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 02/24/25 at 3:09 PM with Maintenance Director revealed one water bug in glue trap in room [ROOM NUMBER]. A live reddish-brown bug came out of Resident #7's (room [ROOM NUMBER]) closet and Maintenance Director stepped on it with his shoe before able to tell if it was a water bug or roach. Maintenance Director told surveyor it was a roach at time of observation.</p> <p>Observation on 02/24/25 at 3:11 PM of Resident #6's room (room [ROOM NUMBER]) revealed the corner of floorboard board coming off with a 1-inch opening. Resident #6 stated the roaches came out of the opening at night. Observation of Resident #6's (room [ROOM NUMBER]) closet revealed a dead bug.</p> <p>Interview on 02/24/25 at 3:31 PM with Pest Control Representative K from Pest Control Company J revealed he came out earlier that day to treat in resident rooms on the 100 hall. He stated he had seen live roaches that day in one of resident room's bathroom, but could not recall which room. He stated the water bugs and the roaches came from the sewage and drains. He stated the bugs could come from under the commodes if they were not sealed properly. He stated he sprayed the resident rooms bathrooms for the roaches. Interview revealed he could not remember which resident bathrooms that he sprayed He stated he left the glue traps in all of the resident bathrooms and gave the facility extra glue traps to replace them.</p> <p>Interview on 02/24/25 at 3:35 PM with the Housekeeping Supervisor stated resident room [ROOM NUMBER] was a focused room that required deep cleaning more often due to keeping food in his room. She stated bathrooms were cleaned daily. She stated when they deep clean, they clean out the closet. She stated both residents in resident room [ROOM NUMBER] did allow housekeeping to clean their room. She stated she was not sure the last time rooms 101, 113 and 115 were deep cleaned.</p> <p>Follow-up interview on 02/24/25 with Housekeeping Supervisor revealed room [ROOM NUMBER] was last deep cleaned on 02/18/25, 113 was 02/07/25, and 115 was 02/21/25. She could not state how often deep cleaning occurred for resident rooms.</p> <p>Interview on 02/24/25 at 4:29 PM with Resident #7 revealed he resided in room [ROOM NUMBER]. He stated he had seen water bugs and roaches in his room in the closet and bathroom constantly in the last couple of months. He stated he did keep food in his room but covered it. He stated the facility staff and maintenance were aware of the bugs in his room.</p> <p>Interview on 02/24/25 at 5:21 PM with CNA G revealed the facility had ongoing issues with roaches and water bugs on Halls 100, 300 and 400 for a long time. She stated pest control came out regularly, but did not know what they specifically did to address the bugs.</p> <p>Interview on 02/24/25 at 6:52 PM with Maintenance Director revealed he put down water bugs in the pest control log for room [ROOM NUMBER]'s closet. He stated he documented the dead bug since this is what was. He stated the water bug was in the trap of resident room [ROOM NUMBER]'s bathroom. He stated he last saw roaches last week in room [ROOM NUMBER]'s bathroom. He stated pest control came and treated the room for roaches. He stated he did not know about the deep cleaning by housekeeping for these rooms.</p> <p>Review of the facility's pest control log for September 2024 to February 2025 reflected the following for waterbugs and roaches:</p> <p>- 09/14/24 room [ROOM NUMBER]B - roach, serviced 09/23/24</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Lakewest Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - 09/17/24 room [ROOM NUMBER] B - bugs, serviced 09/23/24 - 10/16/24 and 10/18/24 room [ROOM NUMBER] - waterbug, serviced 10/16/24 and 10/18/24 - 10/18/24 room [ROOM NUMBER] - roach, serviced - 10/18/24 room [ROOM NUMBER] - waterbug, serviced - 10/24/24 room [ROOM NUMBER] - waterbug, serviced 11/4/24 - 10/29/24 room [ROOM NUMBER] - roach, serviced 11/4/24 - 11/20/24 403 B - roach, serviced 12/2/24 - 11/27/24 room [ROOM NUMBER] - roach, serviced 12/2/24 - 12/4/24 room [ROOM NUMBER]B - roach in closet, serviced 12/10/24 - 12/13/24 room [ROOM NUMBER] - roaches, serviced 12/16/24 - 12/24/24 rooms [ROOM NUMBERS] - roaches, serviced but not dated - 02/08/25 room [ROOM NUMBER] - water bugs, service 2/18/25 - 02/18/25 room [ROOM NUMBER] - water bugs serviced 2/18/25 - 02/24/25 room [ROOM NUMBER] water bug, no service date <p>Review of the facility's pest control company documentation from January 2025 to February 2025 reflected:</p> <ul style="list-style-type: none"> - Date 02/24/25 - target pests of German and American cockroaches, materials: insect monitors - Date 02/18/25 - target pests of American cockroaches and used alpine spray, treated and changed insect monitors in all 100 rooms - Date 01/28/25 - target pests of American, German cockroaches and ants - baited room [ROOM NUMBER] for ants . changed all insect monitors in rooms. <p>Review of facility's policy Pest Control Program dated 04/2024 reflected facility to maintain an effective pest control program that eradicates and contains common household pests and rodents .3. Facility will maintain a report system of issues that may arise in between scheduled visits with the outside pest service and treat as indicated. 4. Facility will utilize at variety of methods in controlling certain season pests .These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations.</p>		