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	05/13/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 (Resident #24) of 5 residents reviewed for pharmacy services. The facility failed to correctly transcribe Resident #1's medication changes when he returned to the facility on [DATE] after hospitalization. The incorrectly transcribed medication was administered from 03/2025 to 05/13/25. These failures could place residents at risk for medication errors, ineffective relief from pain medication, and drug diversion of controlled substances. Findings included: Record review of Resident #1's admission record, dated 05/13/25 revealed a [AGE] year-old male with an initial admission of 08/31/24 and readmission of 03/20/25. His primary diagnosis was chronic obstructive pulmonary disease with acute exacerbation (a lung disease that blocks airflow and makes it difficult to breathe). His secondary diagnoses were respiratory failure with hypoxia (the body not receiving enough oxygen), constipation, unspecified pain, insomnia (difficulty sleeping) and anxiety disorder. Record review of Resident #1's re-entry MDS assessment dated [DATE] reflected Resident #1 readmitted to the facility on [DATE] from a short-term general hospital. The MDS revealed Resident #1 had a BIMS score of 15, indicating that he was cognitively intact. He could understand others and others could understand him. Record review of Resident #1's care plan initiated on 02/28/25 revealed Resident #1 had a behavior problem of calling 911. The interventions were to administer medications as ordered. To monitor/document side effects and effectiveness. Record review of Resident #1's hospital discharge after visit summary physician orders for dated 03/20/25 reflected Resident #1 was admitted to the hospital from [DATE] to 03/20/25. Further review of discharge summary reflected: - Albuterol 90 mcg/actuation HFA Inhaler. Inhale 2 puffs by mouth every 4 hours as needed for wheezing or shortness of breath. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Start; Bisacodyl Extended Release 5 mg tablet. Take 2 tablet by mouth one time a day (for constipation) - Buspirone 5 mg tablet. Take 5 mg by mouth 3 times a day (for anxiety disorder) - Change; Hydroxyzine HCL 25 mg 1 tablet by mouth three times a day as need for anxiety (PRN) Record review of Resident #1's active physician orders for April and May 2025 reflected : - Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT. 1 puff inhale orally every 4 hours as needed for wheezing- ordered 03/05/25. - Bisacodyl Oral Tablet Delayed Release 5 MG. Give 1 tablet by mouth one time a day for constipation- ordered 03/20/25. -BusPIRone HCl Oral Tablet 10 MG (Buspirone HCl). Give 1 tablet by mouth three times a day related to anxiety disorder, unspecified- ordered 03/20/25. -Hydroxyzine HCl Oral Tablet 25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety- ordered 03/11/25. -Hydroxyzine HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day related to anxiety disorder, unspecified- ordered 03/11/25. Record review of Resident #1's MAR for April and May 2025 reflected medications were administered as facility transcribed. Hydroxyzine HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day was administered at 07:00 AM, 2:30 PM and 7:00 PM daily. Buspirone 10 mg was administered 07:00 AM, 2:30 PM and 7:00 PM daily. 1 tablet of Bisacodyl was administered in the mornings daily. 1 puff of Albuterol Sulfate HFA Inhalation Aerosol Solution 108 was last administered 5/6/25 PRN. Hydroxyzine HCl Oral Tablet 25 MG Give 1 tablet by mouth every 8 hours was administered 5/4/25, 5/5/25, 5/7/25, 5/9/25, 5/10/25, and 5/12/25. Record review of Resident #1's nurse progress notes did not reflect changes to medications by facility after hospital discharge and readmission on [DATE]. The hospital pharmacist was not available by phone for interview on 05/13/25. Record review of intake investigation dated 03/18/25, it was revealed by the hospital pharmacist that on many occasions Resident #1 was sent to the hospital without his medication list and when requested, the ADON said patient had visited [hospital name] ER the previous week, the medication list in our records should suffice. hospital pharmacist reported ADON declined to provide an updated list and abruptly ended the call. The hospital pharmacist reported I have observed that even when a patient has recently been seen at our facility, discrepancies in medication records from [facility name] can occur, potentially contributing to patient admissions or complicating existing health issues. She reported this recurring issue raises significant concerns, including: 1. Delays in patient care due to inaccessible or outdated medication information. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Compromised continuity of care when patients transition between facilities. 3. Potential harm to patients if medications, dosages, or administration instructions for high-risk conditions or medications are not accurately verified. In an observation and interview with Resident #1 on 05/13/24 at 11:00 AM, he stated, I am getting too much medication. Resident #1 said at times the medication made it hard for him to stay awake. He said, they give me a cup full of medicines and three inhalers at the same time. He said it was too much. Resident #1 stated that stuff can mess you up. He said that some nurses tell him the names of medications and other nurses say, your doctor prescribed them to you. He said he was aware that some medications were changed during his last hospital visit but he did not know which ones they were, or which medication was making him too sleepy to function . He said he would like to only get a few pills in the morning, and the rest spread out at different times intervals during the day so that he was not getting so much medication at once some of which made him not function well and all he wanted to do was sleep. Resident #1 was alert and oriented and did not appear groggy at time of interview and he was seated upright on the edge of his bed. Resident denied being sleepy at that time. He stated he had gotten his morning medications. In an interview with LVN B on 05/13/25 at 2:30 PM, it was revealed that LVN A, who readmitted Resident #1 on 03/20/25, no longer worked at the facility. LVN B said when a resident returned to the facility after hospital or out of facility to see a specialty, the admitting nurse would fax the new orders to the facility physician or NP. She said at that point the physician or NP would tell them Yes let us use the new orders or let us change them. She said it was the responsibility of the admitting nurse to enter correct medications and doses. She said if you don't understand an order or need clarity ask the physician or pharmacist to avoid medication errors and delay in care. LVN A that readmitted the Resident #1 on 03/20/25 and transcribed the medication, was no longer employed at the facility and no contact information was provided on 05/13/25. In an interview with the ADON on 05/13/25 at 3:56 PM, it was revealed that the hospital pharmacist had called the facility after Resident #1 went to the hospital [03/14/25] to ask for a medication list. The ADON said Resident #1 called 911 himself. She said Resident #1 does this a lot, he calls 911 before we have a chance to assess him. She said when the paramedics came to get him, the facility had not prepared paperwork to send with him to the hospital. The ADON said the process was that any resident being sent out via EMS got a face sheet, medication list and a progress note if needed. The ADON stated she tried to fax the medication list, but the nursing fax machine was not working. She said she tried to explain to the caller the fax issue, and she even tried to go over the medication list over the phone or by sending snap shots of Resident #1's medication list but the caller [hospital pharmacist] refused. The ADON stated the medication list was finally sent out using the fax machine in the administrators' office. The ADON said when a resident is readmitted the admission orders are sent to the physician by the admitting nurse and the physician signs off on the new orders or changes. The ADON did not state risk to the resident. In an interview with the facility receptionist on 05/13/25 at 4:20 PM, she stated the nursing staff use the main nursing station fax machine for physician orders, labs, and hospital referrals. She said she was not aware of the main nursing fax machine not working because only the nursing staff used it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 05/13/25 at 4:44 PM, it was revealed that she was new to the facility. She said that the expectation was that when a resident was admitted or readmitted to the facility, the physician was notified and that if any changes were made for medication, the nurse was responsible for transcribing correctly into EMR. She said the expectation was that the correctly transcribed medication was then sent to pharmacy to be reviewed. The DON stated moving forward all new medication orders would be brought to the clinical nurse meeting the next day to make sure that it was all transcribed correctly. She said herself and ADON's will be monitoring and ensuring all orders are transcribed correctly. She said she would do an in-service. The DON said the potential risk was inaccurate medication dosage would prolong the existing bad symptoms . In an interview with the Administer on 05/13/15 at 6:14 PM, it was revealed that the expectations was that medication was entered and transcribed as ordered and if the nurse needed clarity to reach out to physician. She said the Clinical leadership was responsible for monitoring the orders to make sure they were accurate. She said the potential risk depended on medication for example a blood pressure medication could cause a lower BP . Review of the facility's policy Pharmacy Services, revision date 01/23 reflected the following: The facility will provide pharmaceutical services that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs Review of the facility's policy Medication Orders, revision date 04/23 reflected: 4. (b) Clarify the order. (f), Transcribe newly prescribed medications on the MAR