| 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 03/05/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lakewest Rehabilitation and Skilled Care | 2450 Bickers St<br>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) |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for four of six residents (Resident #1, #2, #3, and #5) reviewed for the resident rights.The facility failed to ensure the call light system in Resident #1, #2, #3, and #5's room was in a position that was accessible to the residents on 03/05/26. This failure could place residents at risk of being unable to obtain assistance when needed, and help in the event of an emergency.Findings included:Record review of Resident #1's Face Sheet, dated 03/05/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses of a need for assistance with personal care and muscle weakness.Record review of Resident #1's Quarterly MDS Assessment, dated 02/10/26, reflected the Resident's BIMS (11) indicated a moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of a need for assistance with personal care and muscle weakness. Record review of Resident #1's Comprehensive Care Plan, dated 01/12/26, reflected Resident #1 was a fall risk and an intervention included the resident to have her call light with reach.During an observation on 03/05/26 at 08:10 a.m., Resident #1 was observed lying in bed and her call light was on the floor, under the bed.During an observation and interview on 03/05/26 at 08:20 a.m., CNA F was shown Resident #1's call light positioned under her bed. She stated the call light should be positioned within reach of the resident so she could call for help.2. Record review of Resident #2's Face Sheet, dated 03/05/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had a diagnosis of paralysis of the left side of her body.Record review of Resident #2's Quarterly MDS Assessment, dated 02/09/26, reflected the Resident's BIMS (15) indicated an intact cognitive response. The Quarterly MDS Assessment reflected a stroke, and paralysis of the left side of her body. Record review of Resident #2's Comprehensive Care Plan, dated 02/05/26, reflected Resident #2 required assistance to perform functional abilities in self-care and mobility and an intervention included to encourage resident to use call light.During an observation and interview on 03/05/26 at 08:11 a.m., Resident #2 was observed lying in bed and her call light was hanging on the lower portion of the left side rail, out of reach from the resident. The resident stated she was trying to get staff to help reposition her in bed, but did not know where her call light was located.3. Record review of Resident #3's Face Sheet, dated 03/05/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses of a lack of coordination and muscle weakness.Record review of Resident #3's Quarterly MDS Assessment, dated 02/19/26, reflected the Resident's BIMS (12) indicated a moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of unsteadiness on feet, and muscle weakness. Record review of Resident #3's Comprehensive Care Plan, dated 02/21/26, reflected Resident #3 required assistance to perform functional abilities in self-care and mobility and an intervention included to encourage resident to use call light.During an observation and interview on 03/05/26 at 08:13 a.m., Resident #3 was observed lying in bed and his call light was hanging on the lower portion of the left side rail, out of reach from the resident. He stated he did not know where his<br>(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 |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | call light was and wanted it to contact staff.During an interview and observation on 03/05/26 at 08:15 a.m., LVN H was shown the locations of the call lights for Resident #2 and #3, and she stated the call lights needed to be in reach of the resident so they could contact staff for assistance. She stated it was everyone's responsibility to ensure the resident's call light was within reach of the resident.4. Record review of Resident #5's Face Sheet, dated 03/05/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #5 had diagnoses of lack of coordination and muscle weakness.Record review of Resident #5's Quarterly MDS Assessment, dated 01/02/26, reflected the Resident's BIMS (10) indicated a moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of a need for assistance with personal care and muscle weakness. Record review of Resident #5's Comprehensive Care Plan, dated 01/01/26, reflected Resident #5 required assistance to perform functional abilities in self-care and mobility and an intervention included to encourage resident to use call light.During an observation and interview on 03/05/26 at 08:22 a.m., Resident #5 was observed lying in his bed. He stated he did not know where his call light was located. The call touch pad was located on the floor and out of reach of the resident.During an observation and interview on 03/05/26 at 08:27 a.m., CNA L was shown Resident #5's call touch pad on the floor. She stated she was not the CNA for that hall. She stated the call touch pad should be positioned near the resident so that he could press it if he needed help.During an interview on 03/05/26 at 12:19 p.m., Unit Manager C was informed of Residents #1, #2, #3, and #5's call light devices not being within reach of the residents, and she stated they should all be in reach of the resident so they could contact staff if they needed assistance. She stated all staff were to check for this when they completed their rounds.During an interview on 03/05/26 at 12:30 p.m., ADON A was informed of Residents #1, #2, #3, and #5's call light devices not within their reach, and she stated the call light needed to be within reach of the resident in case they need help. She stated it was all staff's responsibility to ensure call lights were in reach of resident.During an interview on 03/05/26 at 01:07 p.m., the DON was informed of Resident #1, #2, #3, and #5' call light devices not being within reach of the residents, and she stated they should all be within reach of the residents so they could contact staff if they needed assistance. She stated her nursing staff informed her of the findings. She stated everyone should check to ensure call lights were within reach of the resident.Record review of the facility's policy on Call Lights: Accessibility and Timely Response, revised 02/23, revealed, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 1 of 6 residents (Resident #4 ) reviewed for care plan. The facility failed to ensure Resident #4's care plan reflected a plan of care for the resident's use of a BiPAP device. This failure could place residents at risk of not receiving necessary care and services.Findings included:Record review of Resident #4's Face Sheet, dated 02/18/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had a diagnosis of acute respiratory failure.Record review of Resident #4's Quarterly MDS Assessment, dated 02/21/26, reflected Resident #4's BIMS (15) indicated an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active an diagnosis of acute respiratory failure.Record review of Resident #4's Comprehensive Care Plan, dated 02/23/26, revealed no care plan for the use of the BiPAP device. Record review of Resident #4's Physician orders, dated 03/05/26, reflected BiPAP settings 20/8 with O2 @ 2L at bedtime. During an interview on 03/05/26 at 12:19 p.m., Unit Manager C was informed of Resident #4 not care planned for the use of the BiPAP device, and she stated it should have been care planned. She stated she was not responsible for updating care plans. She stated it should be care planned because it shows what care the resident needed.During an interview on 03/05/26 at 12:30 p.m., ADON A stated the MDS Nurse, the ADON, the DON, and the Treatment Nurse updated care plans. She stated if a resident used a BiPAP machine, it should be care planned. She was informed of Resident #4 not being care planned for the use of the BiPAP device. She stated he should be care planned so his treatment could be monitored.During an interview on 03/05/26 at 12:51 p.m., the MDS Nurse, was informed of Resident #4 not being care planned for the use of the BiPAP device and she stated it should be care planned because if not, it could place him at respiratory distress. She stated the nurses should update the care plans, and since it was coded on her end, she should have updated his care plan.During an interview on 03/05/26 at 01:07 p.m., the DON was informed of Resident #4 not being care planned for the use of the BiPAP device, and she stated it should be care planned because it was a special device. She stated if the resident arrived to the facility with the device, the MDS nurse should have updated the care plan. She stated if the resident had new orders for the device while at the facility, it was the DON and ADON's responsibility. She stated not care planning the use of the device could result in missed care.Record review of the facility's policy, Comprehensive Care Plans, revised 04/2023, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . Policy Explanation and Compliance Guidelines . 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of six residents (Resident #4) reviewed for respiratory care.The facility failed to ensure Resident #4's breathing treatment masks were properly stored in a bag when not in use on 03/05/26. This failure could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #4's Face Sheet, dated 02/18/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had a diagnosis of acute respiratory failure.Record review of Resident #4's Quarterly MDS Assessment, dated 02/21/26, reflected Resident #4's BIMS (15) indicated an intact cognitive response. The Quarterly MDS Assessment reflected the resident had an active diagnosis of acute respiratory failure.Record review of Resident #4's Physician orders, dated 03/05/26, revealed BiPAP settings 20/8 with O2 @ 2L at bedtime and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3ml 1 unit every 6 hours.During an interview and observation on 03/05/26 at 08:18 a.m., LVN H was shown by the Surveyor, Resident #4's BiPAP mask and Nebulizer mask on top of the nightstand unbagged. She stated the masks should be bagged when not in use to avoid infection.During an interview on 03/05/26 at 12:19 p.m., Unit Manager C was informed of Resident #4's BiPAP and Nebulizer mask being observed unbagged while not in use, and she stated they should have been bagged when not in use to avoid infections. She stated all department heads should check to ensure the masks were bagged and dated. During an interview on 03/05/26 at 12:30 p.m., ADON A was informed of Resident #4's BiPAP and Nebulizer mask not bagged when not in use. She stated the masks should be bagged to avoid any type of infection. She stated the nursing staff, and leadership should check to ensure masks were bagged.During an interview on 03/05/26 at 01:07 p.m., the DON was informed of Resident #4's BiPAP and Nebulizer masks not being bagged when not in use. She stated it should have been bagged when not in use to avoid the resident getting an infection. She stated the charge nurse was responsible for ensuring the items were bagged when completing her rounds.Record review of the facility's policy Oxygen Administration, revised 01/2025, reflected Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. PROCEDURES. e. Keep delivery devices covered in a antimicrobial bag when not in use. |