

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/14/2026
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 5 residents of 25 residents (Resident #17, Resident #89, Resident #57, Resident #66, Resident #63) reviewed for ADLs. The facility failed to ensure: 1. Residents #17, #57, and #63's fingernails were trimmed. 2. Residents #89 and #66's fingernails were cleaned and trimmed. These failures could place residents who were dependent on staff for ADL care at a loss of dignity and a decreased quality of life. Findings include: 1. Record review of Resident #17's quarterly MDS assessment, dated 12/11/25, reflected a [AGE] year-old male with an admission date of 09/19/22. Resident #17 had a BIMS score of 15 which indicated he was cognitively intact. He required substantial to maximum assistance for personal hygiene, toileting, bathing and dressing and had not refused care. He had functional limitation in range of motion upper and lower extremities on one side extremities. He was frequently incontinent of bowel and bladder. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #17's care plan revised on 12/17/25 reflected, Functional Abilities: [Resident #17] requires assistance to perform functional abilities in Self Care and Mobility related to his history of cerebral vascular accident with left hemiplegia. Intervention. Provide the following self-care assistance. Personal Hygiene: dependent. In an observation and interview on 01/12/26 at 9:10 AM, Resident #17 was observed lying in bed. His nails on both hands were clean and approximately 1/2 an inch in length. He stated he needed them trimmed badly. He stated no one had offered to trim his nails. Resident had limited use of his left hand, and his wrist was turned downward approximately 90 degrees. Resident stated he did not like his nails that long and stated it had been over a month since anyone had trimmed his nails. On 01/12/26 at 2:15 PM, an observation and interview with Resident #17's nails was made with the DON. She stated his nails definitely needed trimming. She stated that the risk of long nails were skin tears, pressure wounds to the palm of his left hand, and increased infection. She stated the staff saw him every day, getting him up, dressing him, and the nurses perform weekly skin checks. She stated someone should have noticed his nails. Resident #17 stated no one offered to trim his nails. The DON stated she would ensure they were trimmed today (01/12/26) and would be putting in a new process to ensure all of the residents' nails were maintained properly. 2. Record review of Resident #89's quarterly MDS assessment, dated 11/21/25, reflected a [AGE] year-old male with an admission date of 12/21/22. Resident #89 had a BIMS score of 15 which indicated he was cognitively intact. He was dependent for personal hygiene, toileting, bathing, eating and dressing and had not refused care. He had functional limitation in range of motion of both upper extremities and one side lower extremities. He was always incontinent of bowel and bladder. Diagnoses included spinal stenosis of the cervical (neck) regions (narrowing of spaces with the spine that puts pressure on the spinal cord, often causing pain and weakness in the back, neck, arms or legs), and chronic obstructive pulmonary disease (inflammation and obstruction of the airways, making it hard to breathe). He had not (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #89's care plan initiated on 11/19/24 reflected, [Resident #89] requires assistance to perform functional abilities in Self Care and Mobility as indicated by unsafe and poor quality in range of motion related to medically complex conditions .Intervention.Provide the following self-care assistance.Personal Hygiene: dependent. In an observation and interview on 01/12/26 at 1:00 PM, Resident #89 was observed lying in bed being fed lunch by a staff member. Resident's right arm was drawn up to his neck with his hand turned inward. His left hand was contracted with his second finger overlapping his first finger. Unable to determine the length of his nails due to a buildup of thick brown tinged skin with the appearance of snakeskin on his left hand. His nails were jagged and brown tinged. Resident #89 stated no one trimmed them in a while and they needed trimmed. On 01/12/26 at 2:15 PM, an observation and interview with Resident #89 nails was made with the DON. She stated his nails definitely needed trimming, but due to the condition of his hands, they may need to have the podiatrist look at them. She stated his hands definitely needed cleaning and lotion applied. She stated the staff should have alerted her to the condition of his hands. She stated someone should have noticed his nails and hands. The DON stated she would ensure they get his hands cleaned today and then determine if they would be able to trim his nails. In an observation and interview on 01/14/26 at 2:00 PM of Resident #89's hands revealed the buildup of dead; scaly skin had been removed from both his hands and under his nails revealing his nails to be approximately 1/2 inch long but clean. Resident #89 stated they had cleaned his hands and nails and filed his nails. He stated they looked much better. In a follow-up interview with the DON on 01/14/26 at 02:55 PM, she stated she had the CNAs wash Resident #89's hands and only file his nails. She stated she was going to have the treatment nurse cut them due to the severity of his contractures she did not feel comfortable having the CNAs cut his nails. 3. Record review of Resident #57's Annual MDS assessment dated [DATE] reflected, Resident #57 was a [AGE] year-old male with initial admission date of 04/26/2021 to the facility. His relevant diagnoses included: Hypertension (high blood pressure), non-traumatic brain dysfunction (causes damage to the brain by internal factors, such as a lack of oxygen, exposure to toxins, or pressure from a tumor), aphasia (impairment in a person's ability to comprehend or formulate language), and non-Alzheimer's dementia (Cognitive decline). He needed supervision from staff regarding personal hygiene. His BIMS score of 12 indicated Resident # 57's cognition was moderately impaired. He had functional limitation in the range of motion of his upper and lower extremities on one side. Record review of Resident #57's care plan revised on 05/22/2025 reflected, [Resident #57] requires assistance to perform functional abilities in Self Care and Mobility as evidenced by poor quality in functional range of motion related to Non-Traumatic Brain Dysfunction, Dementia. Goal: Intervention: Will have improvement in functional abilities in the following areas. Intervention: Provide the following self-care assistance.Personal Hygiene: supervision/ touching dependence. In an observation and interview on 1/11/2026 at 10:27 AM with Resident #57 revealed he was sitting in his room. Resident had long nails on both hands measuring about 0.5-0.7 inch long. Resident #57 stated that he would like his nails trimmed since he did not prefer long nails. He added that the staff had not offered to clip his nails. He stated that he had not alerted any staff regarding clipping his nails. In an observation and interview on 01/13/2026 at 11:00 AM, Resident # 57's nails on both hands were clipped. Resident #57 stated, they (Staff) came in yesterday to trim my nails. 4. Record review of Resident #66's quarterly MDS assessment dated [DATE] reflected, Resident #66 is a [AGE] year-old male with initial admission date to facility on 11/20/2023. His pertinent diagnoses included coronary artery disease (heart disease, characterized by the buildup of plaque in the coronary arteries), Hypertension (high blood pressure), Dementia (decline in cognitive function), Schizophrenia (serious mental health condition that affects how people think, feel and behave). He needed set up from staff for personal hygiene. He has a BIMS score of 14 which indicated Resident # 66 had intact cognition. Record review of Resident #66's care plan initiated on 01/12/2026 reflected, Focus: Behavior Problem: [Resident (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#66] has an unwanted behavior as evidenced by Refusing Care. Intervention: . Encourage resident to allow staff to trim nails. An observation and interview on 01/11/2026 at 10:56 AM revealed Resident #66 had long, discolored and dirty nails on both hands. Resident #66's nails had black discoloration beneath the nail bed and were about 0.3-0.5 inch long. Resident stated he would like his nails trimmed and cleaned. He stated that he had not informed any staff member regarding nailcare. 5. Record review of Resident #63's quarterly MDS assessment dated [DATE] reflected, Resident # 63 is a [AGE] year-old female with initial admission date to the facility on 7/22/2025. Her pertinent diagnoses included stroke (Decreased blood flow to the brain), hypertension (High blood pressure), Anemia (low blood count), Diabetes (high blood sugar), Hyperlipidemia (elevated lipid levels). She needed substantial assistance from staff for personal hygiene. She had a BIMS score of 8 which indicated Resident # 63's cognition was moderately impaired. Record review of Resident #63's care plan revised on 8/4/2025 reflected, Goal: Functional Abilities: [Resident #63] requires assistance to perform functional abilities in ADL Self Care and Mobility . Intervention I. Personal Hygiene: Substantial/Max. An observation and interview on 01/11/2026 at 10:45 AM reflected Resident #63 had long nails extending from the nail bed to the tip about 0.3-0.5 inch. Resident #63 stated that she would like her nails clipped. She also added that she did not remember if staff had offered nail care to her in the last few days. An observation and interview on 1/12/2026 at 9:05 AM with CNA P revealed she had been working at the facility since November 2024. She stated that CNAs were responsible for trimming and cleaning nails. She stated Nailcare was offered to residents on shower days and as needed. She added, for residents with diagnoses of diabetes, nurses were responsible for cutting nails. She stated that Residents #57, #66, and #63 had long nails, and they needed to be clipped. She stated that Resident #57 could be resistive to care sometimes, but she would offer nail care to him after the interview. She added the risk of not cleaning and cutting nails was the possibility of bleeding, skin infection, and loss of dignity. An interview on 1/12/2026 at 9:09 AM with LVN R, she stated she worked in the facility as a PRN nurse but was aware of resident care needs. She stated CNAs and Nurses were responsible for nail care. She added charge nurses were responsible for clipping nails for residents who were diabetics. She added that Resident #57 and Resident #66 could be resistive to care. However, nail care should still be offered to them on shower days and as needed. She stated that she had not heard of CNAs reporting any refusals to her for Residents #57 and #66 in the past few weeks. She stated the risk of not cutting and cleaning nails was lapses in infection control and decreased quality of life for residents. An interview on 01/12/2026 at 4:20 PM with the Nursing Manager revealed CNAs and nurses were responsible for nail care and should be offered on shower days and as needed. She added nurses were responsible for clipping nails for diabetic residents. She stated the risk of not cutting and cleaning nails was lapses in infection control and decreased quality of life for residents. She stated that if residents refused ADL care, it should be documented and the family and physician should be notified. In an interview on 1/12/2026 at 9:45 AM with the DON, she stated that her expectation was that ADL care should be performed on shower days and as needed. She stated that both CNAs and nurses were responsible for providing ADL care, including nail care. She also stated that nurses were responsible for clipping fingernails for diabetic residents. She stated if the resident refused, refusals should be reported to the charge nurse and documented. She stated that risk to residents with dirty, long fingernails could be skin irritation and loss of dignity. She stated that she ensured quality of care in residents by daily rounding on all residents. She stated the DON and other Nursing Management would be responsible for following up and ensuring those tasks were carried out. Review of the facility's policy titled, Activities of Daily Living revised on 1/2025 reflected, .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for four of seven Residents (Resident #17, Resident #8, Resident #89, and Resident #3) reviewed for quality of care.1. The facility failed to implement interventions to prevent further decline of Resident #17's contracture to his left wrist.2. The facility failed to implement interventions to prevent further decline of Resident #8's contracture to his left hand.3. The facility failed to implement interventions to prevent further decline of Resident #89's contracture to his left hand, right hand and shoulder. 4. The facility failed to implement interventions to increase range of motion for Resident #3's upper and lower extremities. This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included:1. Record review of Resident #17's quarterly MDS assessment, dated 12/11/25, reflected a [AGE] year-old male with an admission date of 09/19/22. Resident #17 had a BIMS score of 15 which indicated he was cognitively intact. He required substantial to maximum assistance for personal hygiene, toileting, bathing and dressing and had not refused care. He had functional limitation in range of motion upper and lower extremities on one side extremities. He was frequently incontinent of bowel and bladder. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #17's care plan revised on 08/01/25 reflected, Cerebral Vascular Accident [Resident #17] has the diagnosis of Cerebral Vascular Accident with left side hemiparesis and is at risk for falls, contractures, over all wellbeing decrease.Interventions.Therapy to eval and screen as ordered and as needed. There were no interventions listed for the contractures. Record review of Resident #17's Skilled Therapy referral initiated by the Director of Rehab dated 12/16/25 reflected, Patient referred to nursing for hand contracture. Patient appropriate for left resting hand splint to be worn for max of 4-hour duration. Patient would benefit from left hand splint to be worn during breakfast and lunch mealtimes to encourage more independence with self-feeding. In an observation and interview on 01/12/26 at 9:10 a.m. Resident #17 was observed lying in bed. Resident had limited use of his left hand, and his wrist was turned downward approximately 90 degrees, and he was unable to straighten his wrist. He stated he had been trying to get a splint from therapy for a few months but stated nothing had happened. He stated he did not want his wrist to get worse. In an observation of Resident #17 and interview with OT L on 01/12/26 at 1:40 p.m. OT L assessed his left arm, wrist and hand and stated she thought he would benefit from therapy to improve his flexibility and decrease the pain. She stated he would benefit from a resting hand splint. She stated he was about the same as he was in December 2025 when they recommended a resting hand splint. 2. Record review of Resident #8's quarterly MDS assessment, dated 11/04/25, reflected a [AGE] year-old male with an admission date of 03/18/24. Resident #8 had a BIMS score of 15 which indicated his cognition was intact. He required substantial to maximum assistance for personal hygiene, toileting, bathing and dressing and had not refused care. He had functional limitations in range of motion upper and lower extremities on one side extremities. He was always incontinent of bowel and bladder. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #8's care plan revised on 11/03/25 reflected, [Resident #8] has a history of Cerebral Vascular Accident.Goal.Minimize the risk of complications for Cerebral Vascular Accident.Interventions.Keep positioning devices on and areas dry and clean to maintain (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	proper alignment. An interview and observation with Resident #8 on 01/11/26, revealed resident lying in bed finishing lunch. His left hand was curled into a fist, and the resident was unable to straighten his fingers or open his hand. Resident #8 stated he had never had a splint or brace for his hand, and he needed one. He stated he had not gotten therapy since he had been here. In an observation of Resident #8 and interview with OT L on 01/12/26 at 2:00 p.m., OT L stated Resident #8's left hand would not be classified as a contracture because it was flaccid and had no tone, but he would benefit from a resting palm guard for comfort and positioning. 3. Record review of Resident #89's quarterly MDS assessment, dated 11/21/25, reflected a [AGE] year-old male with an admission date of 12/21/22. Resident #89 had a BIMS score of 15 which indicated he was cognitively intact. He was dependent for personal hygiene, toileting, bathing, eating and dressing and had not refused care. He had functional limitation in range of motion of both upper extremities and one side lower extremities. He was always incontinent of bowel and bladder. Diagnoses included spinal stenosis of the cervical (neck) regions (narrowing of spaces with the spine that puts pressure on the spinal cord, often causing pain and weakness in the back, neck, arms or legs), and chronic obstructive pulmonary disease (inflammation and obstruction of the airways, making it hard to breath). He had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #89's care plan with the last revision date of 12/03/25 on reflected, [Resident #89] requires assistance to perform functional abilities in Self Care and Mobility as indicated by unsafe and poor quality in range of motion related to medically complex conditions. There were no interventions to address the resident's contractures to his right arm and left hand. Record review of Resident #89's Skilled Therapy referral initiated by the Director of Rehab dated 12/16/25 reflected, Patient referred to nursing for hand contracture. Patient appropriate for left resting hand splint to be worn for max of 4-hour duration. Patient would benefit from left hand splint to be worn during breakfast and lunch mealtimes to encourage more independence with self-feeding. In an observation and interview on 01/12/26 at 1:00 p.m. Resident #89 was observed lying in bed being fed lunch by a staff member. Resident's right arm was drawn up to his neck with his hand turned inward. His left hand was contracted with his second finger overlapping his first finger. Resident was able to move his wrist slightly but was not able move his fingers. He stated he needed something done for his right hand because he would like to be able to use for more independence. He stated he had not had any exercise for his left hand. He stated he was not able to move his right arm or hand at all. In an observation of Resident #89 and interview with OT L on 01/12/26 at 2:05 p.m. OT L assessed Resident #89's left hand, right hand and right arm and stated he would benefit from therapy to improve his flexibility and decrease the pain. She stated he would benefit from a resting hand splint. She stated he was about the same as he was in December 2025 when they recommended a resting hand splint. 4. Review of Resident #3's Face sheet dated 1/13/26 reflected a [AGE] year-old female with an original admission date of 3/25/23 and a readmission date of 10/22/25. Review of Resident #3's Significant Change MDS assessment, dated 10/28/25, reflected her cognition was intact with a BIMs of 13. The resident had upper and lower extremity impairment on one side and used a walker. Resident #3 was dependent on staff for toileting, showering, lower body dressing and putting and taking off footwear. She also needed substantial assistance with upper body dressing and personal hygiene. Resident #3 had no therapy. Active diagnoses included Cerebrovascular Accident (commonly known as a stroke, where blood flow to a part of the brain is interrupted), Hemiplegia and Hemiparesis (muscle weakness or partial paralysis on one side of the body), Hemiplegia following Cerebral Infraction (paralysis or severe weakness of one side of the body due to brain damage), effusion left knee (excess fluid buildup in or around the knee joint) and pain in left knee. Review of Resident #3's Physical Therapy Evaluation & Plan of Treatment dated 8/15/25 reflected .Focus of plan of Treatment = Restoration.Assessment Summary: Clinical Impressions: Patient presents with left-sided hemiparesis, inability to grip with left hand, impairments in motor control, trunk control, postural control, activities tolerance, generalized strength, sitting (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	balance and tolerance, and generalized coordination, thus negatively impacting performance of bed mobility and manual w/c mobility. Reason for Skilled Services: given the assessment above, patient will highly benefit from PT services in order to address the above impairments and allow patient improve bed mobility, Out of Bed frequency and maximize functional manual wheel chair propulsion to improve functional independent in the facility. Assessment Summary: Risk Factors: Due to the documented physical impairments and associated functional deficits, without skilled therapeutic interventions, the patient is at risk for : Deep vein thrombosis(blood clot), falls, immobility, further decline in function, depression, dehydration, limited out of bed activity, muscle atrophy, pressure sores, decreased skin integrity, contracture (s) and compromised general health. Review of Resident #3's comprehensive care plan revised on 10/30/25, reflected, .Resident #3 has the diagnosis of Cerebral Vascular Accident with hemiparesis and is at risk for falls, contractures, over all wellbeing decrease. Left hemiparesis Date Initiated: 05/20/2025 Revision on: 05/20/2025 The resident will not experience signs and symptoms of a Cerebral Vascular Accident unaddressed X 90 days. Date Initiated: 05/20/2025 Revision on: 10/30/2025 Target Date: 11/11/2025 The resident will maintain current level of independence X 90 days. Date Initiated: 05/20/2025 Revision on: 10/30/2025 Target Date: 11/11/2025 . Therapy to eval and screen as ordered and as needed date initiated 5/20/25. Interview with Resident #3 on 01/11/2026 at 11:44 a.m. revealed she had been at the facility for a while and was there for therapy and had not had any therapy since her admission. She also stated no one had assisted her with any exercise. Resident #3 stated she would like to walk again and be more independent. Interview with LVN J 01/12/2026 at 2:23 p.m. revealed she had been Resident #3's nurse for several months. LVN J stated she was not completing restorative therapy with her. She stated therapy had not provided any exercises to do with Resident #3. She stated the risk of not having received any exercises or assistance from therapy would have been the resident could decline and become more contracted. An interview with the Director of Rehab on 01/12/2026 at 1:01 p.m. reflected Resident #3 was not on therapy. The Director of Rehab stated Resident #3 had been evaluated on 6/18/25 and 8/15/25 by therapy, and determined she needed therapy, but when it was submitted to the insurance, it was not approved. She stated the rehab department would reassess the resident whenever her payor source changed to see if they would be approved therapy. Resident #3 had not had therapy in the last year due to not being approved by her insurance. The Director of Rehab stated when the payor source denied therapy the next step would have been to notify the Administrator but did not know if this was done due to her not working at the facility when Resident #3's last evaluation was done. She stated they had not recommended restorative for her because they had not provided any therapy, therefore, they would not have recommended restorative care. She stated the risk to the resident of not receiving rehab was possible decline and/or lack of improvement in her ADLs. In an interview with the DON on 01/12/26 at 2:25 p.m., she stated she was not sure if the therapy department had a contracture management program. She stated she knew therapy was screening residents quarterly, and she would expect them to develop a plan for the management of those residents with contractures and communicate those plans with nursing. She stated there had been 3 Administrator and 2 Directors of Therapy since she had started in March 2025 which had impeded some of the communication between departments. She stated she knew that therapy was looking into some of the residents, but she was not sure if those residents were going to receive therapy or be handed back to nursing. She stated nursing had not received any instruction on education of splint placing for Resident #17 or Resident #89. In an interview on 01/13/26 at 7:35 a.m. with the Previous Administrator/Corporate Compliance, he stated he was the acting administrator from around the first of November 2025 until December 5th, 2025, when he handed off the building to the current Administrator. He stated sometime around the end of November 2025, he had requested the therapy department screen for contractures and to provide a list to them on what residents needed splints. He stated that was the last conversation he had with the therapy department before he handed off the building. He stated therapy was supposed to be screening every time a resident's (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly assessment was completed. He stated they were provided with a list of the upcoming assessments and should be performing those screenings at the time of the MDS assessments. In an interview with MDS Nurse G on 01/13/26 at 10:00 a.m., she stated she was presented with a list, on 01/06/26, of all of the residents in the building who had contractures. She stated the therapy department had been discussing the outcome of the screenings in their morning meetings, but she was not sure what interventions they had determined needed to happen and for which residents. She stated contractures needed to be care planned with the necessary interventions to improve or prevent further decline from happening. In an interview with the Director of Rehab on 01/13/26 at 11:00 a.m., she stated her department had been requested to screen every resident in the building for contractures. She stated it took several weeks to get everyone screened. She stated they identified the residents who had contractures and needed splints. She stated she had submitted the request for the splints to be ordered to central supply, and her plan was once the splints arrived, they would follow up with the DON. She stated they had several residents who would benefit from therapy but did not have a payor source to cover it. She stated Resident #17 and Resident #89 were two of the residents who they had requested splints for. In an interview with the Administrator, DON and Director of Therapy on 01/13/26 at 12:05 p.m., the Administrator stated they had all met and discussed the steps which needed to be taken going forward. The Administrator stated once a resident was evaluated by therapy, and was determined to have a need for therapy, to assess and treat to establish the necessary interventions, they were to submit the evaluation to the payor source and if denied or if there was not a payor source, they were to immediately notify her so they could move forward with meeting the resident's needs. She stated the therapy department had been instructed to re-evaluate those residents who had been identified and put in the necessary orders and interventions to meet those residents' needs. Record review of the facility's policy titled, Prevention of Decline in Range of Motion, dated December 2025, reflected, Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motions is unavoidable. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion. Based on the comprehensive assessment, the facility will provide interventions, exercises, and/or therapy to maintain or improve range of motion. This includes, but is not limited to. Specialized rehabilitation, restorative, maintenance. braces or splints. Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner.		

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NAME OF PROVIDER OR SUPPLIER Lakewest Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2450 Bickers St Dallas, TX 75212	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 24 residents (Resident #98, Resident #68, Resident #12, and Resident #17) and 1 of 4 linen closets (Linen Closet for Hall 100) and the facility's only laundry room observed for infection control. 1. The facility failed to ensure CNA D and LVN E utilized Enhanced Barrier Precautions during incontinence care for Resident # 98 on 01/11/26. 2. The facility failed to ensure LVN E utilized Enhanced Barrier Precautions, performed hand hygiene after glove changes during wound care, and prevent cross contamination of the treatment cart after completion of wound care for Resident # 98 on 01/11/26. 3. The facility failed to ensure CNA C and CNA B changed their gloves and performed hand hygiene while providing incontinence care for Resident #98, used enhanced barrier precautions, and perform hand hygiene before entering and leaving the resident's room on 01/12/26. 4. The facility failed to ensure CNA C performed hand hygiene and glove changes during incontinence care of Resident #17, and CNA C and CNA B performed hand hygiene before entering and leaving the resident's room on 01/12/26. 5. The facility failed to ensure LVN E performed hand hygiene and changed gloves during Fingerstick blood sugar, prevent cross contamination of Resident #68's insulin pen, follow the manufacturer's recommendations for disinfecting the glucometer after obtaining fingerstick blood sugars for Resident #68, and failed to prevent cross contamination of LVN E's medication cart on 01/11/26. 6. The facility failed to ensure Agency LVN K utilized Enhanced Barrier Precautions while performing G tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) medication administration for Resident # 12 on 01/11/26. 7. The facility staff failed to store residents' personal clothing away from clean linens in Linen Closet for hall 100. 8. The facility staff failed to appropriately secure and label bags of residents' clothing in the facility's laundry room on 1/12/27. These failures could place residents at risk of cross-contamination and the development of infection. Findings include: 1. Record review of Resident #98's Significant change MDS assessment dated [DATE] reflected [AGE] year-old female with an admission date of 09/07/23. She was always incontinent of bowel and bladder. Diagnosis included Parkinson's disease (disorder of the central nervous system that affects movement), dementia, and diabetes. Record review of Resident #98's admission Note dated 01/09/26, completed by LVN J, reflected, . readmitted for kidney infection, on cipro until 1/12/26. Foley 18FR (unit for sizing catheters), light pink color. Open area to coccyx, top of right thigh open area no depth, boggy heels, right heel more soft with a scab, MD notified of arrival An observation and interview on 01/11/26 at 10:14 a.m. revealed CNA D providing incontinent care to Resident #98. CNA D put on gloves, but no gown. Resident was observed to have a urinary catheter and a wound dressing above her anus. There was no signage posted to indicate the resident was on Enhanced Barrier precautions. The wound care dressing was covered in bowel movement, and CNA D stated she would have to get the Nurse to come and redress the wound. CNA D removed her gloves, washed her hands and left the room to go and get the nurse. CNA D and LVN E entered the room, washed their hands and put on gloves, but no gown. CNA D continued to provide incontinence care and with instruction from LVN E. She removed the wound care dressing, revealing a stage 3 pressure ulcer (involves full-thickness skin loss). LVN E stated the resident had just returned from the hospital on Friday (01/09/26) She stated she did not have a urinary catheter before she went to the hospital and believed she had the wound before, but stated she only worked the weekends, and was not sure. LVN E stated she would have the Treatment Nurse come and re-dress the wound, if she was here, if not, she would review the orders and re-dress the wound. Both staff removed their gloves, washed their hands, and left the room. An observation on 01/11/26 at 10:49 a.m. revealed LVN E was outside of Resident #98's room preparing the wound care treatment. She gathered a bottle of wound care (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleanser, an open package of 4X4 gauze, collagen sheet (wound care dressing that promotes healing), and a dry dressing. LVN E entered the room and retrieved paper towels from the resident's bathroom and placed them on the Residents over bed table and laid out the wound care supplies. She then washed her hands and put on gloves but did not put on a gown. LVN E picked up the bottle of wound cleanser and sprayed the wound and pulled a few 4x4 gauze from the package of gauze and cleaned the wound. She removed her gloves, but did not perform hand hygiene, then applied the collagen dressing to the wound bed, changed gloves again with no hand hygiene, and covered the wound with a dry dressing. LVN E then removed her gloves, did not perform hand hygiene, and picked up the bottle of wound cleanser and the remaining unused 4x4 gauze and returned them to the top of the treatment caret. She re-entered the Resident's room and performed hand hygiene and returned to the cart and placed the bottle of wound cleanser and the 4x4's back into the treatment cart. In an interview with LVN E on 01/11/26 at 12:50 p.m., she stated Resident #98 should have been placed in Enhanced Barrier Precaution when she returned from the hospital on [DATE]. She stated any resident with a urinary catheter or wound had to be on enhanced barrier precautions, and she and the CNA should have worn a gown while providing care to Resident #98. She stated they did this to prevent the spread of multiple drug-resistant organisms to other residents. She stated she was supposed to perform hand hygiene after every glove change during wound care and just forgot. She stated she should have only taken in the supplies she needed, and by returning supplies to the cart, she had cross-contaminated the cart. She stated the Weekend Supervisor usually did the wound care on the weekends and the Treatment Nurse did the wound care during the week, but they were also responsible for wound care in their absence. She stated she would make sure the Enhanced Barrier Sign was posted. In an interview with CNA D on 01/11/26 at 1:18 p.m., she stated any resident with a catheter or wound was supposed to be in Enhanced Barrier Precautions which required them to wear a gown. She stated it was not posted outside of Resident #98's room, and she did not think to stop and go get a gown. She stated she had been trained on Enhanced Barrier Precautions and knew it was to prevent the spread of infection to other residents. In an observation on 01/12/26 at 09:30 a.m., CNA B and CNA C entered Resident #98's room. An Enhanced Barrier sign was posted outside of the room. Both staff put gloves on without performing hand hygiene, but neither staff put on a gown. CNA B unfastened the resident's brief and wiped across his pubic area, down each groin, but did not separate the labia and wipe down the middle or clean the catheter tube from the insertion site downward. CNA B did not remove her gloves or perform hand hygiene after cleaning the resident's front. Both staff assisted the Resident onto her side, and CNA C wiped from front to back to clean the anal area and then placed a clean brief under her without changing her gloves and performing hand hygiene. Both staff then rolled the resident back onto her back and fastened the brief. Both staff removed their gloves and left the room without performing hand hygiene. 2. Record review of Resident #17's quarterly MDS assessment, dated 12/11/25, reflected a [AGE] year-old male with an admission date of 09/19/22. He was frequently incontinent of bowel and bladder. Diagnoses included diabetes, cerebral vascular accident (stroke), and hemiplegia (paralysis on one side of the body). In an observation on 01/12/26 at 9:15 a.m., CNA C entered Resident #17 to perform incontinence care. CNA C entered the room and without performing hand hygiene put on gloves and unfastened the Residents brief and assisted the Resident to roll onto his left side revealing the resident was wet. CNA C then reached between the resident's legs and wiped downward with the penis and scrotum going toward the anal peri area with a few wipes. Wiped the anal area outward and then placed a clean brief under the resident, still wearing the same soiled gloves. CNA C assisted the resident back onto his back and fastened the brief. CNA B entered the room, put on gloves without performing hand hygiene and assisted with pulling the resident up in bed. CNA B removed her gloves and left the room without performing hand hygiene, while CNA C gathered the trash, removed her gloves and left the room without performing hand hygiene and walked down the hallway, deposited the trash in the soiled linen room, went to use the hand sanitizer in the hallway, which was empty, and then stepped into another resident's room and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	used the hand sanitizer on the wall. In an interview on 01/12/26 at 9:50 a.m. with CNA B and CNA C, they stated both stated they were supposed to sanitize their hands before and after providing care and acknowledged they had failed to do that. They both stated residents who had catheters were supposed to wear a gown when providing care and they had also failed to do that. CNA C stated she was not aware she had to change her gloves when going from dirty to clean during incontinence care. CNA B stated she knew she was supposed to change her gloves when going from dirty to clean and just failed to do it. They both stated they had received training on Enhanced Barrier Precautions, and were skills checked each year on hand hygiene. They stated the risk of not following infection control protocols was the spread of infection to other residents. 3. During a medication pass observation on 01/11/26 at 11:49 a.m., LVN E was at the medication cart preparing to check Resident # 68's blood sugar levels via a fingerstick blood sugar. LVN E retrieved a tray from the medication cart, wiped it down with a germicidal wipe, and then removed glucometer which was wrapped in a germicidal wipe from the top of medication cart. LVN E removed the wipe and placed the glucometer on the tray, along with several needles, a bottle of test strips, and the resident's Insulin pen. LVN E sanitized her hands, put on gloves and entered the resident's room. LVN E pricked the residents' fingers, obtained the blood sample for the blood glucose reading and placed the glucometer with the test strip still in it and the used lancet, on the tray next to the insulin pen and the unused needles. LVN E then attached a needle to the insulin pen, still wearing the same gloves she used to perform the finger stick blood sugar, primed the pen and dialed in the amount of insulin, and administered the insulin. LVN E then placed the pen back on the tray with the dirty glucometer, used lancet, and test strip, and returned to the medication cart where disposed of the lancet and test strip and returned to the medication cart and placed the glucometer on top of the medication cart. She then disposed of the needle and used test strip, removed her gloves, and performed hand hygiene. She then retrieved a germicidal wipe and wiped down the glucometer and the bottle of test strips and placed both of them back into the top of the medication cart without allowing them to air dry and returned the unused needles back into the top of the medication cart. In an interview and observation with LVN E on 01/11/26 at 12:52. p.m., LVN E retrieved the germicidal wipes from her medication cart, which revealed the amount of time an item needed to remain wet to achieve disinfection was 2 minutes. She stated she was not aware the glucometer had to air dry before placing it back in the cart. She stated she took Resident #68's insulin pen with her because he routinely received a set amount insulin regardless of the blood sugar readings. She stated she should have only taken in the supplies she needed and not the whole bottle of test strips. She stated any disposable items she did not use would be considered contaminate since it had been in the resident's room. She stated looking back, she should have completed the fingerstick blood sugar, removed her gloves and performed hand hygiene, before giving the insulin. She stated the risk was the spread of blood borne pathogens. 3. An observation on 01/11/26 at 02:58 p.m. of G-Tube medication administration revealed Agency LVN K at the medication cart outside of Resident #12's room. An Enhanced Barrier sign and a cart containing gowns were outside of the door. Agency LVN K prepared the medication for Resident #12, sanitized her hands and put on gloves, but did not put on a gown. Agency LVN K checked for residual, flushed the tube with water, and then administered the medication and flushed with water following the medication administration. Agency LVN K removed her gloves and performed hand hygiene and left the room. In an interview with Agency LVN K on 01/11/26 at 3:09 p.m., she stated any resident with a G-tube was required to be in Enhanced Barrier Precautions. She stated she should have worn a gown and just overlooked it when she entered the room. She stated the risk of not following Enhanced Barrier Precautions was the spread of MDRO's. 4. During an interview and observation with the Housekeeping Supervisor of the linen closets in the facility on 01/12/2026 at 2:36 p.m. revealed 6 clothing items were observed stored on the shelf with clean linens in the Linen Closet on Hall 100. The Housekeeping Supervisor was unable to state who put the clothing there or who it belonged to. He stated residents' clothing should not have been stored with the linens. He then grabbed the stack of clothes and held them until (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	arriving in the laundry room and put the clothing in a yellow bin on the dirty side of the laundry room. He stated he did not know if the clothing was clean or dirty and therefore put it in the bin to be washed. The Housekeeper Supervisor stated he had never seen clothing in linen closets; clothing should not be stored in linen closets due to risk of cross contamination. Observation of the laundry room revealed two doors. The first door was the dirty side; this was where the dirty clothes were handled. On the floor on the dirty side were two wide open large clear plastic bags with clothes in them. The bags had no label on them and were about 75 percent full. The Housekeeping Supervisor stated the bags were not supposed to be wide open on the floor and should have been closed and labeled with the name of a resident they belonged to. The Housekeeping Supervisor further stated because he was unsure if the clothing was soiled with bodily fluids the bags should have been closed and put in the yellow barrel with the top on to avoid issues with cross contamination. If the clothing were from a resident with EBP the clothing would need to have been stored in a different bag. The Housekeeping Supervisor stated there could be a health risk to the residents due to the bags not being properly closed or labeled. In an interview with Laundry Staff A on 01/12/2026 at 2:59 p.m., it was revealed that all clothes and linens were transported to the laundry room in plastic bins and sealed bags. If the clothing was in a bag, it should have been labeled with the resident's name and tied. She stated she saw the bags of clothes in the laundry room when she started her shift at 2pm, but she did not know who they belonged to as they just showed up. She stated she believed they were dirty but not soiled because they did not look soiled. She stated the risk of having the clothes just thrown there with no name and opened, was it would affect residents getting their items back timely. She stated if they were soiled items there could be a risk of cross contamination especially if they belong to a resident who was on EBP. Laundry Staff A also stated clean linen should not have been stored with residents' clothing. There should not have been any residents' clothing in the linen closets. Interview with CNA O on 01/12/2026 at 3:24 p.m. revealed residents' dirty clothing was stored in a bag or personal laundry basket in the residents' rooms, and once they were full, the laundry was taken to the laundry room. Before dropping the bags off, she would put the name of the resident and room number on a piece of paper and place it in the bag. She then would take the bags to the laundry room and leave them outside the door, and the button to let laundry staff know she dropped off laundry. For rooms that had residents on EBP, they would put the laundry in the infection cardboard boxes, store them in the bathroom and would notify housekeeping staff to pick them up. The red bag held anything with blood and the yellow bins were for linen. She stated the risk to the residents of not properly securing the bags of dirty laundry and not labeling them, would have been the spread of illness. In an interview with ADON H on 01/14/2026 at 2:05 p.m., she revealed she was the infection preventionist for the facility. She stated any resident who had a G-tube, wound, or urinary catheter was supposed to be in enhanced barrier precautions. She stated the admitting nurse was responsible for ensuring the signage was posted and the supplies were available. She stated she had done extensive training with the staff, even going to the residents' room and having them read on the Enhanced Barrier Precaution sign what care level required them to wear a gown and gloves when providing care. She stated in addition, she had not only provided them with instruction but had done return demonstration with the staff on when they were to perform hand hygiene and gloves changes during wound care and incontinence care. She stated they had no excuse for not following infection protocol, and the risk was spreading infections. She also revealed soiled or dirty linen should have been bagged and closed, and residents' dirty laundry should have been bagged, closed and labeled. She stated the big yellow bins were for soiled linen and should always be covered. The risk to the residents when dirty clothing and linen were not properly closed and transported to the laundry room was cross contamination and infection. She stated Resident's clothing, regardless of whether it was clean or dirty, did not belong in the linen closets because there was a risk of cross contamination. In an interview with the DON on 01/14/2026 at 2:21 p.m., she stated any resident who had any type of indwelling medical device was placed on Enhanced Barrier precautions to help reduce the spread of (continued on next page)		

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She stated to disinfect the glucometer, it had to stay wet for the designated amount of time the germicide used and remain on top of the med cart until dry, before placing it back in the cart. She stated when it was put back in the cart wet, it had not been effectively disinfected. As to the handling of soiled resident's clothing, she revealed the expectation of staff was they put residents' dirty clothing in bags with their names on them, tie the bag, and take them to the laundry. It was not okay for staff to place residents' laundry in the laundry room in an open bag without any labels. Not labeling the items could have delayed residents receiving their items back. She stated if clothing had blood or was from a resident diagnosed with c-diff, staff would use the biohazard bags to notify laundry staff the items were contaminated. She did not believe cross contamination was an issue with the bags opened on the floor, because residents that were on special precautions already had biohazard bags in their room, and they would not have their linens in regular bags. The DON stated linen closets should not have had residents' clothing or personal items stored in them. She stated personal items should not have been stored with clean linens because of the risk of cross-contamination if the clothing was dirty. She stated they trained on infection control, during their skills checks, and anytime they had any issues with infections in the building. She stated the risk of not adhering to the protocol was increased risk of infections. Record review of the facility's policy titled, Enhanced Barrier Precautions, dated March 2024, reflected, Enhanced Barrier Precautions (EHPs) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for resident with any of the following. Wounds. urinary catheters. feeding tubes. Implementation. Make gowns and gloves available immediately near or outside or inside of the resident's room. PPE for enhance barrier precautions is only necessary when performing high-contact care. High-contact resident care activities include. changing briefs or assisting with toileting. Device care or use. urinary catheters. feeding tubes. Wound Care. Record review of the facility's policy, Hand Hygiene, dated February 2023, reflected, All staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, resident, and visitors. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand hygiene. Hands are visibly soiled. Between resident contacts. After handling contaminated items. Before applying and after removing personal protective equipment (PPE), including gloves. Before and after handling clean or soiled dressings, linens, etc. When, during resident care, moving from a contaminated body site to a clean body site. Record review of the facility's policy, Glucometer Disinfection, dated January 2025, reflected, The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne disease to residents and employees. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant. Procedure. Put on gloves. Obtain capillary blood glucose sampling. Remove and discard gloves, perform hand hygiene prior to exiting the room. Reapply gloves. Retrieve (2) disinfectant wipes from container. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry. Perform (continued on next page)		

Department of Health & Human Services
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene. Record review of the facility's Laundry policy revised on 6/2025 reflected .1. Aligning with principles of standard precautions, staff shall consider all previously worn clothing and used linens as potentially contaminated.3. Soiled laundry shall be kept separate from clean laundry at all times. Record review of the facility's Safe and Homelike Environment policy revised on 7/2025 reflected .3. Housekeeping and maintenance services will provide as necessary to maintain a sanitary, orderly and comfortable environment. Record review of the facility's Infection Prevention and Control Program revised on 1/2024 reflected .12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. b. Clean linen shall be separated from soiled linen at all times. c. Clean linen shall be delivered to resident care units on covered linen carts with covers down. d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets. e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. f. Environmental services staff shall not handle soiled linen unless it is properly bagged.		

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility or the resident through a means other than a postal service, including the right to privacy of such communications for 1 (Resident #65) of 7 residents reviewed for resident rights. The facility failed to ensure staff distributed unopened mail packages to Resident #65. This deficient practice could result in residents not receiving their mail in a timely manner and diminished quality of life. Findings included: Record review of Resident #65's face sheet dated 1/14/26 reflected a [AGE] year-old female with an original admission date of 2/25/21 and re-admission date of 9/12/25. Resident #65 had the following diagnoses: Major Depressive Disorder (a serious mood disorder, marked by persistent sadness) and Generalized Anxiety Disorder (a condition marked by excessive, persistent and hard to control worry). Record review of Resident #65's Quarterly MDS Assessment on 12/31/25 reflected she had a BIMs score of 15 which indicated intact cognition. An interview with Resident #65 on 01/11/2026 at 10:11 AM revealed she had been receiving her Amazon packages opened. The last time this occurred was around December 2025. An interview with the Business Office Manager on 1/14/26 at 10:13 AM revealed when the facility received resident mail, they would pass it out to the residents. However, if the mail was medical insurance claims or bank statements, she would open the mail, scan it to herself, and put it in the residents' file on the computer. Interview revealed she would have done that process for bank statements, and insurance mail for all residents at the facility. She would not give residents mail pertaining to bank statements or insurance forms, but would file it in a cabinet. All other mail would have been given to residents as long as they were cognitively alert. The Business Office Manager stated she opened all mail before distributing it for residents who were cognitively impaired, but would give cognitively intact residents their mail closed. She stated if a cognitively impaired resident had gotten a birthday card or gift card, she opened it and then gave it to the resident. When she had a question about whether the resident should have gotten their mail, she would have called the Administrator, but it was rare because she knew who everyone was. The Business Office Manager stated she had delivered closed Amazon packages to residents in the past. Interview with the Business Office Manager revealed the receptionist delivered packages to the residents. Interview revealed she was unaware of the policy on delivering packages to residents. An interview with the Receptionist on 1/14/26 at 10:24 AM revealed she received packages for residents from Amazon, and mail at her desk. She stated she would take the packages to the residents, but before she gave them to the residents, she would show them to the assigned nurse for that resident. Interview with the Receptionist revealed if it was in a soft envelope package, the nurse would feel for what it was and would inform her if she could give the package to the resident. If the package was a box, the nurse would open the box to make sure it was not medication or something the resident could not have, and then she would take it to the resident. She stated she delivered packages to Resident #65 and could not recall if they were open or closed when she delivered them. An interview with the DON on 01/14/2026 at 2:21 PM revealed nursing was not responsible for packages or mail to residents. Interview with the DON revealed she had not heard of any staff opening mail or packages. She was not aware of any policy related to nursing having to check mail or boxes before providing them to the residents. She stated staff opening residents' mail and packages affected the residents' rights to privacy. An interview with the Administrator on 1/14/26 at 4:18 PM revealed when mail was received by the receptionist, it should have been taken to the Business Manager and/or the Activities Director, sorted, and given to the residents. Interview with the Administrator revealed the residents' mail should not have been opened before delivery. There was no reason the facility should open all residents' mail. The residents should have received their Amazon packages closed as well. It was the residents' right to privacy with their mail. The Administrator stated she was unaware staff was (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 01/14/2026
NAME OF PROVIDER OR SUPPLIER Lakewest Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2450 Bickers St Dallas, TX 75212	
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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opening Resident #65's mail packages. Record review of the facility's policy Communications Within and External to the Facility revised on 3/2025 did not reflect residents' rights to receive closed mail.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for two of 25 (Residents #17 and #89) reviewed for comprehensive care plans. 1. The facility failed to include, in the care plan for Resident #17, his left wrist contracture and interventions to prevent further decline. 2. The facility failed include, in the care plan for Resident #89, his contracture to his left hand, right hand and shoulder and interventions to prevent further decline of Resident #89's. These failures could place residents at risk for possible adverse side effects, adverse consequences, and decreased quality of life and care and did not represent a person-centered coordination of care. Findings included: 1. Record review of Resident #17's quarterly MDS assessment, dated 12/11/25, reflected a [AGE] year-old male with an admission date of 09/19/22. Resident #17 had a BIMS score of 15 which indicated his cognition was intact. He required substantial to maximum assistance for personal hygiene, toileting, bathing and dressing and had not refused care. He had functional limitations in range of motion upper and lower extremities on one side. He was frequently incontinent of bowel and bladder. Diagnoses included diabetes, cerebral vascular accident (stroke), and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7-day look back period. Record review of Resident #17's care plan revised on 08/01/25 reflected, a focus of Cerebral Vascular Accident. [Resident #17] has the diagnosis of Cerebral Vascular Accident with left side hemiparesis and is at risk for falls, contractures, over all wellbeing decrease. Interventions. Therapy to eval and screen as ordered and as needed. There were no interventions listed to address the contractures. Record review of Resident #17's Skilled Therapy referral initiated by the Director of Rehab dated 12/16/25 reflected, Patient referred to nursing for hand contracture. Patient appropriate for left resting hand splint to be worn for max of 4-hour duration. Patient would benefit from left hand splint to be worn during breakfast and lunch mealtimes to encourage more independence with self-feeding. In an observation and interview on 01/12/26 at 9:10 AM, Resident #17 was observed lying in bed. Resident had limited use of his left hand, and his wrist was turned downward approximately 90 degrees, and he was unable to straighten his wrist. He stated he had been trying to get a splint from therapy for a few months, but nothing had happened. He stated he did not want his wrist to get worse. In an observation of Resident #17 and an interview with OT L on 01/12/26 at 1:40 p.m., OT L assessed Resident #17's left arm, wrist and hand, and stated she thought he would benefit from therapy to improve his flexibility and decrease the pain. She stated he would benefit from a resting hand splint. She stated he was about the same as he was in December 2025 when they recommended a resting hand splint. 2. Record review of Resident #89's quarterly MDS assessment, dated 11/21/25, reflected a [AGE] year-old male with an admission date of 12/21/22. Resident #89 had a BIMS score of 15 which indicated his cognition was intact. He was dependent on staff for personal hygiene, toileting, bathing, eating and dressing and had not refused care. He had functional limitations in range of motion of both upper extremities and one side lower extremities. He was always incontinent of bowel and bladder. Diagnoses included spinal stenosis of the cervical (neck) regions (narrowing of spaces with the spine that puts pressure on the spinal cord, often causing pain and weakness in the back, neck, arms or legs), and chronic obstructive pulmonary disease (inflammation and obstruction of the airways, making it hard to breath). He had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7-day look back period. Record review of Resident #89's care plan with the last revision date of 12/03/25 on reflected, [Resident #89] requires assistance to perform functional abilities in Self Care and Mobility (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as indicated by unsafe and poor quality in range of motion related to medically complex conditions. There were no interventions to address the resident's contractures to his right arm and left hand. Record review of Resident #89's Skilled Therapy referral initiated by the Director of Rehab and dated 12/16/25 reflected, Patient referred to nursing for hand contracture. Patient appropriate for left resting hand splint to be worn for max of 4-hour duration. Patient would benefit from left hand splint to be worn during breakfast and lunch mealtimes to encourage more independence with self-feeding. In an observation and interview on 01/12/26 at 1:00 p.m., Resident #89 was observed lying in bed being fed lunch by a staff member. Resident's right arm was drawn up to his neck with his hand turned inward. His left hand was contracted with his second finger overlapping his first finger. Resident was able to move his wrist slightly but was not able to move his fingers. He stated he needed something done for his right hand, because he would like to be able to use for more independence. He stated he had not had any exercise for his left hand. He stated he was not able to move his right arm or hand at all. In an observation of Resident #89 and interview with OT L on 01/12/26 at 2:05 p.m., OT L assessed Resident #89's left hand, right hand, and right arm, and stated he would benefit from therapy to improve his flexibility and decrease the pain. She stated he would benefit from a resting hand splint. She stated he was about the same as he was in December 2025 when they recommended a resting hand splint. In an interview with CNA D on 01/11/26 at 10:00 a.m., she stated she was the restorative aide in the facility but also worked on the floor as a CNA. She stated her restorative care mainly consisted of doing weights on the residents. She stated the facility was big on getting weights. She stated she did not do any range of motion or placement of splints on residents. She stated therapy took care of the splints as far as she knew. In an interview with MDS Nurse G on 01/13/26 at 10:00 a.m., she stated she had only been with the facility since October 2025. She stated she was responsible for updating the comprehensive care plan when she completed the Annual, quarterly or significant change assessment. She stated she assumed the DON and ADONS updated the care plan when there were changes. She stated she was presented with a list on 01/06/26 of all of the residents in the building who had contractures but had not updated the care plans yet. She stated the therapy department had been discussing the outcome of the screenings in their morning meetings, but she was not sure what interventions they had determined needed to happen and for which residents. She stated contractures needed to be care planned with the necessary interventions to improve or prevent further decline from happening. She stated the care plan was supposed to be a comprehensive approach to what the needs of the resident were or what their wishes were. An interview with the DON on 01/12/26 at 2:25 p.m. p.m. revealed the MDS Coordinator, herself, and the ADONS were all responsible for updating the care plans. She stated all contractures should have been care planned with interventions in place. She stated if a resident had splints ordered, it should be placed in the physician's orders. The DON stated if a resident refused the required splint, then it should be documented on the care plan. She stated failing to have interventions in place, put residents at risk of further decline and decreased range of motion, and by not updating the care plan, they had no evidence of what attempts had been made to prevent a resident's decline. She stated she knew the therapy staff was supposed to be screening the residents every quarter and would expect if they determined the resident had a new contracture, they would develop a plan with interventions. She stated she knew they were looking at Resident #17 and Resident #89 for possible splints, but the contractures should have been care planned and updated with the interventions they put in place. Record review of the facility's policy, Comprehensive Care, revised April 2023, reflected, 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, mental and psychosocial needs that are identified in the comprehensive assessment. Record review of the facility's policy titled, Prevention of Decline in Range of Motion, dated December 2025, reflected, Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition demonstrated that a reduction in range of motions is unavoidable. Based on the comprehensive assessment, the facility will provide interventions, exercises, and/or therapy to maintain or improve range of motion. This includes, but is not limited to. Specialized rehabilitation, restorative, maintenance braces or splints. Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 (Resident #39 and Resident #48) of 4 residents reviewed for wound treatment. 1. The facility failed to provide care for Resident #39's wounds as identified on the resident's physician's orders on 1/9/2025. 2. The facility failed to provide care for Resident #48's wound and obtain physician order for another wound that had reopened on 1/8/2025. These failures could place residents at risk for delayed wound healing or worsening of the existing wound. Findings included: 1. Record review of Resident 39's quarterly MDS assessment dated [DATE] reflected, Resident # 39 was a [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included: Stroke (Decreased blood flow to the brain), Anemia (low blood count), Hypertension (High blood pressure), Hyperlipidemia (elevated lipid levels in blood), Hemiplegia (one sided weakness in a person's body), Chronic venous hypertension with ulcer of left/Right lower extremity (damaged valves or blockages cause blood to pool, leading to high pressure, skin changes, inflammation, and open sores (venous ulcers)). Her BIMS score was 15 which indicated Resident #39's cognition was intact. Record review of Resident #39's care plan revised on 11/12/2025 reflected, Focus: [Resident #39] has a venous/stasis ulcer of the Right. Posterior Calf related to poor circulation and increased edema. Intervention: .Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. Record review of Resident #39's care plan revised on 11/12/2025 reflected, Focus: [Resident #39] has a venous of the Left Lateral Leg related to poor circulation and increased edema. Intervention: .Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. Record Review of Resident #39's Physician Orders dated reflected dated 12/31/2025 reflected, Non-Pressure Rt. Posterior Leg/Calf cleanse wound bed with Nexodyn solution (type of wound cleanser) or wound cleanser, pat dry, apply Xeroform, cover with gauze, Kerlix gauze and Coban. every Monday, Wednesday, Friday related to NONPRESSURE CHRONIC ULCER OF OTHER PART OF RIGHT LOWER LEG WITH FAT LAYER EXPOSED. Record Review of Resident #39's Physician Orders dated 12/31/2025 reflected, Non-Pressure Lower Lt Lateral Leg cleanse wound bed with Nexodyn solution or wound cleanser, pat dry, apply Xeroform, cover with ABD gauze, Kerlix gauze and Coban. every Monday, Wednesday, Friday related to CHRONIC VENOUS HYPERTENSION (IDIOPATHIC) WITH ULCER OF LEFT LOWER EXTREMITY. Record review of Resident #39 Treatment admission Record (TAR) for January 2026 reflected, Non-Pressure Rt. Posterior Leg/Calf cleanse wound bed with Nexodyn solution or wound cleanser, pat dry, apply Xeroform, cover with ABD gauze, Kerlix gauze and Coban. No administration of treatment was recorded on 01/09/2026. Record review of Resident #39 TAR for January 2026 reflected, Non-Pressure Lower Lt Lateral Leg cleanse wound bed with Nexodyn solution or wound cleanser, pat dry, apply Xeroform, cover with ABD gauze, Kerlix gauze and Coban. No administration of treatment was recorded on 01/09/2026. In an observation and interview on 01/11/2026 at 2:45 PM with Resident #39 revealed the date on wound care bandage on both lower extremities was 1/7/2026. Resident #39 stated that wound care was last performed on Wednesday 1/7/26. She stated that the Wound Care Nurse told her she would be on vacation on Friday 1/9/2026 (when wound care was expected to be performed next) and no other staff member had performed the wound care. An interview on 01/11/2026 at 2:51 PM with RN I revealed she worked as the Weekend Supervisor and performed wound care on the weekends. As needed for residents on the weekend. She stated she was aware that the Wound Care Nurse that usually worked in the facility from Monday through Friday, did not work on 1/9/2026. She stated that the assigned floor nurses (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were responsible for providing wound care to residents on 1/9/2026. She stated that she worked in the facility on 1/10/2026. She stated that she was not aware or informed by any staff that Resident #39 did not receive wound care on 1/9/2026 or over the weekend, until the surveyor brought it to her notice. She stated that she would look at Resident #39's wound care orders after the interview was completed. She stated that the risk of not performing wound care as ordered was worsening of wounds and delayed healing. In an observation on 1/12/2026 at 1:12 PM of Resident # 39's bilateral lower extremity wound care treatment with LVN F revealed Resident # 39 had a new bandage on the wound dated 1/11/2026. Resident #39 stated to LVN F that RN I performed wound care on both the wounds late evening on 1/11/2026. The dressing was dry and the wound was stable. An interview on 1/12/2026 at 1:59 PM with LVN F revealed she worked as the charge nurse on 1/9/26 from 6AM - 2PM. She stated she was aware that the Wound Care Nurse that usually worked in the facility from Monday through Friday, did not work on 1/9/2026 and she was responsible for performing wound care on residents. She stated that she got busy with care for other residents and could not complete the wound care. She asked the oncoming Nurse for 2-10 PM shift (LVN J) to perform wound care for Resident #39. She stated that the risk of not performing wound care, as ordered was worsening of wounds and delayed healing. An interview on 1/12/2026 at 2:16 PM with LVN J revealed she worked as the charge Nurse on 1/9/26 from 2 -10 PM. She stated that LVN F told her that Resident #39 needed wound care. However, she got busy in her shift, taking care of residents that she was not able to complete. She stated that she informed the oncoming Nurse, LVN T, that Resident #39's wound care was pending. She stated that the risk of not performing wound care as ordered was worsening of wounds and delayed healing. In a phone interview on 1/13/26 at 9:02 AM with LVN T revealed she worked as the charge nurse on 1/9/26 from 10 PM to 6 AM on 1/10/26. She stated that LVN J told her that Resident #39 needed wound care. However, she got busy in her shift taking care of other residents, and was not able to complete it. She stated that she informed RN I about Wound care was not performed on 1/9/26. She stated that the risk of not performing wound care as ordered was worsening of wounds and delayed healing. In an interview on 01/13/2026 at 10:07 AM with the DON, she stated that her expectation was that when the Wound Care Nurse wound nurse was not in the building, the floor nurses should be providing the ordered wound care and treatments. She stated that the floor nurses should have notified the physician about the missed treatment and obtained a PRN order for the same. She stated that the RN I called the physician to obtain PRN wound care order and provided wound care to Resident # 39 on 1/11/2026 after surveyor intervention. She stated that all the facility nurses were aware that the wound care nurse was not available in the facility from 1/8/26 through 1/12/2026. She stated that risk of not providing ordered wound care could result in deterioration of the wound and delayed healing process. 2. Record review of Resident 48's quarterly MDS assessment dated [DATE] reflected, Resident #48 was a[AGE] year-old male admitted to the facility on [DATE]. His pertinent diagnoses included: Stroke (Decreased blood flow to the brain), Cancer, Hypertension (high blood pressure), Respiratory failure (not enough oxygen in the blood). His BIMS score was 13 which indicated Resident #48's cognition was intact. Resident # 48 was on hospice services. Record review of Resident #48's care plan revised on 12/12/2025 reflected, Focus: [Resident #48] has a Skin Tear/potential for skin tear of the Left Lower Lateral Leg related to severe edema. Goal: [Resident #48] will be free from skin tears through the review date. Intervention: If skin tear occurs, treat per facility protocol and notify MD, family. Record Review of Resident # 48's progress noted dated 01/08/2026 at 15:44 written by LVN S reflected, per hospice nurse, [Resident # 48] has small open area to left shin/anterior side, already has dressing in place with xeroform and kerlix, [LVN S] sees no wound care orders in place, wound was healed out last week Monday/Tuesday, she said it must have happened after Tuesday 1/6/2026 , her visit with patient, she left wound care supplies, will let [Wound care nurse] know, in case orders need to be added, asked hospice nurse did she usually leave orders, she said [Wound care Nurse] normally just puts them in. Record review of Record review of Resident #48 TAR for January 2026 reflected no new (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders or wound care treatment for left shin wound. An observation and interview on 1/13/25 at 12:50 PM with Resident #48, he stated that he had some wounds on his legs. He had a skin tear on the left shin that was red, but no dressing on it. He stated that the hospice nurse told him that his shin wound had opened up again. In an interview and record review on 1/13/26 at 1:15 PM with the Wound Care Nurse revealed she was on leave, and not in the facility from 1/8/26 to 1/12/2026. She stated that Resident #48 had a prior wound on left shin that had healed. She stated she was not aware that Resident #48 left side shin wound had opened up again until the hospice nurse met her on 1/13/26 and informed her. She stated that she was reading the progress note from LVN S dated 1/8/26 for the first time after this surveyor informed her. She stated that if the Hospice Nurse informed about a re-opened wound and Nurse could not find orders for it, her expectation was that floor nurse would call the physician for orders to treat it. She stated not addressing the wound in a timely manner or obtaining physician orders to treat the wound may lead to worsening of the wound and delayed wound healing. In a phone interview on 01/13/2026 at 1:35 PM with the Hospice Nurse, she stated that she had seen a skin tear on Resident # 48's left lower leg that had previously closed up on. She stated she visited Resident #48 on 1/6/26, and the wound had healed. On 1/8/26, when she visited Resident #48, she saw the wound had opened up and informed LVN S about the same. She stated that usually she would inform the Wound Care Nurse in the facility, but did not see the Wound care nurse on 1/8/2026. She stated that she visited Resident #48 on 1/13/26, and saw that Resident #48 did not receive any treatment for the skin tear. She stated that there was no change in the wound. She added that she met with the Wound care nurse in the facility on 1/13/26 and informed her about the new skin tear. She stated not addressing wounds promptly could lead to worsening of the wound and delayed healing. In an interview on 1/13/26 at 2:15 PM with LVN S stated she had just started working in the facility few days ago and was on training until Wednesday 1/7/26. She stated that she worked the 2 PM -10 PM shift at the facility on 1/8/2026. She stated that Hospice Nurse came to visit Resident #48 and found a wound that had reopened on Resident's left shin. She stated that she was made aware by the DON that the wound care nurse would not be available in the facility from 1/8/26-1/12/26. She stated that she should have called the physician to obtain new wound care orders for the reopened wound rather than waiting on the wound care nurse to come back to the facility. She stated that the risk to the residents, if the wound is not treated in a timely manner, was worsening of the wound. In a follow-up interview on 01/13/2026 at 2:28 PM with the DON, she stated that her expectation was that the nurses should follow up with the physician for any new wound for orders. She added if there was a new wound discovered, nurses should call the physician and have orders put in for treatment. She stated that the risk of not addressing the wound in a timely manner was worsening of the wound. Record review of the facility's policy titled, Wound Treatment Management revised May 2025 reflected, .1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities for 1 (Resident #55) of 2 residents reviewed for prescription eyeglasses. The facility failed to follow up in a timely manner on prescription eyeglasses for Resident #55 after his eye exam was completed on 7/17/25. This deficient practice and failure could place residents at risk for worsening vision and decreased quality of life. Findings included: Record review of Resident #55's face sheet, dated 1/15/2026, revealed a [AGE] year-old male with an admission date of 3/7/22. Pertinent diagnoses included Chronic Kidney Disease, Unspecified Dementia (cognitive decline that severely impairs daily life), Major Depressive Disorder (a mood condition causing persistent sadness, loss of interest and affecting how you feel) and Adult Failure to Thrive (a syndrome of decline, marked by weight loss, poor appetite, inactivity and social withdrawal). Record review of Resident #55's Quarterly MDS assessment, dated 12/24/25, revealed a BIMS score of 15, which revealed intact cognition. Record review of Resident #55's active physician orders on 1/14/26, revealed no order for prescription eyeglasses. Record review of Resident #55's eye exam summary dated 7/17/25 reflected .Assessment:1. Cataract (the clouding of the eye's natural lens), mixed; Stable; Both eyes 2. Hyperopic astigmatism (a refractive error where one or both curves of the eye focus light behind the retina) and presbyopia (the loss of eyes' ability to focus on close-up objects); Stable; Both eyes; update recommended. Plan: 1. Monitor; Follow-Up: Comprehensive 07/17/2026 2. New bifocals; Follow-Up: Comprehensive 07/17/2026.New Glasses recommended? Yes, to be delivered upon approval. Action Required by Nursing Home Staff: Glasses required? Yes, encouraged full-time use for distance and reading. Record review of an email thread between the Social Worker and the eye care provider on 1/12/26 at 2:23pm reflected a request for an update on Resident #55's eye care services stating he had an eye refraction on 7/7/25. An interview with Resident #55 on 1/12/26 at 10:31am revealed he had gone to the optometrist a while ago and had not gotten his glasses. Resident #55 stated he had been waiting for several months for them to arrive. An interview with the Social Worker on 01/13/2026 at 4:06 PM revealed she had just followed up on Resident #55's eyeglasses that week because he asked her for his glasses. She stated it was her first follow up because she had only been working at the facility for a couple of weeks. The Social Worker then stated she did not know what attempts the previous social worker made to obtain Resident #55's eyeglasses. She stated she noted Resident #55 had been prescribed glasses in July of 2025. The Social Worker stated she delivered Resident #55's eyeglasses earlier in the day 01/13/26, as she had received them in the mail. She stated when residents needed an eye exam, she would fax their face sheet and an order from the doctor to see their vision provider. The vision provider came once per month and saw residents who were on their list and had been referred to them. If a resident needed glasses, the provider would send an authorization for the Social Worker to sign, and the provider would order the glasses and shipped them to the facility. She had no way to determine who was pending glasses prior to her employment with the facility, and only knew to follow up on the status of glasses if the resident had asked her. An observation and interview with Resident #55 on 1/14/26 at 10:20 am revealed he was wearing glasses and stated he had gotten his glasses yesterday. Resident #55 stated he waited for over 5 months for his glasses, and couldn't see good during that time. An interview with the DON on 01/14/2026 at 2:21 PM revealed Resident #55's need for glasses fell through the cracks with the previous social worker. The DON stated the Social Worker was responsible for following up with eye exams and glasses. She stated it would not have been good for residents to wait a long time for their glasses because it could affect their vision and their vision could worsen. An interview with the Administrator on 01/14/2026 at 4:28 PM revealed the expectation for a follow up on glasses for a resident who was pending to receive glasses would have been 3-4 weeks, not 6 months. She stated Social Services was responsible for the follow-up of any (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Lakewest Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2450 Bickers St Dallas, TX 75212	
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations from the vision provider to include obtaining glasses for the resident. She stated the lapse of time between when Resident #55 saw the doctor to when he received the glasses, possibly put him at risk of more vision problems or even could have caused headaches. Record review of the Facility's Hearing and Vision Services policy revised on 12/2025 reflected .it is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated.2. Staff should refer to any identified need for hearing or vision services/appliances to the social worker/social service designee. 3. The social worker/social service designee is responsible for assisting residents and their families, in locating and utilizing any available resources.for the provision of the vision and hearing services the resident needs. 4. Once vision or hearing services have been identified, the social worker/social services designee will assist the resident by making appointments and arranging for transportation.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for two of four residents (Resident #17 and Resident #98) reviewed for quality of care. 1. The facility failed to ensure CNA C provided appropriate perineal care for Resident #17 when she failed to clean the resident's penis downward and the pubic area on 01/12/26. 2. The facility failed to ensure CNA B provided appropriate catheter and perineal care for Resident #98, when she failed to separate the labia and wipe the catheter tubing from the insertion site downward while providing care on 01/12/26. These failures could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections. Findings included: 1. Record review of Resident #17's quarterly MDS assessment, dated 12/11/25, reflected a [AGE] year-old male with an admission date of 09/19/22. Resident #17 had a BIMS score of 15 which indicated his cognition was intact. He required substantial to maximum assistance for personal hygiene, toileting, bathing and dressing and had not refused care. He had functional limitations in range of motion upper and lower extremities on one side extremities. He was frequently incontinent of bowel and bladder. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #17's care plan revised on 12/17/25 reflected, Functional Abilities: [Resident #17] requires assistance to perform functional abilities in Self Care and Mobility related to his history of cerebral vascular accident with left hemiplegia. Intervention. Provide the following self-care assistance. Toilet Hygiene: Substantial/max assist. In an observation on 01/12/26 9:15 a.m. CNA C entered Resident #17's room to perform incontinence care. CNA C put on gloves and unfastened the Residents brief and assisted the Resident to roll onto his left side revealing the resident was wet. CNA C then reached between the resident's legs and wiped downward with the penis and scrotum going toward the anal peri area with a few wipes. Wiped the anal area outward and then placed a clean brief under the resident, still wearing the same soiled gloves. CNA C assisted the resident back onto his back and fastened the brief without cleaning his pubic area, the penile shaft, or scrotum. In an interview on 01/12/26 9:48 a.m. with CNA C, she stated she thought she did Resident #17's peri-care correctly because she wiped from his front toward his back. She stated she did not know she was supposed to hold the penis and wipe the penial shaft toward the scrotum. She stated she thought she had cleaned between his legs, but she did not clean the pubic area. She stated she had been checked off for incontinence care not long ago, but she did not remember those steps. She stated the risk of not performing correct incontinence care would be infection if it was not done right. 2. Record review of Resident #98's Significant change MDS assessment dated [DATE] reflected [AGE] year-old female with an admission date of 09/07/23. Resident had a BIMS score of 8 which indicated her cognition was moderately impaired. She was always incontinent of bowel and bladder. Her diagnosis included Parkinson's disease (disorder of the central nervous system that affects movement), dementia, and diabetes. Record review of Resident #98's admission Note dated 01/09/26, completed by LVN J, reflected, . readmitted for kidney infection, on cipro until 1/12/26. Foley 18FR (unit for sizing catheters), light pink color. Open area to coccyx, top of right thigh open area no depth, boggy heels, right heel more soft with a scab, MD notified of arrival In an observation on 01/12/26 at 09:30 a.m. CNA B and CNA C entered Resident #98's room, put on gloves, but no gown and told her they were there to get her changed. CNA B unfastened the resident's brief and wiped across his pubic area, down each side of the groin area, but did not separate the labia and wipe down the middle or clean the catheter tube from the insertion site downward. Both staff assisted the Resident onto her (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side, and CNA C wiped from front to back to clean the anal area and then placed a clean brief under her. Both staff then rolled the resident back onto her back and fastened the brief. In an interview on 01/12/26 at 9:50 a.m. with CNA B and CNA C, they both stated they were supposed to provide catheter care every time they provided incontinence care. CNA B stated I know what I did wrong. I did not go down the middle and wipe down the catheter tube. She stated the risk to the residents were urinary tract infections. She stated she had been skills checked on catheter care and knew the importance of doing it correctly. In an interview on 01/14/26 at 2:50 p.m. with ADON H, she stated she was also the infection preventionist for the building. She stated they did frequent training on infection control, and all of the staff were skilled checked, and had to do a return demonstration. She stated the staff knew the proper procedures; they just needed to follow them. She stated the risk of not following the procedures was increased risk of infection to the resident. In an interview with the DON on 01/14/26 at 2:55 p.m., she stated it was the expectation for all staff to provide timely and appropriate incontinent and catheter care. She stated she could attribute some of it to nerves, but they would do some re-education to ensure staff were following the correct procedures. She stated the risk of not performing correct peri-care or catheter care was increased risk of infection. She stated they did annual competency checks, but going forward, they needed to start doing spot checks while making rounds to see how the staff were providing care to the residents. Record Review of CNA B's Certified Nursing Skills Checklist, dated 07/28/25, reflected she was competent in infection control, peri-care and catheter care. Record Review of CNA C's Certified Nursing Skills Checklist, dated 09/09/25, reflected she was competent in infection control, peri-care and catheter care. Record review of the facility's policy titled, Perineal Care, dated January 2024, reflected, .Males.Assist resident to supine position.Gently raise penis.hold the shaft of the penis with one hand and was with the other. Begin cleansing tip of penis at urethral meatus using a circular motion and working outward.Cleanse the shaft of the penis, using downward stroked toward the scrotum. Use separate section of the washcloth or new disposable wipe with each stroke.Cleanse scrotum, using a clean portion of the washcloth, new washcloth or new disposable wipe with each stroke.Pat dry.Turn the resident on his. Clean and dry the bottom of the scrotum and the anal area.Remove gloves.perform hand hygiene. Record review of the facility's policy titled Catheter Care, dated March 2023, reflected, .Perform hand hygiene.Don gloves.Female: Gently separate the labia to expose the urinary meatus. Wipe front to back with a clean cloth moistened with water and perineal cleaner or moist wipes. Use a new part of the cloth/wipe or different cloth/wipe for each side. With a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as not to pull on the catheter.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy for 1 (Resident #3) of 3 residents reviewed for therapy services. The facility failed to provide physical therapy for Resident #3 after her PT evaluation, recommending therapy, was completed on 8/15/25. This failure could place residents at risk for decline in range of motion, decreased mobility, development of contractures, and a decline in quality of life. Findings included: Review of Resident #3's Face sheet dated 1/13/26 reflected a [AGE] year-old female with an original admission date of 3/25/23 and a readmission date of 10/22/25. Review of Resident #3's Significant Change MDS assessment, dated 10/28/25, reflected her cognition was intact with a BIMS score of 13. The resident had upper and lower extremity impairment on one side and used a walker. Resident #3 was dependent on staff for toileting, showering, lower body dressing, and putting and taking off footwear. She also needed substantial assistance with upper body dressing and personal hygiene. Resident #3 had no therapy. Active diagnoses included Cerebrovascular Accident (commonly known as a stroke, where blood flow to a part of the brain is interrupted), Hemiplegia and Hemiparesis (muscle weakness or partial paralysis on one side of the body), Hemiplegia following Cerebral Infraction (paralysis or severe weakness of one side of the body due to brain damage), effusion left knee (excess fluid buildup in or around the knee joint) and pain in left knee. Review of Resident #3's comprehensive care plan revised on 10/30/25, reflected, .Resident #3 has the diagnosis of CVA with hemiparesis and is at risk for falls, contractures, over all wellbeing decrease. Left hemiparesis Date Initiated: 05/20/2025 Revision on: 05/20/2025 The resident will not experience signs and symptoms of a CVA unaddressed X 90 days. Date Initiated: 05/20/2025 Revision on: 10/30/2025 Target Date: 11/11/2025 The resident will maintain current level of independence X 90 days. Date Initiated: 05/20/2025 Revision on: 10/30/2025 Target Date: 11/11/2025 . Therapy to eval and screen as ordered and as needed date initiated 5/20/25. Review of Resident #3's physician orders on 1/13/26 revealed no orders for restorative therapy or therapy. Review of Resident #3's Physical Therapy Evaluation & Plan of Treatment dated 8/15/25 reflected .Focus of plan of Treatment = Restoration.Assessment Summary: Clinical Impressions: Patient presents with left-sided hemiparesis, inability to rip with left hand, impairments in motor control, trunk control, postural control, activities tolerance, generalized strength, sitting balance and tolerance, and generalized coordination, thus negatively impacting performance of bed mobility and manual w/c mobility. Reason for Skilled Services: given the assessment above, patient will highly benefit from PT services in order to address the above impairments and allow patient improve bed mobility, OOB frequency and maximize functional manual w/c propulsion to improve functional independent in the facility.Assessment Summary: Risk Factors: Due to the documented physical impairments and associated functional deficits, without skilled therapeutic interventions, the patient is at risk for : DVT, falls, immobility, further decline in function, depression, dehydration, limited out of bed activity, muscle atrophy, pressure sores, decreased skin integrity, contracture (s) and compromised general health. Record review of Nurse Practitioner Progress note for Resident #3 dated 9/22/25 reflected PROGRESS NOTE: REASON FOR FOLLOW UP:.Acute left lower extremity DVT. #History of multiple CVA complicated by debilitation and wheelchair-bound #Debility Patient reports compliance with medication at home no new focal neurological sinus symptoms noted -CVA with left-sided hemiplegia: -She is wheelchair dependent -Continue aspirin and Lipitor. -Previous echo showed normal EF, and patent foramen ovale is not demonstrated. -Fall precaution -Continue physical therapy. Record review of Nurse Practitioner Progress note for Resident #3 dated 10/6/25 reflected Progress Note: REASON FOR FOLLOW UP: . Acute left lower extremity DVT.#History of multiple CVA complicated by debilitation and wheelchair-bound #Debility -Patient reports compliance with medication at home no new focal (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neurological sinus symptoms noted -CVA with left-sided hemiplegia: -She is wheelchair dependent -Continue aspirin and Lipitor. -Previous echo showed normal EF, and patent foramen oval is not demonstrated. -Fall precaution -Continue physical therapy. Record review of Nurse Practitioner Progress note for Resident #3 dated 10/24/25 reflected Progress Note: REASON FOR FOLLOW UP. Acute left lower extremity DVT. ASSESSMENT & PLAN #Acute left lower extremity DVT as evident per the ultrasound Doppler Most likely secondary to sedentary lifestyle given left-sided residual weakness from prior stroke and obesity. - S/P heparin drip - Started on Eliquis - PT evaluation. Record review of Nurse Practitioner Progress note for Resident #3 dated 12/22/25 reflected Progress Note: REASON FOR FOLLOW UP:.. Acute left lower extremity DVT. ASSESSMENT & PLAN. #History of multiple CVA complicated by debilitation and wheelchair-bound #Debility -Patient reports compliance with medication at home no new focal neurological sinus symptoms noted -CVA with left-sided hemiplegia: -She is wheelchair dependent -Continue aspirin and Lipitor. -Previous echo showed normal EF, and patent foramen oval is not demonstrated. -Fall Precaution-Continue physical therapy. Interview with Resident #3 on 01/11/2026 at 11:44 AM revealed she had been at the facility for a while, was there for therapy. Resident # 3 stated she had not had any therapy since her admission. Resident #3 stated she would like to walk again, and would like to have been more independent. Interview with LVN J on 01/12/2026 at 2:23 PM revealed she has been Resident #3's nurse for several months. LVN J stated she was not completing restorative therapy with her. She stated therapy had not provided any exercises to do with Resident #3. She stated the risk to the residents not having received any exercises or assistance from therapy would have been the resident could have gotten more contracted. Interview with the Director of Rehab on 01/12/2026 at 1:01 PM reflected Resident #3 was not in therapy. The Director of Rehab stated Resident #3 had been evaluated on 6/18/25 and 8/15/25 by therapy and determined she needed therapy, but when the evaluation was submitted to the insurance, it was not approved. She stated the rehab department would reassess resident whenever her payor source changed to see if they would approve therapy. Resident #3 had not had therapy in the last year due to not being approved by her insurance. The Director of Rehab stated when the payor source denied therapy, the next step would have been to notify the Administrator, but she did not know if this was done due to her not working at the facility when Resident #3's last evaluation was done. The risk of the resident not receiving rehab was possible decline and/or lack of improvement in her ADLs. Interview with CNA U on 01/13/2026 at 10:25 AM revealed she had worked with Resident #3 since she had arrived at the facility, and stated Resident #3 frequently complained about not having gotten therapy. She stated Resident #3 would ask for therapy, and therapy staff would tell her the insurance had not approved it. CNA U stated she had not been provided with any therapy exercises to do with Resident #3. In an interview with the Administrator, DON, and Director of Therapy on 01/13/26 at 12:05 p.m., the Administrator stated they had all met and discussed the steps which needed to be taken going forward. The Administrator stated once a resident was evaluated by therapy and was determined to have a need for therapy, to assess and treat to establish the necessary interventions, they were to submit the evaluation to the payor source, and if denied or if there was not a payor source, they were to immediately notify her so they could move forward with meeting the resident's needs. She stated the therapy department had been instructed to re-evaluate those residents, who had been identified, and put in the necessary orders and interventions to meet those residents' needs. Review of the facility's Specialized Rehabilitative Services revised September 2025 reflected Policy: The facility shall provide or obtain services from an outside resource for specialized rehabilitative services if required by the resident's comprehensive assessment and care plan. These services will assist them in attaining, maintaining or restoring their highest practicable level of physical, mental functional and psycho-social wellbeing.5. Specialized rehabilitative services are considered a facility service and included within the scope of facility services: therefore, if services are not enumerated in the State plan, the facility will not charge Medicaid recipients for specialized rehabilitative services.		