STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676497	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health and Wellness	110 N State Hwy 274 Kemp, TX 75143

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering and receipt of all drugs and biologicals, to meet the needs of 3 of 6 residents reviewed for pharmacy services. (Resident #2, Resident #3, Resident #4) 1. The facility failed to ensure Resident #2 was administered her Nifedipine (medication to treat high blood pressure and chest pain) on 4/12/24 when it was available in the facility's emergency kit. 2. The facility failed to ensure MA D administered Resident #3 only her ordered medication and did not administer Trazodone (anti-depressant medication) and Ativan (anti-anxiety medication) without orders on 6/25/24. 3. The facility failed to ensure MA C administered Resident #4 her amlodipine (medication to high blood pressure and chest pain) on 7/18/24. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings Include: 1. Record review of the face sheet dated 7/17/24 indicated Resident #2 was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including dementia, atrial fibrillation (irregular, often rapid heart rate commonly caused by poor blood flow), and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #2 was understood by others and understood others. The MDS indicated Resident #2 did not have a BIMS score. Record review of the care plan last revised 7/10/24 indicated Resident #2 had hypertension with the potential for abnormal blood pressure, impaired vision, headache, and stroke with interventions including give anti-hypertensive medications as ordered. Record review of the physician orders dated 7/17/24 indicated Resident #2 had an order for Nifedipine Extended Release 30mg 1 tab daily for hypertension starting 3/13/24. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MAR dated April 2024 indicated Resident #2 did not received her Nifedipine 30mg. Record review of Medication Error report dated 4/12/24 indicated Resident #2's Nifedipine was not administered due to not being available. The Medication Error report indicated the immediate action taken by the facility was Resident #2's vital signs were obtained, and notification was made to the nurse practitioner, responsible party, and pharmacy. Record review of the undated emergency kit's Active Inventory list indicated the emergency kit contained Nifedipine Extended Release 30mg, quantity of 10. During an interview on 7/17/24 at 10:20 a.m. the DON said an MA or nurse can obtain medication from the emergency kit. The DON said the emergency kit should be utilized for new medication orders and medications that are not available due to not being delivered from the pharmacy at the time the medication is due. During an interview on 7/17/24 at 12:25 p.m. MA E said she worked 6:00 a.m. to 2:00 p.m. as a medication aide at the facility. MA E said she did not remember the incident on 4/12/24 with Resident #2 not receiving her Nifedipine due to the medication not being available. MA E said only a nurse can access the emergency kit. MA E said if the facility was out of a medication and pharmacy has not delivered the medication the nurse could pull the medication from the emergency kit. MA E said it was important to ensure residents received their medication because it was ordered from the doctor for them to maintain quality of life. MA E said Resident #2 was a resident they had to watch her medication and give them carefully because she would notify her family if she was not receiving her medications. During an interview on 7/18/24 at 9:14 a.m. Resident #2 said she had not had any issues with her medications including getting the wrong medications, not receiving medications, or medications not being on time. 2. Record review of the face sheet dated 7/17/24 indicated Resident #3 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stroke, hypertension (elevated blood pressure), alcohol dependence, and tachycardia (rapid heart rate). Record review of the MDS dated [DATE] indicated Resident #3 was rarely/never understood by others and sometimes understood others. The MDS indicated Resident #3 did not have a BIMS score. Record review of the physician orders dated 7/17/24 indicated Resident #3 did not have an order for Ativan (a medication to relieve anxiety) or Trazodone (a medication to treat depression). Record review of the Medication Error report dated 6/25/24 indicated MA D notified the nurse she gave Resident #3 Ativan 1mg and Trazodone 100mg by mistake. The Medication Error report indicated immediate action taken by the facility was Resident #3's vital signs were obtained, and assessment was completed, and Resident #3 was encouraged to drink fluid. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the nursing progress note dated 6/25/24 at 7:29 p.m. indicated MA D notified the nurse she gave Resident #3 Ativan 1mg and Trazodone 100mg by mistake. The progress note indicated Resident #3's vital signs were withing normal limits. The progress note indicated the nurse practitioner, DON, and resident's family were notified. During an interview on 7/17/24 at 1:05 p.m. MA D said she worked part-time at the facility as of 7/1/24 and had not worked any shifts since moving to part-time status. MA D said on 6/25/24 while passing medication she had popped out Resident #5's Ativan and Trazodone, put the medication in a medication cup, and placed the medication in her medication cart. MA D said she then started preparing Resident #3's evening medication. MA D said while preparing Resident #3's medication she received a phone call from the ADON. MA D said when she took the call, she placed Resident #3's medication in her medication cart. MA D said when she returned to the cart, she grabbed Resident #5's medication instead of Resident #3's medication and administered it to Resident #3. MA D said she realized immediately she had made a medication error and reported it to the charge nurse. MA D said the charge nurse went to assess Resident #3 and found her stable. MA D said the night nurse reported Resident #3 stable. MA D said she should not have pre-prepared Resident #5's medication and should not have left the medication in her medication cart. MA D said she was educated regarding medication administration, not leaving medication in the medication cart, and not pre-preparing medications. 3. Record review of the face sheet dated 7/18/24 indicated Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, hypertension (elevated blood pressure), atrial fibrillation (irregular, often rapid heart rate commonly caused by poor blood flow), and stroke. Record review of the MDS dated [DATE] indicated Resident #4 usually understood others and was usually understood by others. The MDS indicated Resident #4 had a BIMS of 13 and was cognitively intact. Record review of the physician orders dated 7/18/24 indicated Resident #4 had an order for amlodipine 2. 5mg 1 tab daily for hypertension starting 5/2/24. During an observation on 7/18/24 at 10:17 a.m. MA C administered medications to Resident #4. MA C obtained Resident #4's blood pressure prior to administering her medications. During the medication pass the surveyor watched MA C put medications in the med cup and then reviewed medication bottles and cards. MA C administered the following medications to Resident #4: 1. Fexofenadine 180 mg 1 tablet 2. B-Complex Vitamin 1 tablet 3. Aspirin 81mg 1 tablet 4. Multivitamin 1 tablet 5. Magnesium Oxide 400mg 2 tablets 6. Vitamin D3 25mcg 1 capsule 7. Esomeprazole Magnesium 20 mg 1 tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Sertraline 50mg 1 1/2 tablet 9. Coreg 6.25mg 1 tablet 10. Ranolazine 500 mg 1 tablet 11. Gabapentin 100mg 1 capsule 12. Eliquis 5mg 1 tablet 13. Metformin 500mg 1 tablet 14. Oxybutynin 5mg 1 tablet During an interview and observation on 7/18/24 at 10:36 a.m. MA C said she had handed the surveyor all the medication bottles and med cards after placing the medication in the med cup. MA C said she would show the surveyor all the medications she had administered by pulling the cards from the medication cart. MA C pulled all Resident #4's prescription medication cards and she laid three cards aside and the other 7 cards were what she confirmed she had administered to Resident #4. Observation of the 3 medication cards MA C said she did not administer was performed and Amlodipine 2.5mg was one of the 3 medications. MA C said she had administered the Amlodipine 2.5 mg medication and she must have not handed the surveyor the card to examine during the medication pass. MA C said she had been passing medications for [AGE] years and knew what she was doing. The surveyor explained what she witnessed and what MA C had confirmed regarding the medications, medications pass, and medication cards. MA C said she must have misunderstood the surveyor's question because she knew what she was doing, she had given Resident #4 the Amlodipine and that was why she had signed it off on the MAR. During an interview on 7/18/24 at 12:20 p.m. the DON said she expected staff to follow physician orders when administering medication. The DON said staff should not set-up medication ahead of time. The DON said if a medication was not available, she expected staff to look for the medication in the overflow and if it was still not found to pull the medication from the E-kit if available or call the pharmacy. The DON said the importance of ensuring residents received their prescribed medication was the treat their help condition and prevent harm. During an interview on 7/18/24 at 12:41 pm the Administrator said he expected medication to be administered as ordered and within 1 hour before or 1 hour after the scheduled time. The Administrator said medications should not be preprepared. The Administrator said if a medication was not available, he expected staff to obtain the medication from the e-kit or call the pharmacy. The Administrator said the importance of administering medications was following the physician's orders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Administering Medications policy revised April 2019 indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with the prescriber orders, including any required time frame .9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification and other community personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication .23. If the medication is withheld, refused or not available on the med cart, the Medication Aide or Licensed Nurse should immediately notify the supervisor, as physician notification may need to occur OR the E-kit [emergency kit] checked for the medication .27. Medication ordered for a particular resident may not be administered to another resident, unless permitted by state law and community policy, and approved by the director of nursing services .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44637 Based on observation, interview, and record review, the facility failed to 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 2 of 6 staff (CNA A and CNA B) observed for infection control. 1. The facility failed to ensure CNA A did not wipe Resident #1's vaginal area with a wipe visibly soiled by feces during incontinent care on 7/17/24. 2. The facility failed to ensure CNA B performed hand hygiene between glove changes, before exiting resident room, and prior to re-entering a resident room. 3. The facility failed to ensure CNA A and CNA B emptied the trash in Resident #1's room which had dirty gloves visibly soiled with feces following incontinent care and prior to exiting the resident's room. These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings Include: 1. During an observation on 7/17/24 at 10:50 a.m. CNA A wiped Resident #1's vaginal area and between her labia (folds of skin around the vaginal opening) with disposable wipes. Resident #1 had had a bowel movement. The disposable wipe was observed to be visibly soiled with feces when CNA A wiped between Resident #1's labia. CNA A folded the wipe with feces on it and then wiped between Resident #1's labia with the same disposable wipe. Resident #1 then rolled to her side and CNA B was wiping her bottom. CNA B ran out of disposable wipes, disposed of the visibly soiled with feces gloves in a trash can in the resident's room, did not perform hand hygiene and exited the room. CNA B returned to the room with more disposable wipes, did not perform hand hygiene, donned clean gloves, and continued cleaning Resident #1's bottom. When the CNAs finished with the incontinent care and exited the room the trash can with the soiled gloves was not emptied. During an interview on 7/17/24 at 11:06 a.m. CNA A said when she wiped Resident #1's vaginal area she did notice feces on the wipe. CNA A said she should have disposed of the wipe and used a clean wipe instead of folding the wipe with feces on it and reusing it to wipe between Resident #1's labia. CNA A said the importance of not using a visibly soiled wipe was to prevent infections. During an interview on 7/17/24 at 11:07 a.m. CNA B said hand hygiene should be performed before and after providing care to a resident and before entering and when exiting a resident room. CNA B said she realized after the fact she had exited the room and re-entered the room without performing hand hygiene. CNA B said the importance of performing proper hand hygiene was to prevent the spread of bacteria and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 7/17/24 at 11:08 a.m. CNA A and CNA B said they were not aware they left any dirty gloves in the rooms. CNA A and CNA B went back in the resident's room with the surveyor and observed the dirty gloves in the trash. CNA A and CNA B both said they should have removed the trash bag with the dirty gloves in it. CNA A and CNA B both said the importance of removing all dirty items after performing incontinent care was to prevent cross contamination and infections. During an interview on 7/18/24 at 12:20 p.m. the DON said if a staff member was performing incontinent care and a disposable wipe became visibly soiled with feces, she would expect the staff member to dispose of the wipe prior to wiping the resident in their pelvic/urethra area. The DON said the importance of disposing of visibly soiled wipes was infection control. The DON said she expected staff to perform hand hygiene before and after care, before donning and after doffing gloves, and before entering or exiting a resident room. The DON said the importance of proper hand hygiene was infection control and to prevent cross-contamination. The DON said dirty gloves should not be left in a resident room after care for safety and infection control. During an interview on 7/18/24 at 12:41 p.m. the Administrator said he expected staff to perform hand hygiene before and after care, before donning and after doffing gloves, and before entering or exiting a resident room. The Administrator said the importance of hand hygiene was infection control. Record review of the facility's Basics of Care for the Resident Who Had Urinary Incontinence Competency Check-Off revised June 2021 indicated, Steps of Process: 1. Perform hand hygiene and don gloves .5. Cleanse the inner legs and outer peri area along the outside of labia, using a clean area of washcloth or wipe for each swipe of peri area. Visibly soiled gloves and washcloths or wipes exchanged for clean ones. 6. Cleanse outer skin folds from front to back, using a clean area of washcloth or wipe for each swipe of peri area. Visibly soiled gloves and washcloths or wipes exchanged for clean ones. 7. Cleanse inner labia from front to back, using a clean area of washcloth or wipe for each swipe of peri area. Visibly soiled gloves and washcloths or wipes exchanged for clean ones .16. Doff and dispose of gloves. 17. Perform Hand Hygiene . Record review of the facility's Handwashing/Hand Hygiene policy revised August 2019 indicated, This community considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .b. Before and after direct contact with residents .g. Before handling clean or soiled dressings, gauze pads, etc.h. Before moving from a contaminated body site to a clean body site during resident care .i. After contact with a resident's skin .j. After contact with bloody or bodily fluids .m. After removing gloves .8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace handwashing/hand hygiene .