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	11/19/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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	11/19/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to protect the resident's right to be free from verbal abuse for 1 of 4 residents (Resident #1) reviewed for resident abuse. The facility did not ensure Resident #1 was free from abuse when CNA D was observed standing over resident, loudly talking and telling Resident #1 you tripping in response to resident's statements on 03/01/2025.This failure could place residents at risk of psychosocial harm, feeling disrespected or uncomfortable, decreased self-esteem, impaired quality of life and abuse. Findings Included: Record review of Resident #1's admission Record dated 11/18/2025 revealed an [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses to include cerebral infarction (a restriction of blood supply to tissues caused by a blockage that stops blood flow to part of the brain), ataxia (a neurological symptom characterized by lack of muscle coordination), bilateral osteoporosis (a disease that causes bones to become weak and brittle), hypertension (high blood pressure), and radiculopathy (compressed nerve root exiting the spine causing pain, numbness, tingling or weakness). Record review of Resident #1's comprehensive MDS dated [DATE] revealed a BIMS score of 5 indicating severe cognitive impairment. Record review of Resident #1's comprehensive MDS dated [DATE] revealed resident had no upper or lower extremity impairment, utilized a wheelchair for mobility, required supervision in eating, toileting, bathing, upper body dressing, and moderate assistance in lower body dressing, bed mobility and transfers. Record review of Resident #1's care plan, undated, viewed 11/19/25 revealed resident had a communication deficit, impaired cognitive function and thought processes with difficulty making decisions and short-term memory loss. The care plan interventions included using task segmentation to support short term memory deficits, cue, reorient and supervise resident as needed and provide consistent care to decrease confusion. An attempt to interview AP CNA D was made on 11/18/25 at 10:00 a.m. There was no answer, and surveyor was unable to leave a message. Record review of AP CNA D's written statement (undated) revealed she denied any verbal abuse directed at Resident #1. During an interview of Resident #1 on 11/19/25 at 10:57 a.m., Resident #1 denied staff verbal abuse and stated he feels safe in the facility. Record review of PIR dated 0 3/07/2025 revealed Resident #1 did not recall the incident of suspected verbal abuse.During an interview on 11/19/2025 at 10:57 a.m. with the family member of Resident #1, she stated she visits often and has never had a concern about the staff that care for him. The family member stated she recalls being notified that a staff member was observed talking loudly and inappropriately to her husband. Spouse stated she did not notice any mood or behavior changes in Resident #1. During an interview on 11/18/2025 at 2:01 p.m., CNA E stated she had worked at the facility for almost 1 year and has been trained to separate the resident from any staff member who she observed verbally abusing a resident and to notify the Administrator. CNA E stated she was aware of the concern related to Resident #1 but did not have firsthand knowledge.During an interview on 11/18/2025 at 8:10 a.m., CNA F confirmed her statement that she overheard AP CNA D talking loudly and in a very demeaning manner to Resident #1 CNA F stated she removed Resident #1 and took him to his room and then informed the nurse. Record review of CNA F's written statement dated 03/01/2025 revealed she observed what she felt were patronizing and demeaning words from CNA D towards Resident #1.During an interview on 11/19/2025 at 11:30 a.m., LVN G confirmed her statement that she overheard AP CNA D loudly talking to Resident #1 in a very condescending manner and when he was able to respond to her, AP CNA D told him he was tripping. LVN G stated that she intervened, asked AP CNA D to clock out and go home and then contacted the Abuse Coordinator. Record review of LVN G's statement dated 03/01/2025 revealed she overheard CNA D loudly speaking to Resident #1 and asked her to lower her voice and communicate more professionally with the resident. LVN G noted in her statement that CNA D was standing over Resident #1 who was in a wheelchair at the time, and she felt the tone of her voice was condescending. During an interview on 11/19/2025 at 5:01 p.m., the DON stated that she expects all staff to report any case of verbal abuse and intervene at the time of occurrence to keep the resident safe. The DON stated that all new hires receive on-boarding training for Abuse, Neglect & Exploitation and in-services are completed annually and as needed for any concern of abuse. She stated adverse effects of verbal abuse on the resident could be psychosocial wellbeing concerns, increased behaviors or alterations in mood state. The DON stated she was not employed at the facility at the time of this reported incident and has no firsthand knowledge of the incident. During an interview on 11/19/2025 at 5:29 p.m., the Administrator stated that she was not working at the time of this

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	11/19/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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	11/19/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 be free from misappropriation of property and exploitation for 1 of 4 residents (Resident #2) reviewed for misappropriation and exploitation, in that:The facility failed to ensure that Resident #2 was not subject to financial misappropriation or exploitation from CNA C. CNA C purchased personal items with the monies of Resident #2 in the amount of $230.83 during an outing to a local store without the permission of Resident #2. This failure had the potential to affect the residents in the facility by placing them at risk for decreased quality of life, feelings of loss and misappropriation of property. Findings Included: Review of Resident #2's admission Record, dated 11/18/2025, reflected a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses to include spinal stenosis (the narrowing of the spinal canal, which can put pressure on the spinal cord and nerves), spondylosis (a degenerative condition of the spine often called wear and tear arthritis), dementia (a group of symptoms characterized by a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking and behavior), Hypertension (high blood pressure), Parkinsonism (a progressive brain disorder that affects the control of movement, causing symptoms like tremors, slow movement, rigidity and an unsteady gait), and dysphagia (swallowing difficulty). Record review of Resident #2's MDS dated [DATE], revealed a BIMS score of 15 indicating intact cognition. Record review of Resident #2's MDS dated [DATE], revealed resident had no impairment to upper or lower extremity, required use of a cane or walker for mobility, set-up assistance in toileting and upper body dressing, supervision in transfers, bathing and lower body dressing and was independent in bed mobility and gait.Record review of Resident #2's store receipt dated 11/05/2024 revealed Resident #2's purchases totaled $31.98[, and total monies spent was $262.81. The remainder of items were identified as purchases for CNA C. Resident #2 identified three items (1 shapewear undershirt costing $9.00, 1 sweater priced at $11.00 and 1 pair of leggings priced at $11.98 which he stated he purchased for his wife. During an interview on 11/19/2025 at 1:44 p.m., Resident #2 stated that he told the Activity Director after the outing to a locat store that CNA C purchased items for herself on his debit card without his permission. During an interview on 11/19/2025 at 12:50 p.m., the Activity Director stated that Resident #2 had informed her after the outing that CNA C had purchased items on his debit card without his permission. The Activity Director stated she informed the Administrator and DON immediately and they initiated an investigation. During a phone interview on 11/19/2025 at 2:18 p. m., CNA C stated that she did not ask Resident #2 to purchase any items for her while at the local store. CNA C stated that the cashier was at fault because she scanned her items with Resident #2's items. CNA C stated she was told she was notified by the Administrator that she was suspended pending investigation. CNA C stated she did not return to the facility. Record review of the employee file for CNA C revealed that she was suspended on 11/07/2024 pending investigation of this incident and she did not return the phone call from the facility or return to the facility. CNA C self-terminated and is not eligible for re-hire. Resident #2 was provided reimbursement for monies according to the store receipt date 11/05/2025. During an interview on 11/19/2025 at 5:01 p.m., the DON stated she expects all staff to immediately report concerns for exploitation to the Administrator to ensure proper investigation. The DON stated she was not working at the facility at the time of this incident, and feels training for Abuse, Neglect and Exploitation is very important for residents' safety. The DON stated misappropriation can cause undue stress to the resident and affect his/her mental health and social well-being. During an interview on 11/19/2025at 5:29 p.m., the Administrator stated that she is responsible for investigating allegations of misappropriation of monies from residents. The Administrator stated she was not employed at the facility at the time of this incident and noted that misappropriation could affect the overall psychosocial wellbeing of residents and their safety within the facility. Review] of facility policy titled; Resident Abuse and Neglect Policy, dated 2021 revealed in part: 1. When an incident of theft and/or misappropriation of resident property is reported, the Administrator will investigate the incident. Misappropriation of resident property is defined as 2. use of a resident's belongings or money without the resident's consent and all residents will be free from deliberate misplacement, exploitation, temporary or permanent use of a resident's belongings or money without the resident's consent.

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	11/19/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to review and revise Resident Care Plans after each assessment for 1 of 4 Residents (Resident #3) whose records were reviewed for care plan revision/timing, in that: The care plan of Residents #3 was not updated to reflect a pureed diet. This deficient practice could affect any resident and contribute to residents not receiving the care and services they need. The findings included:Record review of Resident #3's admission Record, dated 11/18/2025, revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses to include dementia (a decline in mental ability that affects memory, thinking, and daily function), dysphagia (swallowing difficulty), Chronic Obstructive Pulmonary Disease (a progressive group of lung diseases that make it difficult to breathe), Peripheral Vascular disease (a circulation disorder affecting the arteries and veins outside of the heart caused by blockage from plaque buildup), Obstructive Uropathy (a condition where a blockage in the urinary tract causes urine to back up), osteoarthritis (inflammation of one or more joints causing pain, swelling, stiffness as the protective cartilage that cushions bones wears down over time) and depression (a serious mood disorder with symptoms including persistent sadness, loss of interest, fatigue and sleep or appetite changes). Record review of Resident #3's comprehensive MDS, dated [DATE], revealed a BIMS score of 0, indicating severe cognitive impairment. Record review of Resident #3's comprehensive MDS, dated [DATE], revealed that Resident #3 had upper and lower extremity impairments, required use of a wheelchair for mobility, supervision with eating, maximum assistance in toileting/peri-care, upper body dressing, bed mobility, was dependent in lower body dressing, bathing and transfers. Record review of Resident #3's comprehensive MDS, dated [DATE] revealed resident receives a mechanically altered diet.Record review of Resident #3's care plan, undated, viewed 11/18/2025 revealed a focus problem dated 05/07/2024 and revised 08/04/2025 indicating Resident's diet is: Regular mechanical soft diet with thin liquids. Record review of November 2025 physician's orders for Resident #3 revealed an order for Regular diet, pureed texture dated 10/01/2025. During an interview and observation on 11/19/25 at 12:45 p.m. with Resident #3, observed pureed textured tray served to resident. Resident stated he has been receiving baby food for a while now. During an interview on 11/19/2025 at 3:32 p.m., the MDS Nurse LVN B stated she reviews new orders daily in the morning meeting and updates the care plans accordingly. The MDS Nurse LVN B stated she has been working here since June 2025 and is still updating individual care plans. The MDS Nurse LVN B stated that it is her responsibility to update the care plans to reflect each residents' needs. During an interview on 11/19/2025 at 5:01 p.m., the DON stated that she expects nursing staff and primarily the MDS Nurse to review and update the care plans as orders are received with quarterly reviews. The DON stated that care plans not matching physician's orders could result in harm or injury to a resident. The DON stated that a resident who received the wrong diet could experience aspiration or even death. The DON stated she is ultimately responsible for the accuracy and completeness of the care plans.During an interview on 11/19/2025 at 5:29 p.m., the Administrator stated that she expects the nursing staff to monitor and update the care plans as needed and that not adhering to the physician's orders and the physician's orders not matching the care plan could result in harm, injury or even death to the resident. Record review of the facility policy, titled Care Plan Process, undated, revealed .the resident's care plan must be .revised based on changing goals, preferences and needs of the resident and in response to current interventions. and the facility interdisciplinary team utilizes the CMS requirements of the Resident Assessment Instrument as policy for reviewing and revising care plans.

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	11/19/2025

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 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. (continued on next page)

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	11/19/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice for one (Resident #4) of four residents reviewed for physician orders for treatments. The facility failed to follow physician orders and remove Resident #4's staples to back of head on 11/13/25, five days after insertion during an ER visit on 11/8/25 per physicians' orders. This failure could affect residents currently residing in the facility resulting in not receiving needed care to maintain optimum health and placing them at risk for injury and/or deterioration in their condition. Findings Included:Record review of Resident #4's admission Record, dated 11/18/2025, reflected an [AGE] year-old male admitted on [DATE] with diagnoses to include Congestive Heart Failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body's needs, causing blood and fluid to back up in other organs), Hypertension (high blood pressure), Diabetes Type II (a chronic condition where the body does not use insulin properly, leading to high blood glucose levels), Chronic Kidney Disease Stage 3 (moderate kidney damage, meaning kidneys are not working as well as they should) and Peripheral Vascular Disease (a circulation disorder affecting the arteries and veins outside of the heart often caused by blockages from plaque buildup) Record review of Resident #4's MDS dated [DATE] revealed a BIMS Score of 1 indicating severe cognitive impairment. Record review of Resident #4's care plan, undated and accessed on 11/18/2025, identified an actual fall on 11/08/2025 with interventions that included .staples x2 back of head to be removed in 5 days. Record review of Resident #4's MDS dated [DATE] revealed Resident #4 had no impairment to upper or lower extremities, utilized a wheelchair for mobility, required supervision in self-feeding, toilet hygiene and transfers, moderate assistance in upper and lower body dressing, and maximum assistance in bathing.Record review of Resident #4's physician's orders dated 11/18/2025 revealed an order dated 11/08/2025 that read, remove staples from back of head in 5 days. Record review of Resident #4's nursing progress note dated 11/08/2025 at 7:28 p.m. revealed Resident #4 returned from the ER, had two staples to back of head and had orders to remove staples in 5 days. Record review of Resident #4's Treatment Administration Record, dated 11/02/2025-11/30/2025 and printed on 11/18/2025 revealed no order to remove staples to the back of head. During an interview and observation with Resident #4 on 11/18/2025 at 12:30 p.m., resident observed lying in bed, eyes open, minimally responsive to surveyor's questions. Surveyor observed two staples to the back of head with no sign of infection or indication that staples were embedded. During an interview on 11/18/2025 at 2:27 p.m., Treatment Nurse LVN A stated she is monitoring the staples to the back of [Resident #4's] head. LVN A stated she was not aware that Resident #4 had orders to remove the staples to the back of his head five days after readmission. LVN A stated if the floor nurses do not put the order in the EMR System correctly, it will not trigger to her TAR for completion. LVN A stated she has been monitoring the staples but did not think about when they should be removed. During an interview and observation with Resident #4 on 11/19/2025 at 8:10 a.m., surveyor observed back of head and noted staples were removed. Resident #4 acknowledged and stated, they did it yesterday. During an interview on 11/19/2025 at 3:32 p.m., MDS Nurse LVN B stated she is kept aware of changes with residents daily, reviews physician's orders and updates care plans as needed. LVN B stated she was aware that Resident #4 had staples in place after he returned from the hospital post fall and was scheduled to have them removed. LVN B stated she was not aware if the staples had been removed or not. During an interview on 11/19/2025 at 5:01 p.m., the DON stated she expects nursing staff to follow the physician's orders and to notify her or the physician if they are unable to do so. The DON stated that the floor nurses are responsible for ensuring orders are carried out. The DON stated that orders are reviewed in the stand-up meeting in the mornings and noted that the order to remove the staples for Resident #4 was inaccurately coded in the EMR program which meant the orders for removal were not placed correctly on the TAR for the Treatment Nurse to complete. The DON stated she would complete an Inservice to ensure the floor nurses know how to properly input orders in the EMR system. The DON stated the staples not being removed could result in further injury if the staples become embedded in the skin or infection. During an interview on 11/19/2025 at 5:29 p.m., the Administrator stated that all residents would be at risk for not having orders followed if nursing staff did not accurately in-put orders into the EMR system. The Administrator stated that failure to follow physician's orders could result in residents not receiving the appropriate care as directed by the physician. Requested policy for Skin and Wound Management on 11/19/2025 at 4:50 p.m. from the DON, did not

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	11/19/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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	11/19/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 1 of 6 residents reviewed for respiratory care (Resident #6). The facility failed to ensure Resident #6's oxygen tubing and water were changed out and dated. The facility failed to ensure Resident #6 had an order for her oxygen. The facility failed to have an order in place to ensure Resident #6's oxygen tubing and water were changed and dated, and the filter cleaning was completed weekly on Sundays. These failures could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory disease. Findings Included: Record review of Resident #6's face sheet dated 11/18/25 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses chronic obstructive pulmonary disease (progressive lung condition that causes difficulty breathing due to damage to the airways), fracture of her right leg, dementia (decline in memory and thinking skills that interferes with daily life), and high blood pressure. Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated she made herself understood and she was able to understand others. The MDS assessment also indicated she had a BIMS score of 15 which meant she was cognitively intact. The MDS assessment also indicated Resident #6 required moderate assistance from staff for toileting, bathing, bed mobility and supervision with eating. The MDS assessment did not indicate Resident #6 used oxygen. Record review of Resident #6's order summary report dated 11/18/25 did not indicate she had an order for oxygen use or for changing the oxygen tubing. Record review of Resident #6's care plan dated 07/29/24 indicated she had potential for shortness of breath related to a pulmonary nodule (small spot on the lung caused by inflammation, old infections, or other conditions) and emphysema/chronic obstructive pulmonary disease with interventions to provide oxygen therapy per MD orders. During an observation and interview on 11/18/25 at 11:00 AM Resident #6 was lying in her bed and had oxygen on using a nasal canula set at 2.5L/M with an undated tubing and an empty water bottle dated 11/10/25. Resident #6 said she thought the night nurses were good at changing the tubing, but she guessed they forgot about her this week. During an observation on 11/18/25 at 1:45 PM Resident #6 continued to use her oxygen at 2.5 L/M with an undated oxygen tubing and an empty water bottle dated 11/10/25. During an interview on 11/18/25 at 1:47 PM LVN H said she was the nurse for Resident #6. LVN H said the night nurses were responsible for changing out the oxygen concentrator water and the tubing and cleaning the filters on Sunday nights and then labeling and dating the tubing and bottles. LVN H said the failure placed a risk for infection. LVN H said Resident #6 should have an order for oxygen, but she could not find it in the electronic medical record system. LVN H said the last order was discontinued in July 2025. LVN H said the failure of not having an order for Resident #6's oxygen placed a risk for other nurses not knowing what liters of oxygen Resident #6 should have been getting and LVN H said the failure of not having an order was probably why the canula and tubing were not changed. During an interview on 11/19/25 at 5:09 PM the DON said the charge nurses were responsible for changing the oxygen concentrator tubing and water out on Sunday nights and dating the tubing and water. The DON said Resident #6 should have had an order for oxygen. The DON said the failure placed a risk of Resident #6 getting treatments that she did not have orders for. The DON said the failure of not changing the water and tubing placed a risk for infection and lack of humidification that could cause irritation or thickening of secretions. During an interview on 11/19/25 at 5:28 PM the Administrator said the oxygen tubing should be changed and dated on a weekly basis and the charge nurses were responsible for completing the changing of the oxygen tubing and water and making sure they are dated. The Administrator said the failure placed a risk is for infection control and no water in the bottle could have caused dryness for Resident #6. The Administrator said Resident #6 should have had an order for oxygen use. The Administrator said the failure of not having an order for oxygen placed a risk for error and for nurses not knowing the parameters and liters Resident #6 should have received. Record review of the facility policy Oxygen Administration revised October 2010 indicated: Purpose The purpose of the procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order.14. Periodically re-check the water level in the humidifying jar. The policy did not indicate how often to clean and change the tubing.