

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: 676497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Lakeside Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Actual harm Residents Affected - Some	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 infections and to restore continence to the extent possible for 1 of 2 residents (Resident #10) reviewed for incontinent care. The facility failed to ensure Resident #10's catheter was secured to his leg and CNA T and LVN B properly cleaned the perineal/genital areas for Resident #10 during incontinent care for a catheter. This failure could place residents at risk for urinary tract infections and trauma. 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 infections and to restore continence to the extent possible for 1 of 2 residents (Resident #10) reviewed for incontinent care. The facility failed to ensure Resident #10's catheter was secured to his leg and CNA T and LVN B properly cleaned the perineal/genital areas for Resident #10 during incontinent care for a catheter. This failure could place residents at risk for urinary tract infections and trauma. Finding include: Record review of Resident #10's face sheet, dated 01/20/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #10's had diagnoses which included COPD (chronic lung condition that limits airflow and causes difficulty breathing), unspecified dementia (cognitive disorder that impairs memory, thinking, and judgement), and need for assistance with personal care. Record review of Resident #10's quarterly MDS, dated [DATE], reflected resident required partial/moderate assistance- helper did less than half the effort for toileting hygiene. Record review of Resident #10's significant change MDS, dated [DATE] reflected the resident required substantial/maximal assistance- helper did more than half the effort for toileting hygiene. Record review of Resident #10's care plan, revision dated 12/08/25, reflected an intervention for provide perineal care after each incontinent episode. Record review of Resident #10's order summary report, dated 01/20/25, indicated he had an order for: Catheter Care: Out put Q shift every shift for foley catheter and catheter care Q shift and PRN every shift start date of 06/02/25. Urinary Catheter 16FR,10CC. Diagnosis: Urinary retention. Dated 12/23/24. Catheter: Check that catheter is stabilized/anchored using a leg strap/stabilizer. every shift dated 06/02/25. Record review of Resident #10's December 2025 Nursing MAR indicated he received catheter care daily for the month of December 2025. During an observation on 01/19/26 at 12:30PM, Resident #10 was in his bed fetal position (severe upper and lower extremity contractures), did not have a leg strap secure device for catheter on his leg, line was taught and full of urine. Urinary catheter bag was hung on the right side of the bed, closest to the open door with a blue privacy cover. During an observation on 01/20/26 at 9:08 AM revealed Resident #10 without a catheter secure device leg strap in place. During an observation on 01/20/26 at 11:35 AM revealed Resident #10 without a catheter secure device leg strap in place. During an attempted interview on 01/19/26 at 3:15 PM Resident #10 did not respond to questions. During an interview on 01/19/26 at 3:56 PM, CNA T said she did not complete catheter care because the hospice aide had just provided care to Resident #10, and he did not have a secure device. CNA T stated she was unaware of the last time foley catheter care was completed. CNA T stated each time incontinent care (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 4 of 6 residents (Residents #79, #28, #41 and #61) reviewed for accidents. 1. The facility failed to ensure 2 staff were utilized for bed mobility for Resident #79 on 01/19/26 and 01/20/26. 2. The facility failed to ensure Resident #28's disposable razor, shaving cream, and 3 bottles of liquid air freshener were not stored at the bedside. 3. The facility failed to ensure shaving cream was not stored in Residents #41 and #61's bathroom. These failures could place residents at risk of injury. Findings include: 1. Record review of Resident #79's face sheet, dated 01/22/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #79 had diagnoses which included dementia (loss of memory), stroke, anxiety (feelings of worry, fear, unease, and apprehension), and high blood pressure. Record review of Resident #79's quarterly MDS assessment, dated 10/08/25, reflected Resident #79 understood and was understood by others. Resident #79's BIMS score was 13, which indicated her cognition was intact. Resident #79 required assistance with her ADLs, which included transfers, dressing, personal hygiene, and bed mobility. Resident #79 was frequently incontinent of bowel and bladder. Record review of Resident #79's comprehensive care plan, dated 10/20/22, indicated Resident #79 had an ADL self-care performance deficit related to impaired balance, stroke, and limited range of motion to the right shoulder. The intervention was for two staff members to assist with toileting, turning, and repositioning in bed. During an observation on 01/19/26 at 12:03 p.m., revealed CNA H provided incontinent care for Resident #79. CNA H did not have another staff member to assist with bed mobility or toileting. During an interview on 01/19/26 at 12:55 p.m., CNA H said the ADON told her she should have waited to provide care for Resident #79 until she got help. She said it was hard to get everything done and wait on others when she had about 25 residents. She said she had always provided care for Resident #79 by herself. During an interview and observation on 01/22/26 at 1:43 p.m., CNA H said Resident #79 was a 1-person assist for bed mobility and toileting. She said she had been providing care for Resident #79 as a one-person assist. CNA H called over CNA L, and she said Resident #79 was a one-person assist for bed mobility and toileting. She said she provided care for Resident #79 this morning (01/22/26) by herself. Both CNAs said they knew how to take care of a resident through their care plan. CNA H looked at Resident #79's care plan on their task page and said she was a 2-person assist with bed mobility and toileting. They both said they had been providing care by themselves. They both said failure to use two staff could cause an injury to the resident such as a fall. CNA H said she would be in trouble if Resident #79 had fallen or obtained an injury while providing care by herself, since the care plan indicated Resident #79 required two staff members for bed mobility and toileting. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/22/26 at 2:55 p.m., the ADON said it took two staff members to get Resident #79 out of bed. The ADON said sometimes Resident #79 required two staff members on days she did not feel well. She said she preferred they used two staff members for bed mobility and toileting because of the residents' weakness. She said if the care plan said they should have two staff for bed mobility and toileting, then she expected two staff members to be there. The ADON said failure to use two staff members could cause injury to the resident, such as falls or skin tears. During an interview on 01/22/26 at 5:22 p.m., the DON said Resident #79 required two staff members to assist while providing care. She said the staff should be following the care plan, and she was responsible for ensuring they followed the care plan. She said failure to follow the care plan could lead to injury. During an interview on 01/22/26 at 5:52 p.m., the Administrator said if Resident #79 had a care plan for two staff members to assist with bed mobility and toileting, then she expected staff to follow the care plan. She said nurse management was responsible for ensuring staff were following the care plan. She said if two staff members were not providing care, they could place the resident's safety at risk. 2. Resident #28 Record review of Resident #28's face sheet, dated 01/22/26, reflected Resident #28 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular, often rapid heart rate). Record review of Resident #28's quarterly MDS assessment, dated 12/30/25, reflected Resident #28 made himself understood and understood others. Resident #28's BIMS score was 14, which reflected his cognition was intact. Resident #28 required partial/moderate assistance with personal hygiene which included shaving. Record review of Resident #28's comprehensive care plan, revised on 03/28/25, reflected Resident #28 had an ADL self-care performance deficit related to activity tolerance, dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), fatigue, and impaired balance. The care plan interventions included: the resident required 1 staff assistant with personal hygiene and oral care. During an observation and interview on 01/19/26 at 2:05 p.m., Resident #28 had a disposable razor, a can of shaving gel, and a can of liquid air freshener on his bathroom countertop. Resident #28 had 2 cans of liquid air freshener, and a can shaving cream under his television stand. Resident #28's family member stated she brought these items for Resident #28. During an observation on 01/20/26 at 9:05 a.m., Resident #28 had a disposable razor, a can of shaving gel, and a can of liquid air freshener on his bathroom countertop. Resident #28 had 2 cans of liquid air freshener, and a can shaving cream under his television stand. 3. Record review of Resident #41's face sheet, dated 01/22/26, reflected Resident #41 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #41's annual MDS, dated [DATE], reflected Resident #41 made herself (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understood and understood others. Resident #41 had a BIMS score of 9, which indicated her cognition was moderately impaired. Resident #41 required supervision/touching assistance with personal hygiene including shaving. Record review of Resident #41's comprehensive care plan, revised 02/23/24, reflected Resident #41 had an ADL self-care performance deficit related to impaired balance, limited ROM, and right arm contracture (shortening of muscles). The care plan interventions included: the resident required 1 staff assistant with personal hygiene. Resident #61 Record review of Resident #61's face sheet, dated 01/22/26, reflected Resident #61 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #61's comprehensive care plan, revised on 09/10/24, reflected Resident #61 had an ADL self-care performance deficit related to dementia, fatigue, and ataxia (poor muscle control). The care plan interventions included: the resident required 1 staff assistant with personal hygiene. Record review of Resident #61's quarterly MDS assessment, dated 12/30/25, reflected Resident #61 made herself understood and understood others. Resident #61 had a BIMS score of 15, which indicated her cognition was intact. Resident #61 required supervision/touching assisting with shaving. During an observation and interview on 01/19/26 at 1:10 p.m., revealed there was a can labeled shaving cream on their bathroom countertop. Residents #41 and #61 stated the shaving cream did not belong to them. During an observation on 01/20/26 at 9:15 a.m., there was a can labeled shaving cream on Resident #41's and #61's bathroom countertop. During an interview on 01/22/26 at 12:51 p.m., revealed CNA P observed the disposable razor, mouthwash, shaving cream, 3 bottles of liquid air freshener in Resident #28's room and the can of shaving cream in Residents #41 and #61's room with the state surveyor. CNA P stated all staff should be aware and observant of items that did not belong at residents' bedside. CNA P stated she never noticed the items during her rounds. CNA P stated she knew there were at least two residents who wandered the hall and this failure could potentially put residents at risk for endangerment to themselves or others. During an interview on 01/22/26 at 1:00 p.m., RN G stated all staff were responsible for ensuring items were stored properly and securely. RN G stated razors and shaving cream should be stored in the supply closet and air fresher stored in the ADON/DON office. RN G stated it was important to ensure items were not left at bedside for residents' safety. During an interview on 01/22/26 at 1:10 p.m., the MDS Coordinator stated she was responsible for angel rounds (rounds completed by staff to ensure residents and their rooms were safe) Resident #28. The MDS Coordinator stated during rounds she observed obstacles that should not be stored at the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedside. The MDS Coordinator stated to her knowledge she was unsure if air freshener and shaving cream could be stored at the bedside. The MDS Coordinator stated that her thoughts for razors were to be stored in the supply room. The MDS Coordinator stated she was told what items could or could not be stored at the bedside. The MDS Coordinator stated she did not recall seeing any items during her rounds this week. The MDS Coordinator stated, it was a human error. The MDS Coordinator stated it was important to ensure items were not left at the bedside of residents' safety. During an interview on 01/22/26 at 2:33 p.m., the BOM stated she was responsible for angel rounds for Residents #41 and #61. The BOM stated rounds were done daily and she had not seen any shaving cream on their bathroom countertop. The BOM stated the aides should keep the shaving cream stored in the supply room. The BOM stated it was important to ensure items were not left at the bedside for residents' safety. During an interview on 01/22/26 at 4:03 p.m., the DON stated shaving cream, and razors should be stored in a locked cabinet that CNAs had accessed too. The DON stated air freshener should not be in the building because the chemical was not approved for the facility. The DON stated all staff, which included angel rounds, should be monitored for things that could possibly harm a resident. The DON stated she and the Administrator were responsible for monitoring and overseeing by entering random residents' rooms and making observations. The DON stated it was important to ensure items were not left at the bedside for residents' safety. During an interview on 01/22/26 at 5:04 p.m., the Administrator stated shaving cream, and razors should be stored in a location that was secured in the shower room. The Administrator stated air freshener was not allowed in the facility. The Administrator stated she was not aware these items were stored at the resident's bedside. The Administrator stated nursing staff and angel rounds were responsible for monitoring and overseeing by daily observations. Record review of the Safety and Supervision of Residents .revised on 07/2017 reflected. Our community strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are community-wide priorities. Individualized, Resident-Centered approach to Safety.1. Our individualized, resident-centered approach to safety addressed safety and accident hazards for individual residents.Resident Risks and Environmental Hazards.b. Safe lifting and movement of residents. f. poison control.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident and determined that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 3 of 5 residents (Resident #1, Resident #10, and Resident #56) reviewed for pharmacy services. 1. The facility failed to ensure there was not a delay in administering Resident #1's Debrox (medication that softens and loosens ear wax to make it easier to remove), after it was ordered on 01/16/2026. 2. The facility failed to ensure Resident #56 received 2 puffs of Combivent (medication used to treat/prevent wheezing and shortness of breath) as ordered by the physician on 01/20/2026. 3. The facility failed to ensure LVN B periodically reconciled Resident #10's morphine/diazepam suppositories (medication used for pain/anxiety). These failures could place residents at risk of not having medications available for use, medications errors, drug diversions, and inaccurate records. Findings included: 1. Record review of Resident #1's face sheet dated 01/22/2026 indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system), and bilateral sensorineural hearing loss (type of hearing impairment affecting both ears, often caused by damage to the inner ear or auditory nerve, and it can significantly impact communication and quality of life). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] indicated she was able to understand others and others understood her. The MDS assessment indicated Resident #1 had a BIMS score of 5, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #1 required partial/moderate assistance with dressing, toileting, and personal hygiene. Record review of Resident #1's Order Summary Report, dated 01/19/2026 indicated Debrox solution 6.5% instill 5 drops in both ears two times a day for cerumen (earwax) impaction for 4 days with a start date of 01/16/2026. Record review of Resident #1's January 2026 MAR indicated Debrox solution 6.5% instill 5 drops in both ears two times a day for cerumen (earwax) impaction for 4 days with a start date of 01/16/2026. The following was documented: 01/16/2026: 6 PM-1 AM other/see nurses notes signed by LVN F. 01/17/2026: 6 AM-10 AM refused signed by LVN D. 01/17/2026: 6 PM-1 AM other/see nurses notes signed by LVN F. 01/18/2026: 6 AM-10 AM refused signed by LVN D. 01/18/2026: 6 PM-1 AM other/see nurses notes signed by LVN F. 01/19/2026: 6 AM-10 AM other/see nurses notes signed by LVN C. Record review of Resident #1's Progress Notes indicated: 01/16/2026 at 12:49 PM New order noted earlier for Debrox drops to start later this afternoon signed by LVN D. 01/16/2026 at 9:12 PM an order administration note for Debrox signed by LVN F did not address if Debrox was administered. 01/18/2026 at 10:35 PM an order administration note for Debrox signed by LVN F did not address if Debrox was administered. Resident #1's Progress Notes dated 01/16/2026-01/19/2026 did not further address if Debrox was administered. Record review of Resident #1's care plan with a target date of 02/17/2026 did not address the use of debrox. During an interview on 01/19/2026 at 12:00 PM, Resident #1 said she felt like her ears were stopped up, and she told the nurses she needed them cleaned and they would not do it. Resident #1 said she told the nurses a while ago. Resident #1 was not able to provide a specific date range. During an interview on 01/19/2026 at 12:06 PM, LVN C said she was aware Resident #1 complained about her ears being stopped up and needing to be cleaned. LVN C said an order for ear drops was received Friday (01/16/2026), but they had not been delivered from the pharmacy. LVN C said she had not contacted the pharmacy regarding Resident #1's ear drops. LVN C said LVN D received an order for the ear drops on 01/16/2026, and the ear drops (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lakeside Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have been delivered the following day. LVN C said she did not work on the weekend, so she did not know why the ear drops were not delivered. LVN C said if the pharmacy did not deliver medications the following day, they should contact the pharmacy to see why it was not delivered. LVN C said a delay in receiving medications from the pharmacy resulted in the residents not being treated for their condition. During an attempted phone interview on 01/22/2026 at 11:30 AM, LVN F did not answer the phone. During an interview on 01/22/2026 at 3:25 PM, the DON said staff did not contact her over the weekend to notify her Resident #1's Debrox was not delivered from the pharmacy. The DON said when a new medication was ordered from the pharmacy, and it was not delivered the next day they should contact the pharmacy and notify her and the doctor. The DON said there were many risks associated with not administering medications in a timely manner after they were ordered, and it could effect the care the residents received. During an interview on 01/22/2026 at 3:43 PM, the Administrator said she expected medications to be ordered in a timely manner. The Administrator said administrative staff should ensure medications were ordered from the pharmacy. The Administrator said not administering medications in a timely manner after an order was received could result in a delay in the care provided During an interview on 01/22/2026 at 4:13 PM, LVN D said there was no one available to go get the Debrox from the store. LVN D said she charted Resident #1 refused the Debrox because the DON instructed her to do so. LVN D said they were having issues with the pharmacy, and the DON instructed the staff to chart refused if a medication was not delivered by the pharmacy. LVN D said the DON would deny that she told the staff to chart refused when medications were not delivered from the pharmacy. LVN D said she had to do what her boss told her to. LVN D said she did not report to the Administrator that she was instructed to chart refused when a medication was not delivered. LVN D said it was important for medications to be administered because the doctor ordered it for a reason and to make the resident's life better. During an interview on 01/22/2026 at 5:36 PM, the DON said she never told the staff to chart refused when a medication was not delivered by the pharmacy. The DON said every morning they went over the new orders to ensure medications were delivered. The DON said the pharmacy usually delivered the next day, but if there was a delay the staff should contact her and the pharmacy. The DON said she was not notified over the weekend that Resident #1 needed Debrox. The DON said Debrox was over the counter, and had she been notified she would have brought it to the facility. During an interview on 01/22/2026 at 6:06 PM, the Administrator said it was not reported to her that the DON was telling the staff to document refused when medications were not available for administration. The Administrator said the staff should not document refused for a medication that was not available, and she expected the staff to notify the pharmacy and the DON if a medication was not delivered. 2. Record review of Resident #56's face sheet dated 01/22/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and asthma (a condition that causes the airways to narrow and swell). Record review of Resident #56's Quarterly MDS assessment dated [DATE] indicated he was able to understand others, and he was understood by others. The MDS assessment indicated Resident #56 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #56 had shortness of breath or trouble breathing with exertion and when lying flat. Record review of Resident #56's Order Summary Report dated 01/20/2026 indicated an order for Combivent 18-103 mcg/actuation inhale 2 puffs orally every 12 hours with a start date of 01/22/2025. Record review of Resident #56's care plan revised 01/07/2026 indicated he had asthma with the potential for shortness of breath and respiratory illness, and interventions included to give medications as ordered. During an observation of medication administration and an interview on 01/20/2026 at 9:07 AM, LVN B administered Resident #56's Combivent. Resident #56 only inhaled one puff of Combivent. LVN B said Resident #56 was supposed to inhale 2 puffs of the Combivent, but she was nervous and did not pay attention. LVN B said not administering the correct dose of Combivent could result in Resident #56 having an asthma flare up. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/22/2026 at 3:23 PM, the DON said the nurses should follow the rights of medication administration and ensure the correct dose was administered. The DON said she made random observations of medication administration, and the pharmacy consultant observed medication administration once a month. The DON said Resident #56's medication not administered as ordered could result in respiratory difficulty or the resident could be in distress. During an interview on 01/22/2026 at 3:41 PM, the Administrator said she expected the nurses to follow the policy for medication administration, and ensure the resident received the right medication and all the rights of medication administration were followed. The Administrator said management staff were responsible for ensuring the nurses were administered medications properly. The Administrator said she was not clinical, but not administering medications as ordered could result in adverse effects. 3. Record review of a face sheet dated 01/22/2026 indicated Resident #10 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), chronic pain syndrome (a condition where pain lasting longer than 3-6 months is accompanied by significant emotional, mental, and functional issues, such as depression, anxiety, and daily life disruption), and chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system). Record review of Resident #10's Comprehensive MDS assessment dated [DATE] indicated he was able to understand others and others understood him. The MDS assessment indicated Resident #10 had a BIMS score of 0, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #10 was dependent on staff for personal hygiene and showering/bathing self and required substantial/maximal assistance with toileting hygiene. The MDS assessment indicated Resident #10 received scheduled pain medication, and he did not receive PRN pain medication. Resident #10's MDS assessment indicated he received opioids. Record review of Resident #10's Order Summary Report dated 01/22/2026 indicated he had an order for morphine/diazepam suppository 10 mg insert 1 suppository rectally every 12 hours as needed for pain/anxiety with a start date of 01/13/2026. Record review of Resident #10's care plan revised 01/06/2026 indicated he had a terminal prognosis and was on hospice services to observe resident closely for signs of pain and administered medications as ordered. Record review of Resident #10's Medication Count Sheet indicated morphine/diazepam 10/10 suppositories insert 1 rectally every 12 hours as needed, 12 suppositories were received on 09/03/2025, and none had been administered. During an observation of the facility's medication storage room with LVN B on 01/20/2026 at 4:58 PM, Resident #10's morphine/diazepam suppositories were in the refrigerator in the medication storage room. There were 12 suppositories. LVN B said she had not been counting the morphine/diazepam suppositories every shift. LVN B said she usually counted them when she returned from being off, but she did not count them at the beginning/end of every shift because she knew the suppositories had not been messed with. LVN B said narcotics should be counted at the beginning and end of every shift. LVN B said it was important for narcotics to be counted because there could be a discrepancy, staff could misuse them, and to ensure they were charted properly so the resident was not double dosed. During an interview on 01/22/2026 at 3:28 PM, the DON said narcotics should be counted every shift, including Resident #10's morphine/valium suppositories. The DON said she monitored to ensure the staff was counting by checking the narcotic sheets to ensure they were signed. The DON said narcotics should be counted every shift to decrease the risk of drug diversion, to ensure the residents had the medications when they needed them, and to check the expiration dates of the medications. During an interview on 01/22/2026 at 3:44 PM, the Administrator said she expected the staff to count all narcotics each shift. The Administrator said management should ensure this was happening. The Administrator said not counting the narcotics each shift could result in a drug diversion or the patient could run out of medications. Record review of the facility's undated policy titled, Delivery, Receipt, and Storage of Medication, indicated, .New orders will be delivered upon the next routine delivery. Record review of the facility's policy titled, Administering (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications, revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. 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. Record review of the facility's policy titled, Controlled Substances, revised April 2019, indicated, The community complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. 8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal) reviewed for meal service. The facility failed to ensure [NAME] R followed the recipe for preparing ham for lunch on 01/19/26. This failure could place residents at risk for weight loss, not having their nutritional needs met, and a decreased quality of life. Findings included: During an observation on 01/19/26 at 12:12 p.m., the state surveyor noted 10 residents' lunch trays in which the ham slice appeared small. During an observation and interview on 01/19/26 at 12:56 p.m., [NAME] R said the size of the ham that was needed was documented on the dietary spreadsheet. [NAME] R looked at the spreadsheet and said it was supposed to be 3 ounces. She weighed the ham slice, and it was revealed to be 2.1 ounces. She weighed 1.5 slices of ham, and it measured 3 ounces. She said she had pre-measured the ham slice before cooking, and it weighed 3 ounces. She said she did not reweigh the ham slice after cooking. She said she should have reweighed to ensure she had the correct weight before serving. [NAME] R said she did not realize she was serving the incorrect size of ham until the surveyor's intervention. [NAME] R said she was responsible for ensuring she served the correct amount of ham, and failure to do so placed the residents at risk for receiving less food. During an interview on 01/20/23 at 5:52 p.m., the Registered Dietitian said the correct serving size should be used with all meals. The Registered Dietitian said the spreadsheet menu indicated what size serving of ham was supposed to be used. The Registered Dietitian said the Dietary Manager was responsible for ensuring the cooks followed the menu serving size. The Registered Dietitian said it was important to serve with the correct serving size to ensure the residents received the correct amount of nutrients, and not serving with the correct serving size could result in weight loss. During an interview on 01/22/26 at 1:29 p.m., the Dietary Manager said [NAME] R was supposed to serve 3 ounces of ham for the lunch menu on 01/19/26. She said cook R weighed the ham slice before cooking it but did not re-weigh the ham slice after cooking it. She said the ham shrank during the cooking phase and was not at the correct serving size. The Dietary Manager said not following the serving size or providing enough protein could cause weight loss. During an interview on 01/22/26 at 5:22 p.m., the DON said she expected the dietary staff to use the correct serving size so residents could receive the correct portions. The DON said failure to use the correct serving size placed residents at risk for not receiving the nutrition intended. The DON said the Dietary Manager was responsible for ensuring the correct serving size was used to serve the residents' meals. During an interview on 01/22/26 at 5:52 p.m., the Administrator said she expected the dietary staff to read the menu and use the correct serving size. The Administrator said the Dietary Manager was responsible for ensuring the correct serving size was used when serving the meals. The Administrator said failure to serve the correct serving size could affect the residents' overall health and well-being. During an interview with the Dietary Manager on 01/22/26 at 6:00 p.m., the facility's policy regarding following the menus was requested and not provided before exit. Record review of the facility's policy titled, Meal Service Food Handling and Preventing Contamination Reminders, dated 1/22, indicated, Procedure: Serving diet trays: B. Identify diet tray by card. C. Identify the resident and place tray within easy reach of resident. E. Replace missing items following facility policy. E (3) offer to replace or rewarm food that has become cold. Record review of the facility's policy titled, Portion Control dated 10/01/2018, indicated, Policy: The facility will use standard portion control procedures and utensils to ensure that adequate portions are served to residents. Procedure: 2. A dated copy of the daily menu extensions with portion sizes should be posted in the kitchen near the preparation and serving areas. 3. Portions for each food item should follow the specific portion sizes listed on the menus .		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 16 of 23 residents (Residents #64, #8, #50, #9, and 12 anonymous) and 1 of 1 lunch meals reviewed for palatability. The facility failed to provide palatable food served at an appetizing temperature or taste for Residents #64, #8, #50, #9, and 12 anonymous residents, who complained the food served was cold and bland. The dietary staff failed to provide food that was palatable for the lunch meal observed on 01/20/26. These failures could place residents at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included: During an interview on 01/19/26 at 11:00 a.m., Resident #64 said the food was bland and boring. During an interview on 01/19/26 at 11:09 a.m., Resident #8 said the food was not good. He said the food needed more flavor. He said they needed a new cook. During an interview on 01/19/26 at 11:37 a.m., Resident #50's family member said sometimes when Resident #50 received his food, it was cold. During an interview on 01/19/26 at 12:45 p.m., Resident #9 said the food was not good and could taste better. She said the ham was salty. During an observation and interview on 01/20/26 at 1:29 p.m., the Dietitian and six state surveyors sampled a lunch tray. The sample tray consisted of meatloaf, mashed potatoes, asparagus, and Jello. The Dietitian said the sample tray that was tested did not meet her expectations with flavor or temperature. She said the food was bland and did not retain its heat coming out of the kitchen. During the sampling, the meatloaf was lukewarm. The mashed potatoes were bland and needed more salt, and the asparagus was overcooked. She said the Jello was warm and not at the correct temperature. During a confidential resident group meeting 12 residents stated the food was always cold. During an interview on 01/22/26 at 4:12 p.m., CNA E said she worked on hall 400 and the residents complained about the taste of the food at times, but mostly about the food being cold. She said she would offer them something else. During an interview on 01/22/26 at 4:23 p.m., Dietary Aide K said sometimes the staff would return trays and ask them to warm them. She said they would often fix the resident a new plate. During an interview on 01/22/26 at 4:29 p.m., LVN A said the residents complained about the food in general, about what was served more than anything else, but occasionally about the taste or being cold. She said they did not re-warm food but would get them something else. She said she would also offer supplements because she did not want a resident to lose weight. During an interview on 01/22/26 at 4:36 p.m., the Dietary Manager said she had not had complaints about the food. She said they had a resident council meeting monthly on food, and the residents had not voiced complaints. She said she talked with the dietitian who tasted the food on Tuesday (01/20/26) for lunch, and she said the food could have used more salt. She said they could not use salt because some residents had different diets. She said if the residents did not like the food, they may not eat it, which could cause weight loss. During an interview on 01/22/26 at 5:22 p.m., the DON said she had a test tray randomly but did not eat out of the kitchen regularly. She said she felt the food she tested was fine for her. She said if a resident said their food was cold, she expected staff to go to the kitchen and get a new tray. She said the residents who were not eating or eating less would be placed at risk for malnutrition and weight loss. During an interview on 01/22/26 at 5:52 p.m., the Administrator said she ate out of the kitchen weekly and did not have any concerns. She said the Dietary Manager was responsible for ensuring the food served was palatable and served at an appetizing temperature. She said failure to serve palatable food could cause weight loss. Record review of the facility's policy titled, Taking Temperature, dated 06/01/2019, indicated, Policy: The facility realizes the critical nature of serving foods at the correct temperatures to ensure the health of its residents. The facility will take and record the temperatures of all foods prior to service. Foods not at the correct temperature will be corrected or discarded, as necessary.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 ice machine reviewed for kitchen sanitation. The facility failed to ensure the ice machine, stored in the kitchen area, was free from black and brown substances at the bottom of the bucket on 01/19/26. This failure could place residents at risk for foodborne illness. Findings included: During an observation on 01/19/26 at 11:09 a.m., the ice scoop holder located in the main area of the kitchen had a black and brown substance at the bottom of the bucket. During an observation and interview on 01/19/26 at 11:10 a.m., Dietary Aide S looked into the ice scoop holder and said she saw black and brown substances in the bottom of the bucket. She said they cleaned the ice scoop daily but was not aware that the ice scoop holder came off the wall. She said residents could get sick from what looked like dirt and rust. Dietary Aide S took the ice scoop holder and ran it through the dishwasher, and the black/brown substance was removed. During an interview on 01/22/26 at 1:29 p.m., the Dietary Manager said the kitchen staff were responsible for cleaning the ice scoop and holder. She said the cleaning schedule did not say scoop holder, but it was part of the cleaning schedule. She said the dietary aide was supposed to clean the ice scoop and ice holder daily. She said it should be washed to prevent cross-contamination. During an interview on 01/22/26 at 5:22 p.m., the DON said the kitchen staff were responsible for cleaning the ice scoop and ice scoop container. She said she was not aware of the cleaning schedule but expected it to be cleaned daily to prevent foodborne illness. During an interview on 01/22/26 at 5:52 p.m., the Administrator said she did not expect the ice container to be dirty. She said the dietary staff were responsible for ensuring the ice scoop and ice scoop container were cleaned. She said failure to keep them clean could spread germs. Record review of the facilities policy titled, General Kitchen Sanitation, dated 10/01/2018, indicated, Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Food Service employees will maintain a clean, sanitary kitchen facility in accordance with the state and US food pose in order to minimize the risk of infection and foodborne illness. Procedure.#6. Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles, and otherwise in a clean and sanitary condition.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure complete and accurate documentation for 2 of 3 residents reviewed for medical records. (Resident #10, Resident #11.)The facility failed to ensure accurate and complete documentation was entered for Resident #10, Resident #11 related to wound care. This failure could place residents at risk for inaccuracy of clinical records and decreased continuity of resident care.1. Record review of Resident #10's face sheet, dated 01/20/25, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses COPD (chronic lung condition that limits airflow and causes difficulty breathing), unspecified dementia (cognitive disorder that impairs memory, thinking, and judgement), and need for assistance with personal care. Record review of Resident #10's MDS, dated [DATE], indicated the following pressure ulcers:(3) stage 3 pressure ulcers and (0) present upon admission.(1) stage 4 pressure ulcer and (0) s present upon admission. (1) unstageable pressure ulcer due to coverage of wound bed by slough (dead tissue) and/or eschar (dead black tissue) and (0) present upon admission. Record review of Resident #10's care plan, dated 12/08/25, revealed he had actual impairment to his left hip, right heel, right shin to provide wound care as ordered. Record review of Resident #10's order summary report dated 01/20/26, revealed orders for the following wound care:Clean left hip with wound cleanser and pat dry apply alginate calcium with silver to wound bed and cover with island dressing dated 11/20/25.Clean right heel with NS or wound cleanser and pat dry apply medihoney (ointment used for wounds) to right heel and cover with island dressing. Daily and PRN one time a day start date 12/25/25.Clean left hip with normal saline/wound cleanser, pat dry, apply hydrogel with silver (ointment used for wounds) and cover with dry dressing change every day and as needed every 24 hours as needed for unstageable change if soiled or dislodged dated 08/26/25.Cleanse left hip with normal saline/wound cleanser, pat dry, apply hydrogel with silver and cover with dry dressing every day and as needed one time a day for unstageable start date 08/27/25.Cleanse wound to right shin with normal saline and wound cleanser. Pat dry. Apply alginate calcium with silver. Cover with an abdominal pad. Secure with tube gauze daily and PRN as needed start date 12/04/25.Clean wound to right shin with NS/WC. Pat dry. Apply alginate calcium with silver. Cover with ABD pad. Secure with tube gauze daily and PRN one time a day start date 12/05/25.During an observation with the Treatment Nurse on 01/20/26 at 9:39 a.m., Resident #10 had wounds to his left hip, right shin, and right heel. Record review of weekly skin assessment, dated 12/26/25, revealed documentation of, Inner thigh being addressed via Treatment Nurse. No new skin issues noted. Resident #10 wound to the right heel, right shin, and left hip were not documented. Record review of weekly skin assessment, dated 12/30/25, revealed documentation of, No new issues noted. Has multiple wounds being treated. Resident #10 wound to the right heel, right shin, and left hip were not documented. Record review of weekly skin assessment, dated 01/06/26, revealed documentation for three wound sites with measurements and staged as follows:Left hip stage III- 0.3x0.4x0.1 Right heel stage III- 0.9x2.9x0.2Right Shin stage III- 8.0x4.3x0.1No unit of measurement was indicated. 2. Record review of Resident #11's face sheet, dated 01/21/26, indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of unspecified dementia (memory loss, impaired judgement, and reduced ability to perform activities of daily living independently), dysphagia following other cerebrovascular disease (difficulty swallowing following a stroke), muscle weakness, and need for assistance with personal care. Record review of Resident #11's quarterly MDS, dated [DATE], indicated a functional limit in range of motion of the lower extremity (hip, knee, ankle foot) impairment on both sides and used a wheelchair for mobility. Resident #11 required partial/moderate assistance with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, and personal hygiene. Resident #11 required substantial/maximal assistance with lower body dressing and putting (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on/taking off footwear. Resident #11's MDS indicated she was always incontinent of bowel and bladder. Resident #11's MDS indicated she had two stage III pressure ulcers and zero that were present upon admission. Record review of Resident #11's care plan, dated 12/03/25, indicated right heel stage III pressure and risk for impairment to skin integrity of the left heel related to history of impairment to left heel. Resident #11's care planned intervention was: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration (skin breakdown due to moisture) to MD. Weekly skin assessment. Notify MD of impaired skin integrity PRN. Record review of Resident #11's order summary indicated an order for the following: Weekly skin assessment Thursday 6:00 a.m. - 6:00 p.m. complete head to toe assessment and document findings on the weekly skin observation tool with a start date of 10/09/25. Wound care consult for open area to left heel active date of 08/24/25. Wound care consult for redness to bony prominence of resident right lateral ankle active date of 07/01/25. Cleanse right heel with normal saline and wound cleanser, pat dry. Apply calcium alginate with silver. Cover with dry dressing daily and PRN for soiled displaced one time a day start date of 12/04/25. During an observation on 01/20/26 at 1:34 p.m., the Treatment Nurse performed wound care to the right heel on Resident #11. CNA H then placed pressure relieving boot back on Resident #11's heel. No care was provided for the left heel. The wound to Resident #11 heel was pink with slight clear drainage. During an interview on 01/20/26 at 1:45P p.m. the Treatment Nurse stated there was an order to perform care for the right heel only. The WC LVN stated Resident #11 wore pressure relieving boots to both feet. During an interview on 01/20/26 at 2:00 p.m., Resident #11 stated wound care was provided daily to her right heel. Resident #11 did not report any wounds to the left heel. Record review of Resident #11's weekly skin observation tool, dated 12/18/25, revealed documentation of no new skin issues noted at this time. No documentation of Resident #11 wound to the right heel. Record review of Resident #11's weekly skin observations tool, dated 12/25/25, revealed documentation of no new skin issues seen or reported. No documentation of Resident #11 wound to the right heel. Record review of Resident #11's weekly skin observation tool, dated 01/01/26, revealed documentation of a stage III pressure to the left heel with measurements of 2.0x2.1x0.1. No documentation of Resident #11 wound to the right heel. No unit of measurement was documented. Record review of Resident #11's weekly wound assessment, dated 01/15/26, revealed documentation of one right heel unstageable pressure with measurement of 1.7x2.8x0.1. Record review of Resident #11's weekly wound assessment, dated 01/22/26, revealed documentation of one right heel unstageable pressure with measurements of 1.9x2.8x0.1. Record review of Resident #11's wound evaluation and management summary, dated 12/09/25, revealed wound care physicians reported Resident #11 had wounds to her right and left heel. Documentation revealed a wound to the right heel stage III and left heel unstageable. During an interview on 01/20/26 at 9:50 a.m., LVN B stated she was responsible for completing and documenting the weekly wound assessment in the residents electronic medical record. LVN B stated the floor nurse was responsible for completing the weekly skin assessments to track changes and existing conditions. Treatment Nurse stated she documented on the wounds she was currently providing care for. LVN B reported that the wound care provider oversaw Resident #10, Resident #11 care. During an interview on 01/20/26 at 11:42 a.m., LVN B stated the floor nursing staff on duty was responsible for completing weekly skin assessments. LVN B reported that she only documents was there was a new skin condition and was not aware of the need for documentation of existing skin issues. After surveyor intervention LVN B stated she should have documented all existing skin conditions to ensure accurate documentation and tracking was done. LVN B stated the resident was at risk of missing documentation. During an interview on 01/20/26 at 1:55 p.m., the Treatment Nurse stated she completed a weekly wound report, and the floor nurse completed the weekly skin assessment. During an interview on 01/22/26 at 4:50 p.m., the DON stated she expected nursing staff to document weekly skin assessment and the wound care nurse to complete weekly wound assessment. The DON stated Resident #10 and Resident #11 were at risk of a wound undetected or (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worsening if accurate documentation was not available. The DON stated she was aware of previous incorrect documentation of skin assessments and stated she completed an in-service with the staff but was unaware it was still happening. During an interview on 01/22/26 at 5:44 p.m., the Administrator stated she expected skin and wound assessments to be accurately documented timely by the floor nursing staff. She expected the DON to oversee documentation of wound assessments and weekly skin. The Administrator reported an in-service regarding documentation was done on 11/13/25. Record review of system pathway #1 - Skin and Wound Management, undated, revealed:Ongoing all residents should be checked from head to toe weekly by a licensed nurse to identify any new pressure injuries or other types of skin concerns. The licensed nurse should document the results of weekly skin checks by completing a Weekly Skin Observation tool and note either: Any new identified area(s), or Updates existing current areas previously identified status, or In Section A. #2 of the tool document the following Skin intact with no new issues In between weekly head to toe skin checks conducted by a license nurse if a pressure injury, ulcer, skin breakdown or wounds was identified, the licensed nurse should: document in the resident's electronic health record progress notes, noted new area identified, include location, description, size, color, drainage and if odor present. complete the weekly skin observation tool with the date identified AND then complete a Weekly Wound Progress Report UDA as includes more descriptive details Notified the DON/ADON/Treatment nurse and the log to include, but not limited to size, stage, location, drainage, and odor. Record review of Charting and Documentation policy revision date July 2017 revealed The following information was to be documented in the resident medical record: a. Objective observations;b. Medications administered;c. Treatments or services performed;d. Changes in the resident's condition;e. Events, incidents or accidents involving the resident; andf. Progress toward or changes in the care plan goals and objectives. To ensure consistency in charting and documentation of the resident's clinical record, only community approved abbreviations and symbols may be used when recording entries in the resident's clinical records.Documentation of procedures and treatments will include care-specific details, including:a. the date and time the procedure/treatment was provided;b. the name and title of the individual(s) who provided the care;c. the assessment data and/or any unusual findings obtained during the procedure/treatment;d. how the resident tolerated the procedure/treatment;e. whether the resident refused the procedure/treatment;f. notification of family, physician or other staff, if indicated; andg. the signature and title of the individual documenting.A Weekly Skin/Wound Progress Report UDA in the resident(s) E.H.R was completed and updated weekly for any non-pressure skin condition, including Arterial Ulcers, Diabetic Neuropathy Ulcers, Venous Insufficiency Ulcers, Bruises, Skin Tears and Surgical Wounds. A Weekly Skin/Wound Progress Report UDA was completed upon any identification of pressure injury(s), ulcers and updated at least weekly and as needed with any significant change. All pressure injuries are staged according to the updated NPUAP guidelines (see Protocol 1-F). The Resident's overall care plan was completed for each site and updated with any changes to interventions.		

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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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 5 of 6 residents (Resident #4, Resident #8, Resident #10, Resident #67, and Resident #79) reviewed for infection control. 1. The facility failed to ensure CNA E followed enhanced barrier precautions and performed proper glove while providing incontinent care to Resident #67 on 01/20/2026. 2. The facility failed to ensure CNA E did not handle linens with blood on them without gloves on 01/20/2026. 3. The facility failed to ensure CNA H performed hand hygiene while providing incontinent care for Resident #79 on 01/19/26. 4. The facility failed to have PPE signage outside Resident #8's room on 01/19/26 and 01/20/26. 5. The facility failed to ensure CNA T and LVN B used enhanced barrier precautions for Resident #10 while providing catheter care on 01/19/2026. 6. The facility failed to ensure Resident #4 had enhanced barrier precautions signage on his door and enhanced barrier precautions cart in place for staff to use. These failures could place residents at risk for cross contamination and the spread of infection.1. Record review of a face sheet dated 01/22/2026 indicated Resident #67 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood), and benign prostatic hyperplasia without lower urinary tract symptoms (overgrowth of prostate tissue blocks the flow of urine). Record review of Resident #67's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #67 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #67 required partial/moderate assistance with personal hygiene and toileting hygiene, and substantial/maximal assistance with showering/bathing self. The MDS assessment indicated Resident #67 had an indwelling catheter (flexible tube inserted into the bladder to drain urine when someone cannot urinate on their own) and was frequently incontinent of bowel. Record review of Resident #67's Order Summary Report dated 01/22/2026 indicated: Catheter care every shift and as needed with a start date of 09/25/2025 Enhanced barrier precautions PPE required when performing high contact activities every shift with a start date of 09/28/2025. Record review of Resident #67's care plan revised 10/13/2025 indicated he had the potential for skin impairment to cleanse resident after incontinent episodes as needed. Resident #67's care plan indicated he had an indwelling catheter to provide catheter care every shift and as needed. Resident #67's care plan indicated he required enhanced barrier precautions related to an indwelling catheter. His care plan indicated enhanced barrier precautions should be utilized during ADLs including but not limited to providing hygiene and changing linens/briefs or when toileting. During an observation and interview on 01/20/2026 at 5:17 PM, CNA E provided incontinent care to Resident #67. Outside of Resident #67's room a sign was observed that indicated enhanced barrier precautions should be followed and there was a cart with PPE inside of it. CNA E entered Resident (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#67's room and put on gloves. CNA E did not put on a gown. Resident #67 had an episode of bowel incontinence. CNA E cleaned Resident #67's front perineal area and provided catheter care, turned him on his side, and then cleaned his buttocks. CNA E removed the dirty brief, applied a clean brief, while using the dirty gloves. CNA E then turned Resident #67 on his back. CNA E raised Resident #67's scrotal sac to check underneath. Resident #67 still had stool underneath his scrotal sac, so she cleaned him on top of the clean brief. CNA E proceeded to fasten the same brief. CNA E did not change her gloves prior to applying the clean brief. CNA E did not change Resident #67's brief after she finished cleaning off the stool underneath his scrotal sac. CNA E removed her dirty gloves. Resident #67's top sheet was dirty and had dried blood spots on it from the wounds to his legs. CNA E grabbed the top sheet without gloves and placed it in a bag. CNA E gathered the trash and linen bag and walked out of the room. CNA E performed hand hygiene in the hallway. CNA E said when changing a brief, gloves should be changed and hand hygiene performed when the dirty brief was removed. CNA E said new gloves should be applied when putting on the new brief. CNA E said she should have cleaned Resident #67 completely before placing a clean brief underneath him. CNA E said leaving the brief on Resident #67 after cleaning him up made the clean brief dirty. CNA E said she did not provide incontinent care as she should have because she was in a rush. CNA E said not providing incontinent care properly could result in an infection. CNA E said she should have put gloves on before touching the dirty linens. CNA E said touching dirty linens without gloves could result in cross contamination. CNA E said she was not aware Resident #67 required enhanced barrier precautions. She said there were signs outside of the residents' rooms, but it was hard to determine which resident required enhanced barrier precautions when there were two residents in the room. CNA E said enhanced barrier precautions should be followed so they did not contaminate other residents or themselves and to prevent cross contamination. During an interview on 01/22/2026 at 3:18 PM, the DON said when the CNAs provided incontinent care, they should change gloves and perform hand hygiene when they went from dirty to clean. The DON said the CNAs should ensure the residents were clean before putting on a clean brief. The DON said Resident #67 required enhanced barrier precautions, and CNA E should have worn a gown and gloves when providing incontinent care to Resident #67. The DON said dirty linens should not be touched without gloves. The DON said she monitored incontinent care by going to help on the hall at least once a shift when she was in the building. The DON said competency checks were completed, and if they saw anything wrong it was corrected, and everyone was re-educated. The DON said she had not noticed any issues with incontinent care. The DON said not following enhanced barrier precautions placed the residents at risk of not being protected from infections. The DON said not handling the linens properly was an infection control issue and placed the residents at risk of cross contamination. During an interview on 01/22/2026 at 3:38 PM, the Administrator said when the staff provided incontinent care, she expected them to follow the infection control procedures, the training they received, and to wear the proper PPE because it was important to protect the residents. The Administrator said management was responsible for ensuring the staff were providing proper incontinent care and following infection control procedures. The Administrator said not providing proper incontinent care placed the residents at risk of infection and the spread of infection. The Administrator said she expected the staff to follow the facility's infection control procedures when handling linens. The Administrator said not handling linens properly placed the residents at risk for the spread of infection. The Administrator said she expected the staff to follow enhanced barrier precautions, and management was responsible for ensuring they did this. The Administrator said not following enhanced barrier precautions could result in the spread of infection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #79's face sheet, dated 01/22/26, indicated she was an [AGE] year-old female, admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses which included dementia (loss of memory), stroke, anxiety (feelings of worry, fear, unease, and apprehension), and high blood pressure Record review of Resident 79's quarterly MDS assessment, dated 10/08/25, indicated Resident #79 understood and was understood by others. Resident #79's BIMS score was 13, indicating her cognition was intact. The MDS indicated Resident #79 required assistance with her ADLs, including transfers, dressing, personal hygiene, and bed mobility. The MDS indicated she was frequently incontinent of bowel and bladder. Record review of Resident #79's comprehensive care plan, dated 10/20/22, indicated Resident #79 had an ADL self-care performance deficit related to impaired balance, stroke, and limited range of motion to the right shoulder. The intervention was for two staff members to assist with toileting, turning, and repositioning in bed. During an observation on 01/19/2026 at 12:03 p.m., CNA H provided incontinent care for Resident #79. CNA H wiped Resident #79's front and then assisted to turn her on her left side without hand hygiene or changing her gloves. CNA H wiped Resident #79's buttock which contained bowel and assisted in turning Resident #79 to her back without hand hygiene or changing her gloves. CNA H then changed her gloves, washed her hands, applied a new brief, and completed care. During an interview on 01/19/26 at 12:55 p.m., CNA H said she did not perform hand hygiene or change her gloves after wiping Resident #79, front to back or when she turned her. She said she should have washed and changed her gloves from dirty to clean. She said she knew that without hand hygiene or removing dirty gloves, she could cause cross-contamination. During an interview on 01/22/26 at 2:24 p.m., LVN A said she was Resident #79's nurse. She said she expected staff to provide incontinent care to keep the residents clean. She said she expected them to practice hand hygiene and change gloves when going from dirty to clean. 3. Record review of Resident #8's face sheet, dated 11/24/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, pressure ulcer to the left heel stage 3 (a severe, full-thickness wound extending through the skin to the subcutaneous fat, appearing as a deep crater), right tibia fracture (a break in the main shinbone, usually caused by high-energy trauma (e.g., falls, accidents), resulting in immediate, severe pain, inability to bear weight, swelling, and potential deformity), and diabetes (a chronic disease where the body doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood sugar levels). Record review of Resident #8's admission MDS assessment, dated 12/03/25, indicated Resident #8 understood and was understood by others. Resident #8's BIMS score was 03 which indicated his cognition was severely impaired. The MDS indicated Resident #8 required maximum assistance with his ADLs. The MDS indicated Resident #8 was occasionally incontinent of bladder and had a wound. Record review of Resident #8's comprehensive care plan, dated 12/02/25, indicated, Resident #8 had an actual impairment to his skin integrity of the L heel. The interventions were for staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface and weekly treatment per the doctors' orders with documentation to include (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Record review of Resident #8's Physician order, dated 12/05/25, indicated to cleanse wound to left heel with Normal saline or wound cleaner. Pat dry. Apply Leptospermum Honey (medication used for wounds). Cover with dry dressing daily and as needed. Record review of Resident #8's medication administration record, dated 01/08/26 through 01/13/26, indicated enhanced barrier precautions for stage 3 pressure ulcer, left heel. Resident #8 must remain on precautions for the duration of their PPE requirements when performing high contact activities every shift for the residents' protection from potential infections. During an observation and interview on 01/19/26 at 11:35 a.m., Resident #8 was lying in his bed. Resident #8 said he had a wound. Observation revealed there was no EBP posting or a PPE cart outside his door. During an observation and interview on 01/20/26 at 10:33 a.m., the treatment nurse was about to perform wound care when CNA M walked up to the treatment nurse and asked if he needed to wear PPE (glove and gowns) since he did not have a sign posted or cart by his door. The treatment nurse said, Yes. CNA M applied a gown and gloves and helped the treatment nurse with Resident #8's wound. The treatment nurse said she did Resident #8's treatment yesterday (01/19/26) and Resident #8 did not have the EBP sign or the cart outside his room. She said Resident #8 was supposed to go home last week, so his signage and cart were removed. She said since he did not leave his signage and cart should have been put back because he had a wound and PPE (glove and gown) were required when providing care. During an interview on 01/20/26 at 1:30 p.m., CNA M said he was Resident #8's aide. He said he was not aware that Resident #8 still required PPE when providing care because his signage and cart were removed. He said he was aware of what to do if the signage and cart were outside his door but since it was not, he had not worn PPE (gown). He said he helped Resident #8 with his urinal earlier today (01/20/26) and did not wear a gown. He said without wearing the proper PPE (gown and gloves) it placed him and the resident at risk of infection. During an interview on 01/22/26 at 5:22 p.m., the DON said she expected the CNAs to perform incontinent care correctly. She said she expected staff to change their gloves between dirty to clean and use hand hygiene between glove changes. She said the ADON oversaw the infection control process. She said she thought she heard in the morning meeting (unknown date) that his wounds were healed and therefore the signage, carts and orders were removed. She said if he still had wounds then he was supposed to have signage on his door and a cart outside his door. She said staff should change gloves, practice hand hygiene, and wear proper PPE (gown and gloves) when caring for residents on EBP to prevent infection and cross-contamination. During an interview on 01/22/26 at 5:55 p.m., the Administrator said she expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the nurse management were responsible for ensuring staff were trained on incontinent care, hand washing, EPB, and infection control. She said improper hand hygiene and not wearing the proper PPE (gown and gloves) could place residents at risk for cross-contamination or infection. 4. Record review of Resident #10's face sheet, dated 01/20/25, indicated he was a [AGE] year-old (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	male admitted to the facility on [DATE] with the diagnosis COPD (chronic lung condition that limits airflow and causes difficulty breathing), unspecified dementia (cognitive disorder that impairs memory, thinking, and judgement), and need for assistance with personal care. Record review of Resident #10's MDS quarterly, dated 09/01/25, stated resident required partial/moderate assistance - helper does less than half the effort for toileting hygiene. Record review of Resident #10's MDS significant change, dated 10/13/25, stated resident required substantial/maximal assistance - helper does more than half the effort for toileting hygiene. Record review of Resident #10's care plan, revision dated 12/08/25, stated an intervention for provide perineal care after each incontinent episode. Record review of Resident #10's order summary report, dated 01/20/25, indicated he had an order for: Catheter CARE: OUT PUT Q SHIFT every shift for catheter and catheter care q shift and PRN every shift start date of 06/02/25. Urinary Catheter 16FR,10CC. Diagnosis: Urinary retention. Dated 12/23/24. ENHANCED BARRIER PRECAUTIONS: GOWNS AND GLOVES to be utilized during ADLs including but not limited to: Dressing, bathing, transferring, providing hygiene, changing linens/briefs or when toileting, care of indwelling medical devices, such as: catheter, Pressure stage 3 right heel, right shin, left hip, and/or close contact was anticipated for transfer/mobility every shift for RESIDENT PROTECTION from potential infections resident care that does not require Enhanced barrier precautions include: peripheral intravenous line (not peripheral central catheter), answering a call light, conversing with resident, providing medications that do not require high-contact. During an observation on 01/19/2026 3:36 p.m., revealed CNA T and LVN B failed to use enhanced barrier precautions for Resident #10 catheter care during perineal care provided for with an incontinent episode of bowel. CNA T and LVN B only put gloves on prior to starting care for Resident #10. CNA T failed to perform hand hygiene or hand sanitize before, during, and after care was provided. CNA T wore the same soiled gloves throughout the entire incontinent care and catheter care when her gloves were visibly soiled. During an interview on 01/19/26 at 3:56PM, CNA T said she forgot to use enhanced barrier precautions and wash her hands. CNA T stated there was a sign on the door to notify staff to use EBP for care. CNA T stated that the resident was at risk for UTI. CNA T reported that catheter care was performed by the CNAs. During an interview on 01/19/26 at 3:45PM, the LVN B said the CNAs are responsible for performing catheter care and the nurse was responsible for ensuring the care was provided every shift using enhanced barrier precautions. LVN B reported Resident #10 was at risk for sepsis and more UTIs when EBP was not used. During an interview on 01/22/26 at 4:38PM, the DON said she expected nursing staff to wear EBP when providing catheter care for Resident #10. The DON stated she expected nursing staff to check for a supply box and sign on the door each time they entered the room. The DON reported aides perform catheter care, but any nursing staff can provide care for Resident #10. The DON stated she (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lakeside Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 110 N State Hwy 274 Kemp, TX 75143	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was responsible for ensuring EBP was used with care by all direct care staff, monitoring all catheters in the building, and hand hygiene audit. The DON stated that Resident #10 was at risk of infection when catheter care was not provided using EBP with hand hygiene. The DON stated in-service was completed for all nursing staff annually to ensure competence of perineal care, hand hygiene and use of EBP. During an interview on 01/22/26 at 5:40PM, the Administrator said she expected enhanced barrier precautions to be provided according to orders. The Administrator stated that she expected Resident #10 to receive care from staff wearing EBP. The DON reported Resident #10 was at risk of UTI due to his catheter and stage 4 pressure wounds. Record review of competency checklist dated 12/2025 for CNA T revealed a check off was completed for incontinent care, catheter care, hand hygiene, and enhanced barrier precautions. 5. Record review of Resident #4's face sheet dated 01/22/26 indicated he was a [AGE] year-old male, re-admitted [DATE], with diagnoses which included end stage renal disease, anxiety, depression, and need for assistance with personal care. Record review of Resident #4's quarterly MDS assessment, dated 10/28/25, indicated he could make himself understood and he understood others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated he required staff for set up or clean up assistance for all ADLs. The MDS also indicated he received hemodialysis while he was a resident. Record review of Resident #4's care plan, dated revised 01/15/25, indicated he required enhanced barrier precautions related to him being at risk for multi-drug resistant organisms due to his indwelling medical device with interventions in place to educate staff and visitors of enhanced barrier precautions, enhanced barrier precautions signs placed on resident doors, and enhanced barrier precautions supplies to be located in designated areas on the halls. Record review of Resident #4's physicians order summary report, dated 01/20/26, indicated 1) Dialysis &ndash; monitor AV shunt/fistula to left arm for thrill and bruit every shift. Notify MD/NP for any unusual/unexpected findings every shift related to end stage renal with a start date of 11/12/25 and no end date. 2) Enhanced barrier precautions: gowns and gloves to be utilized during ADLs including but not limited to: Dressing, bathing, transferring, providing hygiene, changing linens/briefs or when toileting, care of indwelling medical devices, such as: catheters, g-tubes, and PICC lines, and wound care of chronic wounds (pressure ulcers, diabetic ulcers, unhealed surgical wounds or venous stasis ulcers), and/or close contact was anticipated for transfer/mobility every shift for resident protection from infection. Resident care that does not require enhanced barrier precautions included: peripheral intravenous line (not peripheral central catheter), answering a call light, conversing with resident, providing medications that do not require high contact with a start date of 06/02/25 and no end date. During an interview on 01/22/26 at 2:49 p.m., LVN A said Resident #4 should probably have enhanced barrier precautions, but he cared for himself for most of his ADLs. LVN A said he had dialysis access (a port or catheter used for dialyzing) that nurses must care for at times. LVN A said the importance of enhanced barrier precautions was to keep infection from being passed. During an interview on 01/22/26 at 5:21 p.m., the DON said the staff should have been using enhanced barrier precautions during direct care. The DON said the charge nurse should have been using enhanced barrier precautions while assessing Resident #4's dialysis access. The DON said the Infection Preventionist (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(the ADON) and DON were responsible for ensuring the person protection equipment cart and the signs for enhanced barrier precautions were outside of the room. The DON said the failure placed a risk for Resident #4 having increased risk for infection and the community of the facility could be at risk if Resident #4 developed an infection. During an interview on 01/22/26 at 5:52 p.m., the Administrator said she expected the signage and the cart for enhanced barrier precautions to be placed at Resident #4's room and door if it was required and she expected everyone to adhere to the infection control policy. The Administrator said the DON and ADON were responsible for ensuring enhanced barrier precautions were placed. The Administrator said the failure placed at risk of spread of infection. Record review of the facility policy Preventing and Controlling infections, dated 1/2022, did not include enhanced barrier precautions. Record review of the facility's policy titled, Perineal Care, dated revised February 2018, indicated, The purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Put on gloves. For a male resident a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area starting with urethra and working outward c. If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches. Gently rinse and dry the area. d. Retract foreskin of the uncircumcised male. e. Wash and rinse urethral area using a circular motion. f. Continue to wash the perineal area including the penis, scrotum and inner thighs. g. Thoroughly rinse perineal area in same order, using fresh water and clean washcloth. h. If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter. i. Gently dry perineum following same sequence. j. Reposition foreskin of uncircumcised male. Ask the resident to turn on his side with his upper leg slightly bent, if able. l. Rinse wash cloth and apply soap or skin cleaning agent. m. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. n. Dry area thoroughly. 9. Discard disposable items into designated containers. 10. Remove gloves and discard into designated container. 11. Wash and dry your hands thoroughly 12. Reposition the bed covers. Make the resident comfortable. 13. Place the call light within easy reach of the resident. 14. Clean wash basin and return to designated storage area. 15. Clean the bedside stand. 16. Wash and dry your hands thoroughly. Record review of the facility's undated policy titled, Implementing the use of Enhanced Barrier Precautions in Skilled LTC Nursing Facilities, Recommendations following Enhanced Barrier Precautions for nursing home staff based on care activities. Examples of Care Activities use hand hygiene, gown, gloves (high-contact activities) providing care under clothes or dressings, providing bundled AM or PM care including oral care, dressing, bathing, grooming, taking the resident to the toilet or providing peri care, having prolonged high-contact with items in the resident's room, resident equipment, or with resident clothing or skin in the resident's room, shower room, or the therapy gym, or doing extended therapy/restorative activities, changing the linens, providing bed mobility, including rolling from side to side.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat each resident with respect, dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and protecting and promoting the rights of the resident for 1 of 5 residents (Resident #10) reviewed for resident rights. The facility failed to ensure CNA T spoke in a manner of dignity to Resident #10. These failures could place residents at risk of embarrassment, isolation, and diminished quality of life. Findings Include: Record review of Resident #10 face sheet, dated 01/20/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included COPD (chronic lung condition that limits airflow and causes difficulty breathing), unspecified dementia (cognitive disorder that impairs memory, thinking, and judgement), and need for assistance with personal care. Record review of Resident #10's Quarterly MDS, dated [DATE], reflected the resident required partial/moderate assistance- helper does less than half the effort for toileting hygiene. Resident #10 had a BIMS of 11, which indicated only moderate cognitive impairment. Record review of Resident #10's Significant Change MDS, dated [DATE], reflected the resident required substantial/maximal assistance- helper who did more than half the effort for toileting hygiene. Resident #10 had a urinary catheter and was frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one continent bowel movement). Despite coded BIMS score of 00 which indicates severe impairment, the resident was observed to respond to questions and verbalize feeling during interview, which indicated retained ability to communicate concerns, and suggesting a potential inconsistency between the code cognitive status and the resident demonstrated abilities. Record review of Resident #10's care plan, revision dated 12/08/25, was care planned for an ADL self-care deficit related to fatigue and impaired balance. Resident #10's care plan reflected an intervention for providing perineal care after each incontinent episode. During observation on 01/19/26 at 3:36 PM, CNA T and LVN B were observed providing incontinent care to Resident #10. While the resident had an active bowel movement and passed gas, CNA T stated, Thanks, [Resident 10], in a mocking tone. During an interview on 01/19/26 at 3:15 PM, Resident #10 stated he felt ashamed of how he was being treated. The resident further stated staff were treating me like wrestling during care. Resident #10 described the way staff treated him roughly when performing perineal care but could not identify or describe the staff. Resident #10 was alert and labile (able to answer most questions but not all; resident #10 had blank stare) and not consistently able to answer all questions. Surveyor attempted to interview resident regarding the privacy curtain; however, resident was asleep and did not wake up. Reasonable expectation is that the door would be closed while perineal care is being provided. During an interview on 01/19/26 at 3:45 PM, LVN B stated the comment made by CNA was inappropriate and she would not have said that. LVN B stated when providing care, she or CNA T should have closed the door. LVN B stated Resident #10 was at risk of loss of dignity and humiliation. LVN B stated she forgot to close the door. During an interview on 01/19/26 at 3:56 PM, CNA T stated Resident #10's door did not remain shut when providing care. CNA T indicated the door did not click when closing. CNA T stated when she said Thanks it could have been taken wrong or upset Resident #10 and hurt his self esteem. CNA T stated the comment she made was inappropriate. CNA T stated that she jokes around with Resident #10. During a phone interview on 01/19/26 at 4:23 PM, Resident #10 representative reported she was unsatisfied with the care her family member was receiving Resident #10's Representative stated she believed he was not being treated with respect and dignity. During an interview on 01/22/26 at 4:36 PM, the DON stated she was not aware CNA T spoke to Resident #10 in a undignifying way. DON stated she was not aware that CNA T and LVN B performed perineal care with the door open. The DON stated she expected all staff to treat residents with dignity and respect at all (continued on next page)		

Department of Health & Human Services
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Printed: 07/18/2026
Form Approved OMB
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times. All staff were responsible for ensuring resident rights and dignity. The DON claimed ultimate responsibility for ensuring resident rights. The DON stated the resident was at risk of humiliation. During an interview on 01/22/26 at 5:27 PM, the Administrator stated she expected the staff honor resident rights and ensure their dignity was held. The Administrator reported all staff were responsible for ensuring resident rights and Resident #10 was at risk for his needs not being met. The Administrator stated I don't think they should say that. It's not acceptable to joke with the resident. It could be taken wrong and can considered making fun and embarrass him. The Administrator stated resident rights were addressed in in-services on orientation, quarterly and as needed along with abuse and neglect. Record review of the Resident Rights policy, revised 12/2016, reflected: Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to: a dignified existence. be treated with respect, kindness, and dignity. be free from abuse, neglect, misappropriation of property, and exploitation.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had a right to secure confidential and personal medical records and privacy during medical treatments for 2 of 24 residents (Residents #28, and #10) reviewed for resident rights. 1. The facility did not ensure RN G used a secure telephonic device to communicate with the facility NP. 2. The facility failed to ensure CNA T and LVN B provided privacy when providing incontinent care to Resident #10. These failures could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings include: Record review of Resident #28's face sheet, dated 01/22/26, reflected Resident #28 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular, often rapid heart rate). Record review of Resident #28's quarterly MDS assessment, dated 12/30/25, reflected Resident #28 made himself understood and understood others. Resident #28's BIMS score was 14, which reflected his cognition was intact. Record review of Resident #28's nurse's note, dated 01/07/26 completed by RN G, reflected Resident was complaining of feeling dizzy and lightheadedness. He is sitting on the side of his bed. He stated, They put a patch on my shoulder today. Upon further assessment, the resident had a nicotine patch on his right shoulder. Vitals were taken and were stable. family member at bedside. The nurse's note did not address whether the NP was notified. Record review of a text message, dated 01/07/26 at 3:39 p.m., between RN G and the facility NP reflected, Hey there. FYI. we had a med error on [Resident #28] (which included his last name). Med Aide put a nicotine patch on him! He was dizzy and lightheaded and had chills. Continuing to monitor. The facility NP did not respond to the text. During an interview on 01/21/26 at 10:49 a.m., RN G stated she was notified by Resident #28 that he did not feel good. RN G stated she went down to his room, assessed him and that was when he stated he had a patch on his shoulder. RN G stated she looked at his right shoulder and noted a nicotine patch with an initial and dated 01/07/26. RN G stated she went and got the DON and notified the NP via text using her personal cell phone. RN G stated the NP did not respond via text but called the facility and instructed her to continue to monitor. RN G stated sending a text using her personal cell phone was how she coordinated with the NP. RN G stated if the resident was in danger she would call the NP. RN G stated this failure was a HIPPA violation and put Resident #28 at risk for confidentiality of his personal medical records. During an interview on 01/22/26 at 3:39 p.m., the NP stated she would like to be notified via phone before 4:00 p.m. and after 4:00 p.m. to contact the on-call provider. During an interview on 01/22/26 at 4:03 p.m., the DON stated her expectation was RN G coordinate with the provider, however the provider requested. The DON stated it was okay for RN G to text the provider using her personal cell phone if that was what the provider requested, and RN G's phone was secured by having her screen locked. The DON stated the risk of not using a secure device to send residents information was Resident #28 PHI could be shared. During an interview on 01/22/26 at 5:04 p.m., the Administrator stated she learned RN G sent a text to (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the NP regarding an incident that occurred with Resident #28 using her personal cell phone after the state surveyor intervention. The Administrator stated she expected staff to either coordinate with the physician either by phone, fax or PCC. The Administrator stated nursing management was responsible for overseeing and monitoring by in-service and education. The Administrator stated the risk of not using a secure device was the release of secure information or HIPPA violation. 2. Record review of Resident #10 face sheet, dated 01/20/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included COPD (chronic lung condition that limits airflow and causes difficulty breathing), unspecified dementia (cognitive disorder that impairs memory, thinking, and judgement), and need for assistance with personal care. Record review of Resident #10's Quarterly MDS, dated [DATE], reflected the resident required partial/moderate assistance- helper does less than half the effort for toileting hygiene. Resident #10 had a BIMS of 11, which indicated only moderate cognitive impairment. Record review of Resident #10's Significant Change MDS, dated [DATE], reflected the resident required substantial/maximal assistance- helper who did more than half the effort for toileting hygiene. Resident #10 had a urinary catheter and was frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one continent bowel movement). Despite coded BIMS score of 00 which indicates severe impairment, the resident was observed to respond to questions and verbalize feeling during interview, which indicated retained ability to communicate concerns, and suggesting a potential inconsistency between the code cognitive status and the resident demonstrated abilities. Record review of Resident #10's care plan, revision dated 12/08/25, was care planned for an ADL self-care deficit related to fatigue and impaired balance. Resident #10's care plan reflected an intervention for providing perineal care after each incontinent episode. During observation on 01/19/26 at 3:36 PM, CNA T and LVN B were observed providing incontinent care to Resident #10 without ensuring privacy by closing the door or drawing the privacy curtain. During an interview on 01/19/26 at 3:15PM Resident #10 was alert and labile (able to answer most questions but not all; resident #10 had blank stare) and not consistently able to answer all questions. Surveyor attempted to interview Resident #10 regarding the privacy curtain; however, resident was asleep and did not wake up. Reasonable expectation is that the door would be closed while perineal care is being provided. During an interview on 01/19/26 at 3:45 PM, LVN B stated when providing care, she or CNA T should have closed the door. LVN B stated Resident #10 was at risk of loss of dignity and humiliation. LVN B stated she forgot to close the door. During an interview on 01/19/26 at 3:56 PM, CNA T stated Resident #10's door did not remain shut when providing care. CNA T indicated the door did not click when closing. CNA T stated not providing privacy during care could hurt his self-esteem. During a phone interview on 01/19/26 at 4:23 PM, Resident #10 representative reported she was unsatisfied with the care her family member was receiving Resident #10's Representative stated she believed he was not being treated with respect and dignity. (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/22/26 at 4:36 PM, the DON stated she was not aware that CNA T and LVN B performed perineal care with the door open. The DON stated she expected all staff to provide privacy when providing care. The DON claimed ultimate responsibility for ensuring resident rights. The DON stated not providing privacy placed the residents at risk of humiliation. During an interview on 01/22/26 at 5:27 PM, the Administrator stated she expected the staff honor resident rights and ensure their dignity was held. The Administrator reported all staff were responsible for ensuring resident rights and Resident #10 was at risk for his needs not being met. The Administrator stated resident rights were addressed in in-services on orientation, quarterly and as needed along with abuse and neglect. Record review of the facility's policy titled Resident Rights, last revised on 12/2016, reflected . employees shall treat all residents with kindness, respect, and dignity.1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: t. privacy and confidentiality. dd. communicate in person and by mail, email and telephone with privacy.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 1 of 5 residents (Resident #10) reviewed for unnecessary psychotropic drugs. The facility failed to ensure Resident #10's GDR, dated 12-25, was completed after pharmacy recommended a dose reduction. This failure could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Record review of Resident #10 face sheet, dated 01/20/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included COPD (chronic lung condition that limits airflow and causes difficulty breathing), unspecified dementia (cognitive disorder that impairs memory, thinking, and judgement), and need for assistance with personal care. Record review of Resident #10's quarterly MDS, dated [DATE], reflected the resident had an active diagnosis of depression and the resident was currently taking the following medication by pharmacological class: antidepressant, antibiotic, opioid, and anticonvulsant. Resident #10 had a BIMS of 11, which indicated only moderate impairment. Record review of Resident #10's significant change MDS, dated [DATE], reflected the resident was currently taking the following medication by pharmacological class: antidepressant, antibiotic, opioid, and anticonvulsant. Resident #10 had a BIMS of 00, which indicated severe impairment. Record review of Resident #10's care plan, revision dated 12/08/25, reflected the resident used antidepressant medication for depression. Resident #10 had interventions listed as Monitor/document/report PRN adverse reactions to Antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness, fatigue, insomnia; appetite loss, weight loss, nausea and vomiting, dry mouth, dry eyes. Record review of Resident #10's medication regimen review, dated for the time period 12/02/25 to 12/06/25, reflected the need for Resident #10's medication regimen of Lexapro 15mg daily since 6/17/25. The recommendation of initiating gradual dose reduction to: Lexapro 10mg daily. Record review of Resident #10 order summary report, dated 01/20/25, indicated he had an order for: Escitalopram Oxalate Tablet Give 15 mg by mouth one time a day for Depression related to Depression, Unspecified (F32.A) Active start 06/17/2025, with no end date. Record review of Resident #10 medication administration record, dated 01/20/26, indicated resident had received Lexapro (Escitalopram Oxalate medication used for depression) Tablet with the instructions to give 15 mg by mouth one time a day for Depression every day the month of January 2026. During an interview on 01/22/25 at 10:40 AM, the DON said she was unable to provide documentation of a GDR for Resident #10 Lexapro. During an interview on 01/22/25 at 4:36 PM, the DON said at the time he went on hospice he was no longer being seen by the nurse practitioner for psychiatric care. The DON stated at that time the facility NP should have taken over his care and monitoring timeline. The DON reported when contacting the NP, the NP stated she never took over his medication regime review. The DON reported she was responsible for ensuring the GDR process was completed and Resident #10 was at risk of being over or under medicated and having unnecessary medications. During an interview on 01/22/25 at 5:36PM, the Administrator said she expected the GDR to be considered, discussed, and policy and procedures followed. The Administrator stated the DON was responsible for ensuring this process was completed and it was done between nursing, pharmacy, and the provider. The Administrator reported the resident was at risk for adverse effects of the medication. Record review of Medication Therapy Policy, dated April 2007, reflected the following: 1. Periodically, and when circumstances are present that represent (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a greater risk for medication-related complications, the staff and practitioner will review the medication regimen for continued indications, proper dosage and duration, and possible adverse consequences. 2. The physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example: a. when a medication is being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale; b. when the results of ongoing assessment, or the presence of clinically significant adverse consequences monitoring, suggest that a medication should be reduced or discontinued entirely; and c. when a medication is being prescribed to treat, or in anticipation of, an adverse consequence of another prescribed drug. 3. The consultant pharmacist shall review each resident's medication regimen monthly, as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected. 4. The community shall review medication-related issues as part of its quality assurance and performance improvement committee and activities.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 5 residents (Resident #3 and Resident #68) reviewed for accuracy of MDS assessments. 1) The facility failed to ensure Resident #3's MDS accurately reflected the resident was PASRR positive for mental illness. 2) The facility failed to ensure Resident's #68's MDS accurately reflected PASRR positive for mental illness. These failures could place residents at risk of not receiving the necessary care and services to prevent falls and injuries related to inaccurate MDS assessments. Findings included: 1. Record review of Resident #3's face sheet, dated 1/22/26, indicated reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had with the diagnoses which included PTSD (post-traumatic stress disorder), depression (a mood disorder that cause a persistent feeling of sadness and loss of interest), and anxiety (persistent, excessive worry that interferes with daily life). Record review of Resident #3's admission MDS assessment dated [DATE] indicated reflected she could make self understood and she understood others. The MDS also indicated she Resident #3 had a BIMS score of 12, which meant she was cognitively intact. The MDS also indicated in Section A1500: documented Resident #3 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, which indicated she was PASRR negative. Record review of the PASRR Evaluation (level II assessment), completed on 12/15/25 indicated reflected Resident #3 was PASRR positive for mental illness. Record review of Resident #3's care plan, dated 12/15/25, indicated reflected Resident #3 was PASRR positive. 2. Record review of Resident #68's face sheet, dated 01/22/26, reflected Resident #68 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included depression (a mood disorder that cause a persistent feeling of sadness and loss of interest), bipolar (a disorder associated with episodes of mood swings ranging from depression lows to manic highs) and anxiety (excessive worry). Record review of Resident #68's PASRR Evaluation (level II assessment), completed on 01/07/25, reflected Resident #68 met the PASRR definition of mental illness, which indicated she was PASRR positive. Record review of Resident #68's comprehensive care plan, revised on 12/10/25, reflected Resident #68 was PASRR positive for mental illness. Record review of Resident #68's annual MDS assessment, dated 01/05/26, reflected in Section A1500: Resident #68 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, which indicated she was PASRR negative. During an interview on 01/22/26 at 11:19 a.m., the MDS Coordinator stated the MDS Consultant was (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for completing Resident #68's annual MDS assessment and she was responsible for completing Resident #3's admission MDS assessment. The MDS Coordinator stated Resident #3's admission MDS assessment should have reflected the resident had mental illness and was positive for PASRR. The MDS Coordinator stated it was important for the PASRR status to be coded accurately to ensure the residents received the services needed. During a telephone interview on 01/22/26 at 11:30 a.m., the MDS Consultant stated she was responsible for completing Resident #68's annual MDS assessment. The MDS Consultant stated it should have been marked yes because Resident #68 was PASRR positive. The MDS Consultant stated it was a mistake on her part. The MDS Consultant stated she did an audit about two weeks, but Resident #68's annual was not done until after the audit. The MDS Consultant stated it did not affect Resident #68's care by not coding the annual MDS accurately. During an interview on 01/22/26 at 5:04 p.m., the Administrator stated she expected the MDS assessments to accurately reflect the resident's status. The Administrator stated the MDS Coordinators were responsible for accurately coding the MDS assessments and the MDS Consultant was responsible for monitoring to ensure MDS assessments were completed accurately. The Administrator stated not coding the MDS assessments correctly could affect the residents' function and diagnoses. Record review of the facility's, undated, policy Minimum Data Set Process reflected . the long-term care facility follows CMS requires RAI as a policy the facility completes an MDS and codes the MDS per the RAI manual and coding is based upon clinical assessments, interviews, etc. Record review of the RAI Manual, dated October 2025, reflected A1500: PASRR . code 1, yes: if PASRR Level II screening determined that the resident had a serious mental illness.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments were coordinated with Preadmission Screening and Resident Review (PASRR) program under Medicated in subpart C to the maximum extent practicable to avoid duplicative testing and effort and coordination included incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 1 of 8 residents (Resident #41) reviewed for PASRR. The facility did not ensure the correct PASRR (a preliminary assessment completed for all individuals before admission to a Medicaid-certified nursing facility to determine whether they might have a mental illness or intellectual disability) Level 1 Screening was submitted to the local authority for Resident #41 who had a diagnosis of mental illness upon admission. This failure could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings include: Record review of Resident #41's face sheet, dated 01/22/26, reflected Resident #41 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included major depressive disorder (chronic sadness that interferes with daily life), bipolar (a disorder associated with episodes of mood swings ranging from depression lows to manic highs), anxiety (excessive worry), and personal history of other mental and behavioral disorders. Record review of Resident #41's comprehensive care plan, revised on 01/14/24, reflected Resident #41 used antipsychotic medication related to schizophrenia (a condition that can make you feel detached from reality and can affect our mood) and bipolar. Record review of Resident #41's annual MDS assessment, dated 12/27/25, reflected Section A1500 asked Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? This section was marked 0 which meant No. Section A.1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions did not have A. Serious mental illness, B. Intellectual Disability, or C. Other related conditions checked. Resident #41 understood others and made herself understood. Resident #41 had a BIMS score of 9, which indicated her cognition was moderately impaired. Record review of a referral entity assessment dated [DATE] reflected Resident #41 had a history of depression and bipolar (chronic mental health condition characterized by extreme mood swings, alternating between emotional highs and lows). Record review of Resident #41's PASRR Level 1 Screening form, dated 09/23/21, reflected Resident #41 had no evidence or indicator of dementia or a mental illness. Record review of Resident #41's PASRR Level 1 Screening form, dated 05/25/23, reflected Resident #41 had evidence of mental illness. During an interview on 01/19/26 at 1:08 p.m., Resident #41 stated she always had a history of mental illness. During an interview on 01/22/26 at 11:19 a.m., the MDS Coordinator stated the previous MDS Coordinator was responsible for ensuring PASRR Level 1 was completed accurately. The MDS Coordinator stated a Form 1012 should have been completed to correct the inaccurate PASRR Level 1, which would determine whether to submit a new PL1 screening form for a possible PASRR positive dx. The MDS Coordinator stated it was important for the residents to be screened for PASRR to ensure they're evaluated for eligibility and services. During a telephone interview on 01/22/26 at 11:30 a.m., the MDS Consultant stated if a Level 1 was incorrect or a diagnosis was added that was not previously there, she expected a Form 1012 to be completed so the resident could be reevaluated for services. The MDS Consultant stated the previous MDS Coordinator was responsible for ensuring a Form 1012 was completed for Resident #41 when the first PASARR Level 1 was completed in 2021. The MDS Consultant stated she was not the consultant at the time of Resident #41 admission. The MDS Consultant stated it was important for residents to be screened for PASRR to ensure they're evaluated for eligibility and services. During an interview on 01/22/26 at 5:04 p.m., the Administrator (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if there was a discrepancy she would expect the MDS Coordinator to follow the appropriate steps to rectify. The Administrator stated it was important for the residents to be screened for PASRR to provide the right services. Record review of the facility's undated policy, Minimum Data Set Process, reflected . the long-term care facility follows CMS requires RAI as a policy the facility completes an MDS and codes the MDS per the RAI manual and coding is based upon clinical assessments, interviews, etc.		

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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 interview and record review the facility failed to ensure residents received proper treatment devices to maintain vision and hearing abilities, and if necessary, assisted the residents in making appointments for 1 of 2 residents (Resident #61) reviewed for hearing devices. The facility did not ensure an appointment for an audiologist (healthcare professional specialized in hearing) for Resident #61 after she reported missing hearing aids. This failure could place residents at risk of decreased communication ability, quality of life, and/or social isolation. Findings include: Record review of Resident #61's face sheet, dated 12/30/26, reflected Resident #61 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #61's quarterly MDS assessment, dated 12/30/25, reflected Resident #61 made herself understood and understood others. Resident #61 had a BIMS score of 15, which indicated her cognition was intact. Resident #61 had adequate ability to hear and did not have hearing aide appliances. Record review of Resident #61's comprehensive care plan, revised on 01/13/26, reflected Resident #61 had a communication problem related to a hearing deficit. The care plan interventions included: anticipating, meeting needs and validating residents' message by repeating aloud. Record review of Resident #61's order summary report, dated 01/22/26 reflected an active physician order for audiological care PRN with an order date 08/19/24. During an interview on 01/19/26 at 12:06 p.m., Resident #61 stated she had two pairs of hearing aids taken from her. Resident #61 stated she told several staff members, including the social worker, about her needing hearing aids. Resident #61 was unable to give the exact date but stated it was last year when she told the social worker about needing hearing aids. Resident #61 stated not been able to hear what others were saying aggravates her. During a telephone interview on 01/21/26 at 3:05 p.m., Resident #61's family member stated he had talked to several staff members which included the social worker repeatedly about Resident #61 needing hearing aids. Resident #61's family members stated but the facility would use every excuse in the books on why she still has not been seen by the ear doctor. During an interview on 01/21/26 at 3:05 p.m., the Social Worker stated she was responsible for sending referrals to the audiologist. The Social Worker stated she had spoken to Resident #61 and Resident #61's family members about needing hearing aids but could not recall the exact date. The Social Worker stated Resident #61 stated to her that a pair of hearing aids were missing so she went to check her room and did not have any luck finding them. The Social Worker stated she spoke with an agency about Resident #61 being seen for hearing aids but did not have the document she spoke with about her hearing aids in December. The Social Worker stated she was going to start a grievance about the missing hearing aids but got interrupted. The Social Worker stated not being able to hear could affect her communicating her needs and wants. During an interview on 01/22/26 at 4:03 p.m., the DON stated the Social Worker was responsible for making the appropriate referral to the audiologist and starting a process of having the hearing aids replaced or initiated. The DON stated Resident #61 or Resident #61's family member had not mentioned to her that Resident #61 needed hearing aids. The DON stated it was important to ensure the residents were referred to an audiologist to prevent decrease quality of life and being able to hear to communicate. During an interview on 01/22/26 at 5:04 p.m., the Administrator stated the Social Woker was responsible for making a referral to the audiologist. The Administrator stated Resident #61 or Resident #61's family members had not mentioned to her that Resident #61 needed hearing aids. The Administrator stated she was not monitoring the Social Worker because for as she knew there was not a problem with residents receiving services. The Administrator stated the Social Worker would start providing a list of ancillary services and she would ensure each resident received the services that were needed. The Administrator stated it was important for the residents to receive audiologist services to prevent (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decreased quality of life. During an interview on 01/22/26 at 5:15 p.m., a request for the facility policy regarding audiologists was submitted to the DON. A policy regarding audiologists was not received prior to exit.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences for 1 of 2 residents (Resident #41) reviewed for oxygen therapy. The facility failed to ensure Resident #41's oxygen concentrator filter was cleaned. This failure could place residents at risk for developing respiratory complications and a decreased quality of care. Findings include: Record review of Resident #41's face sheet, dated 01/22/26, reflected Resident #41 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #41's comprehensive care plan, revised 08/01/23, reflected Resident #41 had COPD. The care plan interventions included: oxygen therapy per MD order. Record review of Resident #41's annual MDS assessment, dated 12/27/25, reflected Resident #41 made herself understood and understood others. Resident #41 had a BIMS score of 9, which indicated her cognition was moderately impaired. Resident #41 received oxygen therapy. Record review of the physician order report, dated 01/22/26, reflected Resident #41 had an active physician order for oxygen at 2-3 liter per minute at bedtime with a start date 09/25/25. Resident #41 had an active physician order to check oxygen filter for placement and cleanliness every night every Sunday with a start date 08/25/24. During an observation and interview on 01/19/26 at 1:08 p.m., revealed Resident #41 was sitting in her wheelchair. Resident #41's oxygen concentrator filter had a thick, grey, fuzzy material. Resident #41 stated she wore oxygen at night due to SOB. During an observation on 01/20/26 at 9:07 a.m., revealed Resident #41 was sitting in her wheelchair. Resident #41's oxygen concentrator filter had a thick, grey, fuzzy material. During an observation and interview on 01/22/26 at 1:00 p.m., RN G stated the nurse staff on Sunday nights were responsible for changing/cleaning the oxygen filter. RN G observed with the state surveyor Resident #41's oxygen filter and stated, it definitely needs to be cleaned. RN G stated it was important to ensure filters were cleaned to prevent an infection. During a telephone interview on 01/22/26 at 2:02 p.m., LVN P stated she was the 6a-6p charge nurse on 01/18/26. LVN P stated she was responsible for cleaning Resident #41's oxygen filter. LVN P stated she believed she changed the filter but could not remember for sure. LVN P stated not changing the filter put Resident #41 at risk for a respiratory infection. During an interview on 01/22/26 at 4:03 p.m., the DON stated the nurse on the 6a-6p shift on Sunday was responsible for cleaning the filter. The DON stated she monitored by daily random rounds. The DON stated there had not been any issues in the past. The DON stated it was important those tasks were completed to prevent a respiratory infection. During an interview on 01/22/26 at 5:06 p.m., the Administrator stated she expected oxygen filters to be cleaned according to the physician orders. The Administrator stated nursing management was responsible for overseeing and monitoring. The Administrator stated this failure could potentially put Resident #41 at risk for a respiratory infection. Record review of the facility's Oxygen Concentrator & Other Respiratory Equipment, revised on 02/2024 reflected .the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment. among residents and staff. Steps in the Procedure.3. Wash external filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry before re-inserting.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act upon the recommendations of the pharmacist report of irregularities for 1 of 24 residents (Resident #41) reviewed for (DRR) Drug Regimen Review. The facility failed to timely implement Resident #41's signed Pharmacist Recommendation to Physician on 05/08/2025, which agreed with the pharmacy recommendation to discontinue Mag-Oxide 400 mg QAM (supplement). This failure could place residents at risk for receiving unnecessary medications at the most effective dosage. Findings included: Record review of Resident #41's face sheet, dated 01/22/26, reflected Resident #41 was a [AGE] year-old female, admitted [DATE] with diagnosis of COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the order summary report, dated 01/22/26, reflected an active physician's order for: Mag-Oxide 400 mg; 1 tablet by mouth one time a day for supplement with a start date of 05/02/24. Record review of Resident #41's annual MDS assessment, dated 12/27/25, reflected Resident #41 made herself understood and understood others. Resident #41 had a BIMS score of 9, which indicated her cognition was moderately impaired. Record review of the comprehensive care plan, revised on 05/26/25, reflected Resident #41 had altered cardiovascular status related to hyperlipidemia (condition defined by abnormally high levels of fats (lipids), such as cholesterol and triglycerides, in the blood), coronary artery disease (a common heart condition caused by plaque buildup that narrows or blocks the arteries supplying blood to the heart muscle), high blood pressure, and congestive heart failure (a chronic, progressive condition where the heart cannot pump enough blood to meet the body's needs a chronic, progressive condition). The care plan interventions included administer medications per MD orders. Record review of the Pharmacist Recommendation to Physician, dated 05/08/25, reflected Resident #41 had an order for Mag-Oxide 400 mg QAM. The recommendation note reflected discontinue, medication no longer necessary. The NP agreed to the recommendation and signed on 05/15/25 to discontinue medication. The order was not clarified or implemented until state surveyor intervention on 01/22/26. Record review of Resident #41's MAR, dated 01/01/26-01/31/26, reflected Resident #41 received Mag-Oxide 400 mg one time a day per the physician's orders on 01/01/26-01/22/26. During an interview on 01/22/26 at 9:50 a.m., the NP stated she expected orders to be followed. The NP stated whoever handled the GDR was responsible for discontinuing the Mag-Oxide. The NP stated she believed it was either LVN N or RN O who handled the GDR at the time of the recommendation. The NP stated the risk of not discontinuing the Mag-Oxide was elevated magnesium level which could cause heart issues. An attempted telephone interview on 01/22/26 at 10:28 a.m., with LVN N, was unsuccessful but a message was left An attempted telephone interview on 01/22/26 at 10:30 a.m., with RN O, was unsuccessful but a message was left During an interview on 01/22/26 at 4:03 p.m., the DON stated she was not employed at the time of the recommendation and could not say who was responsible for ensuring the pharmacy recommendation was implemented. The DON stated a full audit of last year's recommendation was not completed. The DON stated it was important to ensure the pharmacy recommendations were implemented to prevent electrolyte imbalance and residents did not receive unnecessary medications. During an interview on 01/22/26 at 5:04 p.m., the Administrator stated she expected the nursing staff to ensure pharmacy recommendations were implemented timely. The Administrator stated the nursing management was responsible for monitoring to ensure pharmacy recommendations were implemented. The Administrator stated she was not employed at the time of the recommendation therefore she could not say who was responsible. The Administrator stated it was important to ensure pharmacy recommendations were implemented to prevent adverse side effects. Record review of the Medication Therapy, revised on 04/2007 reflected. 1. Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. 3. All medication (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders will be supposed by appropriate care processes and practices.5. The physician will identify situations where medications should be discontinued.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 4 medication carts (200 hall Nurse Medication Cart) reviewed for drugs and biologicals. The facility failed to ensure one vial of albuterol sulfate 2.5 mg/3ml (medication used for breathing treatments) and a tube of diclofenac topical gel 1% (medicated gel applied on the skin to decrease pain/inflammation) were stored properly, when they were left on top of the 200 hall Nurse Medication Cart unattended on 01/21/2026. This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: During an observation and interview on 01/21/2026 starting at 4:57 PM, one vial of albuterol sulfate 2.5 mg/3ml and a tube of diclofenac topical gel 1% were on top of the 200-hall Nurse Medication Cart, unattended, on the 200 hall. Multiple staff and residents were observed in the hallway around the unattended 200 hall Nurse Medication Cart. LVN A said someone called her to take them to the dining room and she forgot to put the medications back inside the medication cart. LVN A said she should not leave medications on top of the medication cart because someone could take them. During an interview on 01/22/2026 at 3:32 PM, the DON said medications should not be left on top of the medication cart. The DON said she monitored to ensure medications were stored properly by providing education to the staff, making rounds, and watching the staff. The DON said she had not noticed any medications not stored properly. The DON said medications on top of the medication cart could result in a resident getting a hold of it or eating it or a visitor taking the medication. During an interview on 01/22/2026 at 3:45 PM, the Administrator said she expected all medications to be secured at all times. The Administrator said management staff were responsible for ensuring the staff were trained to do things properly. The Administrator said leaving medications on top of the medication cart could result in someone else taking them or having them come up missing. Record review of the facility's undated policy titled, 6. Delivery, Receipt, and Storage of Medication, indicated, .6.3. Storage of Medication. Scheduled medications should be stored in a separate locked area within the medication carts or medication room.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to assist residents in obtaining routine dental services to meet the needs for 1 of 2 (Resident #61) residents reviewed for dental services. The facility did not ensure Resident #61 was provided with routine dental services related to dentures in a timely manner. This failure could place residents at risk of oral complications, dental pain, and diminished quality of life. Findings included: Record review of Resident #61's face sheet, dated 12/30/26, reflected Resident #61 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #61's order summary report, dated 01/22/26 reflected an active physician order for PRN dental care with an order date of 08/19/24. Record review of Resident #61's quarterly MDS assessment, dated 12/30/25, reflected Resident #61 made herself understood and understood others. Resident #61 had a BIMS score of 15, which indicated her cognition was intact. Resident #61 required set-up or clean-up assistance with eating. Resident #61 has not had a weight loss of 5% or more in the last month or loss of 10% or more in the last six months. Record review of Resident #61's comprehensive care plan, revised on 08/26/24, reflected Resident #61 had the potential for oral/dental problems related to edentulous (no natural teeth) status. Resident #61 stated she had upper and lower dentures but lost them prior to admission. The care plan interventions included oral care daily/PRN and notify charge nurses of oral/dental problems. Record review of Resident #61 weight summary report dated 11/13/25-01/20/26, reflected Resident #61 had not had significant weight loss in the past six months. During an interview on 01/19/26 at 12:06 p.m., Resident #61 stated, I need dentures. Resident #61 stated she told several staff members, including the social worker, about her needing dentures. Resident #61 was unable to give the exact date but stated it was last year when she told the social worker about needing dentures. Resident #61 stated not having dentures made it hard for her to chew her food. During a telephone interview on 01/21/26 at 10:15 a.m., the Customer Care Representative from the dental agency stated Resident #61 needed an alternative payor source before being seen. During a telephone interview on 01/21/26 at 3:05 p.m., Resident #61's family member stated he talked to several staff members, including the social worker, repeatedly about Resident #61 needing dentures. Resident #61's family member stated they used every excuse in the books on why she has not been seen by the dentist. During an interview on 01/21/26 at 3:05 p.m., the Social Worker stated she was responsible for sending referrals and scheduling dental services for the facility residents. The Social Worker stated she had spoken to Resident #61 and Resident #61's family member about needing dentures but could not recall the exact date. The Social Worker stated she received an email from the dental agency on 12/08/25 stating Resident #61 would not be seen due to her payor source. The Social Worker stated she did not follow up with the dental agency to get more clarity about what was needed for her to be seen. The Social Worker stated she thought the dental agency would notify Resident #61 of what documents were needed but she should have notified the BOM herself to see if Resident #61 had coverage or not. The Social Worker stated it was important for the residents to be referred to the dentist because it could affect their quality of care to be able to chew and speak clearly and prevent weight loss. During an interview on 01/21/26 at 3:30 p.m., the BOM stated the Social Worker had not asked about Resident #61's payor source until 01/21/26. The BOM stated Resident #61 had a lapse of payor coverage from 06/01/25 until 07/31/25 but she renewed her coverage on 08/04/25 and was approved on 09/15/25. The BOM stated if the Social Worker had told her that there was an issue with her payor source she would have notified the dental agency herself and provided them with updated information. The BOM stated it was important for Resident #61 to be referred to the dentist because it could affect her quality of life and avoid weight loss. During an interview on 01/22/26 at 4:03 p.m., the DON stated the Social Worker was responsible (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for initiating the dentures replacement by starting a referral process and following up on any issues with the payor source. The DON stated Resident #61 or Resident #61's family member had not mentioned to her that Resident #61 needed dentures. The DON stated it was important to ensure the residents were referred to dental care so they could eat, communicate and prevent a decline in health. During an interview on 01/22/26 at 5:04 p.m., the Administrator stated the Social Woker was responsible for making a referral to the dental agency. The Administrator stated Resident #61 or Resident #61's family members had not mentioned to her that Resident #61 needed dentures. The Administrator stated she was not monitoring the Social Worker because for as she knew there was not a problem with residents receiving services. The Administrator stated the Social Worker would start providing a list of ancillary services and she would ensure each resident received the services that were needed. The Administrator stated it was important for the residents to receive dental services to prevent weight loss. Record review of the Dental Services, revised on 10/2016 reflected. Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 1. Routine.dental services are provided to our residents through a. a contract agreement with a license dentist that comes to the facility monthly.6. Social services representatives will assist residents with appointments, transportation arrangements.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safe and sanitary storage of resident's food items for 2 of 4 residents reviewed for personal food safety. (Residents #3 and Resident #52)The facility failed to ensure Residents #3's and Residents #52's personal refrigerator temperature logs were properly checked and documented. This failure could place the residents at risk for food borne illnesses.Findings included: 1.Record review of Resident #3's face sheet, dated 1/22/26, indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included PTSD (post-traumatic stress disorder), depression (a mood disorder that caused a persistent feeling of sadness and loss of interest), and anxiety (persistent, excessive worry that interferes with daily life). Record review of Resident #3's admission MDS assessment, dated 12/11/25, indicated she made herself understood and she understood others. The MDS also indicated a BIMS score of 12, which indicated she was cognitively intact. The MDS also indicated she required moderate assistance with all ADLs. During an observation on 01/19/26 at 12:03 p.m., Resident #3 was out of her room. Resident #3's refrigerator temperature log was last dated 01/14/26. During and observation and interview on 01/20/26 at 1:20 p.m., Resident #3 was lying in the bed and her refrigerator temperature log continued was last updated 01/14/26 and Resident #3 said, Oh shit, that's not good for me. During an observation on 01/22/26 at 09:32 a.m. Resident #3's refrigerator temperature log was updated through 01/23/26. 2.Record review of Resident #52's face sheet, dated 01/22/26, indicated he was a [AGE] year-old male, re-admitted to the facility on [DATE], with diagnoses which included fracture of the right femur, high blood pressure, dementia (a progressive decline in mental ability that interferes with daily life), and need for assistance with personal care. Record review of Resident #52's significant change MDS, dated [DATE], indicated he understood others and made himself understood. The MDS also indicated he had a BIMS score of 3 which meant he was severely cognitively compromised. The MDS also indicated he required total assistance for transfers, maximal assistance for toileting, dressing, bathing, and bed mobility, and supervision for eating. During an observation and interview on 01/19/26 at 11:50 a.m., Resident #52 was in bed and said he did not know how long he was in the facility. Resident #52's refrigerator had a temperature log on it and it was last checked on 1/6/2025. Resident #52 said he was unsure who logged the refrigerator temperatures. During an observation and interview on 01/22/26 at 9:55 a.m., Resident #52 was in bed and the temperature log for the refrigerator was missing. Resident #52 said he was unsure where the log was but he thought his kids checked it but he did not know for sure. During an interview on 01/22/26 at 5:19 PM the DON said the guardian angels' rounds were responsible for ensuring the temperature logs were kept in place. The DON said she was unsure of the exact staff member who had Resident #3 and Resident #52's room for rounds. The DON said the failure placed a risk for the refrigerator not maintaining the proper temperature, food spoilage, and food born illnesses if the residents consumed the food. During an interview on 01/22/26 at 5:54 p.m., the Administrator said she expected the temperature logs for all residents to be checked and logged daily. The Administrator said each member of staff on their angel rounds (rounds completed by the staff to check residents and rooms) were responsible for ensuring the refrigerators were checked. The Administrator said the failure placed residents at a risk for temperatures out of range and spoiled food which could cause residents to get very sick. Record review of the facility policy titled, Personal Refrigerators & Nourishment Rooms & Refrigerators, dated 3/1/22, indicated Objective: Residents are encouraged to bring personal and familiar belongings to their new home, such as furniture and appliances; i.e. televisions, refrigerators, etc.Guidelines Please check with the community maintenance director prior to bringing in furniture and appliances; i.e.: televisions, refrigerators, etc. to ensure it is in a safe working condition, an allowable item and to ensure there is ample room for the resident to move about in the room. If the resident chooses to have a refrigerator in their room they can use it for beverages (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and food that is brought into the community for the resident to consume. A staff member should place a thermometer in the refrigerator and begin to record temps to ensure the refrigerator is properly working and maintaining food at proper storage temps. During angel rounds or during the temping of the refrigerator in an attempt at culture change and assisting our residents in remaining as independent as possible, an assigned staff member is to check the refrigerator and will assist the resident in throwing away any item(s) that had appeared to have gone bad or are expired.		