

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>455903</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/06/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>LAKE LODGE NURSING AND REHABILITATION LP</b>		STREET ADDRESS, CITY, STATE, ZIP <b>3800 MARINA DR LAKE WORTH, TX 76135</b>	
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 0921  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Some</b>	<p><b>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary comfortable, environment for residents, staff and the public on four (100 Hall, 200 Hall, 500 halls and 600 hall) of six halls reviewed for environment. 1. The facility failed to ensure ceilings and walls were free from water damage, mold, penetrations, and unsealed openings on Halls 100, 200, 500 and 600. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept environment. Findings included: Observation on 03/03/20 at 9:22 AM of room [ROOM NUMBER] revealed outside the door was a posted sign that read, closed for maintenance. The Housekeeping Supervisor had to unlock the room. Inside room [ROOM NUMBER] there was a very large hole in the ceiling near the window. Visible through the large hole was the insulation in the ceiling, which was black with superficial growth of decaying organic matter and wet to the touch. Condensation was visible on the exposed roof, 4 ceiling joists (cross beams) that were exposed, and the popcorn ceiling was peeling. There were large, brown water stains that spread throughout the floor in the room. On the floor below the large hole in the ceiling was a 2-gallon orange bucket and 2-gallon gray bucket. Inside the buckets were brown stains. There was a three-drawer dresser in front of the window and on top of it was the clear light cover for the room's overhead light. On the black wall close to the window was an overhead light that was not covered, and wires were exposed. There was a white/gray box fan, about 20 inches, sitting inside of the window sill, along with the box the fan came out of. The box that the fan came out of was covered with a plastic sheet that was taped to the window. On the left side of the window was blackish gray stain on the wall that ran down to the base board of the floor. Inside the restroom behind the toilet was a hole in the wall about the size of a tennis ball where the water supply line ran from to the toilet. Observation on 03/03/20 at 9:31 AM of room [ROOM NUMBER] revealed outside the door of the room was a posted sign reading closed for maintenance. Inside of the room the popcorn ceiling was peeling and there was a large hole in the ceiling. The exposed roof had patches of black superficial growth of decaying organic matter, there were 9 ceiling joists that were exposed, and there was noted crystallization on the exposed insulation. The floor was heavily stained with brown water stains underneath the large hole in the ceiling. There were broken pieces of dry wall noted on the floor. There was an orange extension cord noted on the floor that connected to the box fan sitting in the window. There was a recliner and nightstand sitting on top of the bed that was covered in pieces of broken dry wall from the roof and insulation. There was a white/gray box fan, about 20 inches, sitting inside of the window sill, and the box that the fan came out of. There was a 7-gallon black trash can on the floor in front of the closet door. The air vent was covered in paper and blue tape. Observation on 03/03/20 at 9:36 AM of room [ROOM NUMBER] revealed outside the door of the room was a posted sign reading, closed for maintenance. Inside the room on the popcorn ceiling were large brown water stains in front of the closet. In the middle of the ceiling near the rail for the privacy curtain was a large brown water stain running vertical and horizontal. Inside the closet were areas of brown/black superficial growth of decaying organic matter and water stains about the size of basketball. There were several brown stains in the left corner of the closet about the size of grapefruit. There was a water stain noted underneath the water sprinkler in the closet that was the size of baseball. There were three beds noted inside of the room. There was a white/gray box fan, about 20 inches sitting inside of the window seal, and the box that the fan came out of. Underneath the window seal on the wall was a black stain running down to the base board onto the floor. There were large brown water stains on the floor in front of the window. The lower vent on the side of the bed closet to the door was covered with paper and tape. Inside the bathroom the base board was dirty and covered with a black substance. Observation on 03/03/20 at 9:47 AM of room [ROOM NUMBER] outside the door was a sign posted, close for maintenance. There were two beds on the left side of the entrance door to the room. There was a white/ gray box fan, about 20 inches, sitting inside of the window sill, and the box that the fan came out of. There was a large hole in the ceiling near the window. The popcorn ceiling was removed, the insulation was exposed with a brown/black substance noted, and 3 joists were exposed. Underneath the hole in the ceiling was tan 3-gallon trash can and large brown water stains spreading to the baseboard. Observation on 03/03/20 at 9:51 AM of room [ROOM NUMBER] revealed outside the door was a posted sign reading, close for maintenance. Inside the closet in the room was a hole in the popcorn ceiling about the size of a baseball. The popcorn ceiling was peeling around the hole. There was a brown water stain near the top of the ceiling inside of the closet, running vertically near the hole in the ceiling. room [ROOM NUMBER] and 506's closet was joined at the top and shared the same ceiling. Observation on 03/03/20 at 9:54 AM of room [ROOM NUMBER] revealed outside the door was a posted sign reading, under construction. Inside the closet in the room was a hole in the popcorn ceiling about the size of a baseball. The popcorn ceiling was peeling around the hole. There was a brown water stain near the top of the ceiling inside of the closet, running vertically near the hole in the ceiling. Inside the closet on the back wall was a large brown water stain approximately three-feet-long running down from the top shelf on the wall down to the baseboard. On the side of the wall in the closet was a brown water stain approximately three-feet-long running down to the baseboard. Inside the window sill was a white/gray box fan, about 20 inches, and the empty box that the fan came out of surrounded by blue tape. Observation on 03/03/20 at 9:57 AM of room [ROOM NUMBER] revealed outside the door was a posted sign reading, under construction. Inside the closet was a water stain about the size of a baseball surrounding the water sprinkler. Observation on 03/03/20 at 9:59 AM of room [ROOM NUMBER] revealed outside the door was a posted sign reading, under construction. There was a white/gray box fan, about 20 inches, sitting inside of the window sill, and the box that the fan came out of. There was tape around the empty box and along the top of the window. Inside the closet the popcorn ceiling was peeling, there were dark black fuzzy spots, and there was a hole about the size of baseball. Observation on 03/03/20 at 10:01 AM of room [ROOM NUMBER] revealed inside the closet was a large brown water stain in the top right-hand area. Underneath the base of the clothing rod were brown water stains running vertically and horizontally, approximately 12 inches. Observation on 03/03/20 at 10:42 AM of rooms [ROOM NUMBERS] joined closet revealed at the top of the closet ceiling was a large brown water stain approximately 24 inches long. Observation on 03/03/20 at 10:47 AM of room [ROOM NUMBER] revealed inside the room were 14 brown stains the size of a quarter noted on the ceiling. Inside the closet was a brown water stain the approximate size of a volleyball in the right corner of the ceiling. Observation on 03/03/20 at 10:51 AM of the ceiling in the 100 hallway between Rooms 110-111 revealed a brown water stain that ran horizontal approximately 48 inches and 18 inches vertically. Observation on 03/03/20 at 10:53 AM inside the restorative therapy room on the 100 hallway revealed inside the room the popcorn ceiling was peeling. There was a large water stain approximately 18 inches long and 10 inches wide on the ceiling. Observation on 03/03/20 at 10:58 AM on Hallway 100 between rooms [ROOM NUMBERS] revealed 5 brown water stains on the ceiling. One stain was the size of a grapefruit, one stain about 6 inches in diameter and the other three were about one-foot wide. Observation and interview on 03/03/20 at 11:28 AM of room [ROOM NUMBER] revealed in the inside of the closet</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 0921  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Some</b>	<p>(continued... from page 1)</p> <p>was a large brown water stain near the baseboard. On the floor of the closet was an unidentified, large, pink stain. Resident #63 stated she had not noticed any leaking inside of the room and she was not sure what the pink stain on the floor was. She stated she admitted to the facility in August 2019 and she reported the pink stain to the facility and had tried to clean up the stain herself; however, the stain would not come up. She stated it made her feel like the facility did not care about her and left the stain inside of closet week after week. The door to gain entry to room [ROOM NUMBER] also scraped the floor when it was opened. Observation of the end of Hallway 100 near the chapel on 03/04/20 at 8:45 AM revealed active water leaking down from the ceiling and two big water puddles noted under the light fixture. Interview with the Administrator and Vice President of Clinical on 03/03/20 at 8:20 AM revealed the 500 and 600 halls had water damaged. The Vice President of Clinical stated they were having a meeting that morning at 9:30 AM. She had spoken to the people who came out and conducted environmental testing for asbestos to see what the final report was. Once they received the final report in writing, their corporate team would decide the best way to proceed with repairs. She stated once the decision was made she would come to the facility to give instructions and information on how they were going to proceed. She agreed the 500 and 600 hallways were affected. The Administrator was informed access to the rooms in the facility was needed. She stated that RN A had the keys to the rooms on the 600 hallway, and was she was not sure if the rooms were locked on 500 hallway but she would find out. The administrator stated when water leaks were identified in room [ROOM NUMBER], Resident #53 and Resident #51 were transferred immediately to another facility on 01/31/20. She stated the ceiling fell shortly after they moved the residents out. She stated that some of the ceiling had been pulled down by the maintenance man. She stated that other residents were moved to non- affected rooms on 600 hall. Interview with the Administrator on 03/03/20 at 9:31 AM revealed the facility roof had repairs completed , and after repairs were completed a new leak occurred. She stated the Activity Director was the ambassador on 600 hallway. She stated that he had informed her there was a pinhole leak in room [ROOM NUMBER], and the residents were moved immediately. Interview with the interim Maintenance Director on 03/03/20 at 10:06 AM revealed he was informed that results from the mold testing showed the facility was positive for mold. He stated the facility had a mold test completed on 02/26/20. He stated he was informed if there was mold in one room, all the other rooms with water damage were affected by mold. He stated the facility started fixing on the roof back in January 2020. Interview with the facility's Corporate Life Safety specialist on 03/03/20 at 10:42 AM revealed it took about 24 hours after the mold test was complete to get the results from the lab. She stated on 02/27/20 or 02/28/20 she received the results. She stated her email was down at that time and she was unable to give the exact date. She stated that the results from the asbestos report should be in the next day (03/04/20). Interview with the Administrator on 03/03/20 at 11:55 AM revealed corporate had not provided the mold reports until that day (03/03/20). She stated that corporate had a meeting that morning to discuss the results of the mold testing. Review of the Asbestos Consultant report that was provided by the facility on 03/04/20 at 10:35 AM revealed, completion date for this inspection was on 02/25/20. Observations, materials tested that found to contain asbestos in amounts greater than 1% ceilings: white joint compound, white texture, walls, white joint compound . Review of the mold assessment report dated 02/26/20 revealed, On 2/25/20 inspection was conducted. Findings: Surface mold was detected as follows: location and list of all spore types detected on sample: A surface swab sample was collected from room [ROOM NUMBER] the results indicated 'low' Cladosporium mold spores and 'Rare' Fibrous Particulates to be present. Indoor air mold spore counts detected are as follows: location and list of amplified spore types on sample. Amplification means that individual genus was detected. The air sampled collected from room [ROOM NUMBER], 603, 600 hallway, and 500 room did indicate elevated airborne mold spores at the time of sample collection, in comparison to outdoor mold levels. The air sampled collected in 500 hallway did not indicated elevated airborne mold spores at the time of sample collection, in comparison to outdoor mold levels. Section 4 discussion note this inspection is limited to the subject areas discussed in this report only. Observed significant mold growth and water damage in all rooms samples were collected in. Rooms adjacent to those rooms showed high levels of moisture, Section 5 Conclusion is mold remediation in the subject areas, involving a licensed mold remediation contractor required? Yes. Section 6 Recommendation that client allow a post remediation clearance assessment after mold remediation is completed. Interview with the facility's Life Safety Specialist on 03/03/20 at 1:04 PM revealed she was moving some of the residents' beds off 600 hallway to another facility. She stated that she was responsible for moving the beds and not the people. She stated the residents would be following soon after their beds were moved. Interview with the Activity Director on 03/03/20 at 1:20 PM revealed he noticed water leaking a couple of week ago on 600 hallway. He stated that he wrote the issue inside of the maintenance book. He stated that the Maintenance Director put a lock on the door of the room where the water was leaking: room [ROOM NUMBER]. He stated that he was informed by a CNA on 600 hallway that the roof in 601 was about to cave in. He stated when he observed room [ROOM NUMBER] that morning the ceiling was leaking. He stated that Resident #53 and Resident #11 were transferred to another facility. He stated that he reported the leaks to the Administrator. He stated that he was not aware of any other leaks in any other rooms. He stated that he had not had any problems respiratory issues and had not noticed any of the resident's getting sick. Interview with CNA A on 03/03/20 at 1:29 PM revealed she had noticed water leaks in room [ROOM NUMBER]. She stated at the time of the leak she also noticed a mildew odor inside of the room. She stated inside room [ROOM NUMBER] she noticed water marks by the resident's window but was not sure when that was. She stated that she reported the issue to the maintenance director and the charge nurse. She stated that Resident #16 did not move until the ceiling collapsed in room [ROOM NUMBER] and room [ROOM NUMBER]. She stated that none of the residents' family members had complained to her about water leaking . Interview with the DON on 03/03/20 at 1:59 PM revealed she was not informed of the results of the mold testing until that day (03/03/20). She stated that the facility's Life Safety Code Specialist had received the results last week. She stated that the Administrator had just gotten back from vacation the day before. She stated before the surveyors arrived, the facility was planning to have an evaluation based on the report, and the facility was going to have a meeting at 9:30 AM. She stated that she asked the regional director last week if the report was back for the mold and she was not aware. She stated that no family members or residents had reported any leaks. She stated that she had not had any respiratory issues. Review of the list provided by the facility of the residents that had been moved within the facility during the time of water leaks on 600 revealed: On 0/14/20 Resident # 34 was moved between rooms. On 01/15/20 Resident #31 was moved between rooms. On 1/20/20 Resident #16 was moved between rooms. On 01/20/20 Resident #72 was moved between rooms. On 01/20/20 Resident # 39 was moved between rooms. On 01/31/20 Resident #53 was moved between rooms. On 1/31/20 Resident #11 was moved to another facility . On 02/12/20 Resident # 37 was moved between rooms. On 02/13/20 Resident # 1 was moved from one bed to another. Review of an invoice #201 dated 01/22/20 revealed, description repaired roofing as per proposal \$ 1,500.00 balance due upon receipt \$1,500.00. The invoice was addressed to Corporate Life Safety, regarding roof repair. Review of invoice #205 dated 02/11/20 revealed, description repaired roofing as per proposal \$ 3,250.00 balance due upon receipt \$ 3,250.00. The invoice was addressed to Corporate Life Safety regarding 8 roof leaks. Review of a letter dated 02/24/20 revealed, regarding roofing repair 8 roof leaks. The following bid includes the labor and materials to complete the following for the above referenced property. 1. Remove debris at (7) roof scuppers and re-flash as per manufactures specification. 2. Re-flash (2) roof vents as per manufactures specification. 3. Probe all seams in the area for water integrity as needed. We completed repairs as per proposal. Interview with the Director of Operations on 03/04/20 at 9:31 AM revealed based on the continued number of leaks, the facility would be moving more residents to their sister facility. She stated the facility could not get started replacing the roof until it stopped raining. She stated that she had talked to her boss about the situation. She stated the facility had tried to move the residents out of the rooms with active leaks but there was nowhere else to put them. She stated the facility was staring to transfer residents where there were active leaks, quickly. She stated that their sister facility had an empty wing and the facility would like for the residents to have a smooth transition. The residents would also be able to reside on the same hallway together. The staff would be able to move with the residents to the new facility. She stated the residents that were moved the day before (03/03/20), staff were able to go with them. She stated the facility had 59 residents to transfer to another sister facility. Review of the facility undated Maintenance Manual revealed roof maintenance should be in good repair, no tears, bubbles or gaps around roof penetrations.</p>		