STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135042	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	210 West Lacrosse Avenue Coeur D'Alene, ID 83814

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and policy review, the facility failed to develop the comprehensive care plan to include the use of an indwelling urinary catheter for one of 21 sampled residents (Resident (R)7) and include extreme pain with movement or touch for one of 21 sampled residents (R74) reviewed for care planning. This had the potential for the residents not to be monitored for an indwelling catheter, pain, and have unmet care needs. Findings include:1.Review of R7's electronic medical record (EMR) located under the MDS tab revealed the 5-Day Minimum Data Set (MDS) with Assessment Reference Date (ARD) 07/25/24 revealed an admission date of 07/18/25 and a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating cognitively intact. R7's diagnosis included benign prostatic hyperplasia without lower uropathy and that R7 has an indwelling urinary catheterReview of R7's EMR Care Plan under the Care Plan tab revealed that the care plan did not indicate R7 has a foley catheter.Review of the facility's policy titled Comprehensive Person-Centered Care Planning revised 4/2025 stated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes residents' needs identified in the comprehensive assessment.During an interview on 08/27/25 the Registered Nurse Supervisor (RNS) stated that R7's care plan did not include the use of the indwelling urinary catheter and that it absolutely should be included in the care plan. The RNS also stated that the care plan is to provide staff information related to the care for R7's indwelling urinary catheter.During an interview on 08/27/25 at 3:45PM, the Director of Nursing (DON) stated the indwelling urinary catheter should be included on R7's care plan because it's a snapshot of his care.During an interview on 08/27/25 at 4:10PM, the Infection Preventionist (IP) stated that the indwelling urinary catheter could not be located on the care plan. The IP confirmed that R7 does have an indwelling urinary catheter, and it should be care planned so that staff know how to provide the proper care.2.Review of R74's admission Record located under the Profile tab in the EMR revealed the resident was initially admitted on [DATE] with the most recent re-admission [DATE]. R74 had diagnoses that included functional quadriplegia; multiple sclerosis; polyneuropathy; contracture of muscle, multiple sites; and abnormal posture.Review of the quarterly MDS located under the MDS tab in the EMR revealed a BIMS score of 15 out of 15 which indicated R74 was cognitively intact.During an interview on 08/25/25 at 12:26 PM, R74 stated, I try to get out of bed once a day and on the weekends when my family visits. I don't like to be moved. R74 stated that he is always in pain, receives pain medications and that touch or movement sets off spasms that he cannot release.Review of the most recent Physician Orders located under the Orders tab in the EMR dated August 2025 noted R74 was receiving treatment for a stage III pressure ulcer on his right buttock, skin tears to his mid back, and a pressure ulcer on the right posterior ear. Review of the Progress Notes dated 07/23/25 located under the Progress Notes tab in the EMR revealed a notation by the Nurse Practitioner (NP) that read, Nurse is concerned of pain control, patient states it is better now that he has more muscle relaxers.Review of the most current Comprehensive Care Plan located under the Care Plan tab in the EMR dated 05/29/25 had revisions related to the resident's pressure ulcers dated 07/17/25, 07/21/25, 07/29/25, and 08/22/25. A focus was noted to identify the resident's potential for skin impairment and pressure ulcer development with an intervention, turn and reposition q (every) 2-3 hrs (hours) as resident allows. The care plan did not identify R74's pain upon touch which was reported to cause spasms or how to accomplish repositioning in the least painful manner. During an interview on 08/25/25 at 12:56 PM, Licensed Practical Nurse (LPN2) said R74 did not like to be repositioned because it caused him pain. During an interview on 08/28/25 at 8:23 AM, LPN3 stated, He often refuses to be repositioned because of the pain it causes him.During an interview on 08/28/25 1:35 PM, the Assistant Director of Nurses (ADON) stated, He (R74) has very bad chronic pain and we try to reposition him, but he refuses. When he is touched, the spasms set off, and it's extremely painful for him. When asked why the specific information about R74's significant pain with touch, movement, and spasms was not on his care plan, the ADON stated, The care plan system did not transfer over after the acquisition of the facility [06/01/25]. We're still working on it.During an interview on 08/28/25 at 4:00 PM, the DON confirmed that the care plan did not have specifics about R74's pain or how to position resident to prevent him from experiencing pain. The DON stated, I know we should have had that on his care plan.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy, the facility failed to ensure one resident (Resident (R) 28) was free from significant medication errors out of a total sample of 21 residents. The facility administered insulin to R28 when his blood sugar level was below the identified range to administer the insulin. The medication error had the potential to cause the resident to become hypoglycemic (abnormal decrease of sugar in the blood).Findings include:Review of R28's admission Record located under the Profile tab in the electronic medical record (EMR) revealed R28 was admitted on [DATE] and had diagnoses that included type 2 diabetes mellitus with diabetic neuropathy.Review of the most recent Physician Orders located under the Orders tab in the EMR dated August 2025 revealed an order for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 8 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION.Hold if under 150. Notify physician if CBG [Capillary Blood Glucose] results are less than 70 or more than 360.Review of the Medication Administration Records (MARs) dated June 2025, July 2025, and August 2025 revealed the following dates where insulin was recorded as given with a blood sugar (BS) level below 150:JUNE 2025:06/01/25 BS 134 at 7:30 AM06/03/25 BS 148 at 11:30 AM06/03/25 BS 133 at 4:30 PM06/04/25 BS 119 at 7:30 AM06/08/25 BS 128 at 7:30 AM06/12/25 BS 148 at 7:30 AM06/14/25 BS 118 at 4:30 PM06/15/25 BS 149 at 4:30 PM06/19/25 BS 107 at 4:30 PM06/26/25 BS 131 at 7:30 AM06/29/25 BS 142 at 7:30 AM06/30/25 BS 122 at 7:30 AMJULY 2025:07/03/25 BS 128 at 7:30 AM07/04/25 BS 113 at 7:30 AM07/15/25 BS 116 at 7:30 AM07/15/25 BS 88 at 4:30 PM07/16/25 BS 140 at 7:30 AM07/18/25 BS 117 at 4:30 PM07/20/25 BS 125 at 7:30 AM07/22/25 BS 139 at 4:30 PM07/29/25 BS 96 at 7:30 AM07/30/25 BS 107 at 7:30 AM07/30/25 BS 138 at 4:40 PMAUGUST 2025:08/03/25 BS 86 at 4:30 PM08/04/25 BS 110 at 7:30 AM08/13/25 BS 130 at 11:30 AM08/14/25 BS 111 at 7:30 AMReview of the only Incident Report completed for the medication errors dated 07/20/25 provided by the Director of Nurses (DON) read, Went to give patient his am [morning] insulin and check bs and found lhat [that] bs was wnl [within normal limit] at 125, did not see that bs needed to be over 150 in order to receive the short acting order, pt [patient] noticed after I had that it was under 150, after clarifying the order, called the on call provider and updated, order receive snack. Later bs was elevated, and short acting given as ordered.Review of R28's June, July, and August 2025 Progress Notes located in the EMR under the Progress Notes tab indicated no adverse effects of the medication errors were documented. During an interview on 08/27/25 at 11:00 AM, R28 denied knowledge of medication errors involving his prescribed medications. R28 stated, As far as I know, I get what I'm supposed to.During an interview on 08/28/25 at 8:30 AM, Licensed Practical Nurse (LPN3), responsible for many of the medication errors, said she did not realize the errors.During an interview on 08/28/25 at 8:50 AM, Registered Nurse (RN1) responsible for the 07/20/25 medication error stated, I think we missed the order because of the way it's written.During an interview on 08/28/25 at 4:00 PM, the DON said she was not aware of R28's medication errors. When asked if the facility had investigated any other medication errors following the 07/20/25 incident, the DON said, No.Review of the facility's policy titled Administration of Medication dated 06/25 revealed, Medications must be administered in accordance with the written orders of the attending physician as indicated on the eMAR [electronic medication administration record].