

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555887	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/13/2025
NAME OF PROVIDER OR SUPPLIER  Lakeside Special Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  11962 Woodside Avenue Lakeside, CA 92040	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36471</p> <p>Based on observation, interview, and record review, the facility failed to ensure a licensed nurse checked the meal trays for nine residents in Cottage Two during dining observation.</p> <p>This failure put residents at risk of receiving the incorrect diet based on their medical needs.</p> <p>Findings:</p> <p>On 2/10/25 at 12:08 P.M., a lunch observation was conducted. A Staff Member (SM) was observed pushing a cart from the hallway to the dining area, calling out, Appetizer is here .Appetizer is here!</p> <p>The SM parked the cart inside the dining room. Residents were seated in the dining room and a female resident left the dining area to call another residents. Nine residents were seated in the dining table and were served with the appetizer [cantaloupe] and drinks. After serving the appetizer, the SM removed the appetizer cart from the dining area and returned with the meal cart</p> <p>On 2/10/25 at 12:15 P.M., the SM served the nine residents their meal trays. There was no licensed nurse present to provide supervision in the dining [NAME] while meal trays were being served to the residents by the SM. The residents completed their meals, carried their trays to the sorting area, and left the dining area individually.</p> <p>On 2/10/25, at 12:29 P.M., an interview was conducted with certified nursing assistant (CNA 1). CNA 1 entered the dining room and stated, Oh, residents were finished? CNA 1 acknowledged the LN should have been in the dining room while residents were eating and should have checked the trays before serving to the residents.</p> <p>On 2/10/25 at 12:45 P.M., the SM was interviewed. The SM stated she was a student and had completed the training. The SM further stated she was waiting to take the exam to become a certified nursing assistant (CNA). The SM stated she called out that the appetizer was here, but the LN did not show up and proceeded to serve the meal trays to the residents. The SM further stated the licensed nurse (LN) did not check the meal trays before she gave them to the residents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/10/25 at 12:55 P.M., an interview was conducted with LN 1. LN 1 stated she should have been in the dining room to check the meal trays before the staff passed them to the residents for their safety. LN 1 further stated she should have been in the dining room while the residents were eating to ensure residents did not share foods, take other peer's food, and for safety.</p> <p>On 2/13/25 at 2:05 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the staff member who served the trays was a care provider and an employee of the facility. The DON stated the facility's policy was for the staff, such as the care provider, to check and pass the meal trays. The DON further stated she looked at the regulations and did not see that a licensed nurse was required to check the meal trays.</p> <p>Per the facility's policy and procedure titled Tray Identification, dated 4/07, .Staff (Licensed Nurse, Certified Nursing Assistant, Care Partner, Paid Feeding Assistants, and/or any other personnel trained in diets) shall check each food tray for the correct diet before serving to residents .</p> <p>The facility's policy and procedure did not match the regulations.</p> <p>Per the California Code of Regulations, dated 2010, Title 22, S 72311 - Nursing Service-General - section (c), Licensed nursing personnel shall ensure that patients [Residents] are served the diets as ordered by the attending licensed healthcare practitioner acting within the scope of his or her professional licensure.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36471</p> <p>Based on interview and record review, the facility failed to ensure two of four residents (Resident 14 and Resident 21) reviewed for antipsychotic (a class of drugs that treat symptoms of mental disorder by altering brain function) medication use had an approved indication.</p> <p>This failure had the potential to result in unnecessary use of psychotropic medication.</p> <p>Findings:</p> <p>1. Resident 21 was readmitted to the facility on [DATE] with diagnoses which included schizoaffective (a mental health condition that may interfere with a resident's ability to think, manage emotions, make decisions, and relate to others) disorder per the Admission Record.</p> <p>A review of Resident 21's medical record was conducted. Per the Order Summary Report, dated 3/28/23, Resident 21 was taking Risperidone (an antipsychotic medication) three milligrams at bedtime for schizoaffective disorder. The same document, dated 10/16/23, indicated, SCHIZOAFFECTIVE DISORDER, UNSPECIFIED AEB [As Evidence By- target behavior] requesting horny pills.</p> <p>On 2/13/25 at 9:35 A.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 21 had episodes of asking for horny pills. LN 1 further stated she would not be the best person to say if the behavior monitoring was appropriate.</p> <p>On 2/13/25 at 12:36 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 21 had episodes of agitation, like yelling and screaming at the staff and peers. CNA 2 further stated that Resident 21 had an angry outburst, and she had not heard Resident 21 seeking for horny pills.</p> <p>On 2/13/25 at 1:08 P.M., an interview was conducted with the Consultant Pharmacist (CP). The CP stated she would have to call back to say if the behavior monitoring for Resident 21's antipsychotic medication was appropriate or not. The CP further stated she thought the behavior, such as requesting horny pills as behavior was ok but had room to improve.</p> <p>On 2/13/25 at 2:05 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated antipsychotic medication should have specific behavior monitoring. The DON further stated behavior monitoring should have been hallucinations, risks for self-harm, or others. The DON stated requesting horny pills was not appropriate behavior monitoring for Resident 21.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure (P&amp;P) titled, Psychotropic Medication Use, dated July 2022 was conducted. The P&amp;P indicated, .Residents will not receive medications that are not clinically indicated to treat a specific condition . Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics .Psychotropic medication management includes .adequate monitoring for efficacy and adverse consequences .Consideration of the use of any psychotropic medication is based on comprehensive review of the resident .evaluation of the resident's signs and symptoms in order to identify underlying causes .</p> <p>46235</p> <p>2. Resident 14 was admitted to the facility on [DATE] with diagnoses including Parkinsonism (a brain condition causing slowed movements, stiffness and tremors) and dementia (an impairment of brain function, such as memory loss and judgment) according to the facility's Admission Record.</p> <p>During an observation on 2/11/25 at 7:30 A.M. Resident 14 was in his room in bed with his eyes closed.</p> <p>A review of Resident 14's physician's orders was conducted on 2/11/25 at 9:50 A.M. The physician's orders indicated, .Anti-Psychotic Monitor episodes of Mental Disorder/TBI [Traumatic Brain Injury] AEB [as evidenced by]: sexually inappropriate behavior-attempting to kiss staff. Drug: Haldol [a medication to treat disconnection from reality and other mental health conditions referred to as an antipsychotic medication], every shift .Order date 10/16/23 .</p> <p>An interview was conducted on 2/12/25 at 2:18 P.M. with Certified Nurse Assistant (CNA) 5. CNA 5 stated he had been assigned to Resident 14 and Resident 14 roamed around the halls, ate his meals wherever he wanted and took naps after smoke breaks. CNA 5 stated in the past, Resident 14 touched staff's private areas, but not lately. CNA 5 further stated Resident 14 did not strike out or provoke others.</p> <p>An interview was conducted on 2/12/25 at 2:25 P.M. with CNA 6. CNA 6 stated Resident 14's dementia had advanced and had repetitive talking and cursing but was not combative. CNA 6 stated he had not seen Resident 14 touching or grabbing others. CNA 6 stated Resident 14 was able to follow directions at times and other times not.</p> <p>During an interview and joint record review on 2/12/25 at 2:30 P.M. with Licensed Nurse (LN) 7, LN 7 stated she was assigned to Resident 14. LN 7 stated Resident 14 did not hit others but reached and grabbed staff's private areas. LN 7 reviewed the physician's orders for Resident 14. LN 7 stated Resident 14 had physician's orders for Haldol 5 mg [milligrams] twice a day for attempting to kiss staff. LN 7 stated kissing staff was not harmful and was not an appropriate behavior monitoring for the use of an antipsychotic medication.</p> <p>During an observation on 2/13/25 at 8:50 A.M., Resident 14 was in the hallway propelling his wheelchair using his feet and was not attempting to touch others.</p> <p>A review of Resident 14's Care plan for At risk for becoming physically aggressive towards others AEB unsolicited behavior, initiated on 6/3/24, revised on 2/8, and 2/15/25 was conducted. The goal of care plan indicated, Will not harm self or others .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The care plan did not reflect monitoring of inappropriate sexual behavior.</p> <p>An interview was conducted on 2/13/25 at 12:53 P.M. with the Consultant Pharmacist (CP). The CP stated there were no recommendations for Resident 14 during the January 2025 Medication Regimen Review. The CP stated Resident 14's behavior monitoring for attempting to kiss staff for the use of Haldol was appropriate. The CP stated she was not sure of the Federal Regulations regarding appropriate behavior manifestations for the use on an antipsychotic medication for elderly residents with dementia.</p> <p>An interview was conducted on 2/13/25 at 1:27 P.M., with the Director of Nursing (DON). The DON stated behavior monitoring for the use of an antipsychotic medication should be when there was a risk for self-harm or harm to others. The DON further stated it was important to follow the regulations, for staff to know what they were looking for and monitor for any changes.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled, Psychotropic Medication Use, dated July 2022 was conducted. The P&amp;P indicated, .Residents will not receive medications that are not clinically indicated to treat a specific condition .Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics .Psychotropic medication management includes .adequate monitoring for efficacy and adverse consequences .Consideration of the use of any psychotropic medication is based on comprehensive review of the resident .evaluation of the resident's signs and symptoms in order to identify underlying causes .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36471</p> <p>Based on observation, interview, and record review, the facility failed to ensure food stored and prepared in the kitchen was in accordance with standards of practice when food items were not labeled. In addition, the temperature log was incomplete, and there was an icicle build-up in the reach-in freezer.</p> <p>These failures could cause food-borne illness, and icicle build-up may affect the food's palatability and texture.</p> <p>Based on observation, interview, and record review, the facility failed to ensure storage of food items inside the refrigerator were labeled. In addition, the temperature log was not completed, and the freezer was not maintained in a sanitary manner.</p> <p>These failures had the potential to cause food-borne illness and may affect the texture and palatability of food.</p> <p>Findings:</p> <p>1. On 2/11/25 at 10:54 A.M., an initial tour of the kitchen and observation was conducted with the Director of Dietary Services (DDS). Inside the reach-in refrigerator was a transparent container with a green-colored lid with an unknown white, smooth, and creamy substance inside. The container was labeled open 2/9/25. The DDS stated the item should have been labeled with the name of the food item inside the container.</p> <p>In the same reach-in refrigerator was a large clear plastic tub filled with small plastic containers with lids. The small individual containers contained a smooth, creamy yellow, and white substance with similar consistency to yogurt and apple sauce. The plastic tub was unlabeled and undated. The DDS stated the stored items should have been labeled indicating the food items and the date it was prepared.</p> <p>A metal pan was observed on the shelf in the walk-in refrigerator. Inside the pan were two large frozen meats and unlabeled. The DDS identified the frozen meat were roast beef and should have been labeled and dated.</p> <p>In addition, two large amounts of thick ice build-up covered the top of shelf inside the reach-in freezer. The DDS stated temperature checks should have been done daily and documented.</p> <p>Per the facility's policy and procedure titled Food Safety Program, dated 1/27/12, .The temperature must be checked at least once each day .All foods prepared in operation must be covered and labeled as to contents and date of preparation prior to storage in refrigerators .</p> <p>2. A review of the Daily Temperature Check log was conducted 2/10/25 at 7:55 A.M., from 2/7/25 until 2/9/25. The Daily Temperature Check log was blank. The DDS stated temperature checks should have been done daily and documented.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per the facility's policy and procedure titled Food Safety Program, dated 1/27/12, .The temperature must be checked at least once each day .All foods prepared in operation must be covered and labeled as to contents and date of preparation prior to storage in refrigerators .</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36471</p> <p>Based on interview and record review, the facility failed to ensure a resident's medical record was completed for one of 23 sampled residents (Resident 99) when the licensed nurse (LN) did not document that the physician was notified of the resident's refusal for chest X-ray (CXR- an imaging test to create a picture of the structures in the chest, including the lungs, heart, and rib cage).</p> <p>As a result, Resident 99's medical record did not provide continuity of care between the care team.</p> <p>Findings:</p> <p>Resident 99 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), per the Admission Record. Per the same document, Resident 99 was transferred to the hospital on 12/22/24.</p> <p>A review of Resident 99's medical record was conducted. Per the Progress Notes, the following data were written:</p> <p>On 11/14/24, LN 2 documented Resident 99's productive cough. The physician ordered a CXR to rule out pneumonia (lung infection).</p> <p>On 11/18/24, LN 3 documented Resident 99 refused the CXR. There was no documented evidence that the physician was made aware of the resident's refusal for CXR.</p> <p>On 2/13/25 at 10:30 A.M., LN 3 was interviewed. LN 3 stated she called the physician and left a message on the answering machine, but she did not receive a call back from them. LN 3 further stated she should have documented that the physician was informed of Resident 99's refusal.</p> <p>On 2/13/25 at 2:05 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the LNs should have documented the resident's refusal in the medical records.</p> <p>Per the facility's policy and procedure titled Charting and Documentation, dated 7/17, .Documentation of procedure and treatment .notification of family, physician or other staff .</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46235</p> <p>Based on observation, interview and record review, the facility failed to meet the minimum requirement of 80 square feet (sq. ft.) per resident, for 26 of 27 resident rooms.</p> <p>This failure had the potential to affect resident's health, safety, quality of care, or quality of life.</p> <p>Findings:</p> <p>During 2/10/25 through 2/13/25, 27 resident rooms were observed. All rooms were neat and clutter free. Throughout the survey, residents were interviewed, both individually and during a group interview. The residents voiced no complaints related to privacy, the environment, or their shared rooms.</p> <p>A review of the facility's Client Accommodation Analysis indicated there were 27 resident rooms and 26 rooms did not meet the minimum room size requirement.</p> <p>There were 7 rooms in Cottage 1:</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 74 sq. ft. per resident, totaling 222 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 74 sq. ft. per resident, totaling 222 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>There were 12 rooms (201-212) in Cottage 2. All the rooms had 4 resident occupancy, 70.4 sq. ft. per resident, totaling 281.75 sq. ft.</p> <p>There were 8 rooms in Cottage 3:</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 72 sq. ft. per resident, totaling 216 sq. ft.</p> <p>room [ROOM NUMBER], had 3 resident occupancy, 73 sq. ft. per resident, totaling 219 sq. ft.</p> <p>(continued on next page)</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER], had 3 resident occupancy, 73 sq. ft. per resident, totaling 219 sq. ft.</p> <p>room [ROOM NUMBER], had 4 resident occupancy, 74.5 sq. ft. per resident, totaling 298 sq. ft.</p> <p>room [ROOM NUMBER], had 4 resident occupancy, 74.5 sq. ft. per resident, totaling 297 sq. ft.</p> <p>room [ROOM NUMBER], had 2 resident occupancy, 98 sq. ft. per resident, totaling 196 sq. ft.</p> <p>The variations in room size requirement did not adversely affect the resident's health, safety, quality of care, or quality of life during the survey.</p> <p>Continuance of the room size waiver for all affected rooms was recommended.</p>		