STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan to meet the highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Residents #1) reviewed for care plans. The facility failed to implement a care plan area for physician order for pressure ulcer treatment of coccyx (the small bone at the bottom of the spine), left thigh, coccyx, and left hip. The facility did not have a care plan area for Resident #1 removing his own dressing from his pressure ulcers. These failures could place residents at risk of not receiving the care required to meet their individualized needs. Findings include: Record review of Resident #1 face sheet revealed a [AGE] year-old male, admitted on [DATE] with a primary diagnoses of lung cancer, anemia, low potassium, high blood pressure, hyperlipidemia, atherosclerotic heart disease, nicotine dependence, cancer in bone, tachycardia, congestive heart failure, acid reflux. Record review of Resident #1's Admission MDS dated [DATE] revealed Resident #1 had a BIMS of 9 which indicates Resident #1 is moderately impaired cognition. Under Bladder and Bowel Resident #1 is listed as always being incontinent with urinary and bowel. Under skin conditions Resident #1 is listed as being a risk of developing pressure ulcers but is not listed as having any pressure ulcers upon admission. Record review of Resident #1's Care Plan date revealed: on 06/03/2024, Resident #1 was care planned for wound care with interventions of: monitor ulcers for signs of infection, notify provider if no signs of improvement on current wound regimen, provide wound care per treatment orders. There is no care plan for Resident #1 removing his own bandages. Record review of Resident #1's Order Summary, date received 06/04/2024, revealed: On 05/27/2024 verbal orders were given for wound care to the coccyx. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure as needed for wound 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	On 05/27/2024 verbal orders were given for wound care to the coccyx. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care. On 05/27/2024 verbal orders were given for wound care to the left hip. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure as needed for wound care. On 05/27/2024 verbal orders were given for wound care to the left hip. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care. On 05/27/2024 verbal orders were given for wound care to the left thigh. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure as needed for wound care. On 05/27/2024 verbal orders were given for wound care to the left thigh. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care. Record review of Resident #1's Treatment Administration Record for June 2024, date received of 06/04/2024, revealed: Wound Care: coccyx, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. Treatment record indicated that June 1st and 2nd wound care was provided. There was nothing indicated for the 3rd. Wound Care: left hip, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. Treatment record indicated that June 1st and 2nd wound care was provided. There was nothing indicated for the 3rd. Wound Care: left thigh, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. Treatment record indicated that June 1st and 2nd wound care was provided. There was nothing indicated for the 3rd. Wound Care: coccyx, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. There was nothing indicated for PRN. Wound Care: left hip, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. There was nothing indicated for PRN. Wound Care: left thigh, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. There was nothing indicated for PRN. (continued on next page)

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(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	Observation had been made of Resident #1 on 06/03/2024 at 8:37 PM, revealed the ADON went with the Surveyor to show Resident #1's pressure ulcers. The ADON gathered a few supplies to cover Resident #1's pressure ulcers when completed with observation. Resident #1 was lying on his back in his room, sleeping. Resident #1 awakened to interview and allowed observations of his pressure ulcers. It was observed that Resident #1's pressure ulcer on his left thigh was uncovered, and with no dressing. Resident #1's pressure ulcer on his coccyx was observed with having a dressing hanging off the backside above the pressure ulcer and being exposed, the dressing was dated 06/02/2024 with initials. Resident #1's pressure ulcer to his coccyx was observed with a dressing soaked with drainage from the wound. The dressing had a watery brown drainage from the pressure ulcer on the dressing that was hanging off the top of the pressure ulcer. Resident #1 had blood on the backside and side of his gown and bedding. Observed the ADON following physician's orders per cleaning all wounds and covered with foam dressings with date and initials. Interview on 06/03/2024 at 8:32 PM with CNA A revealed she said that she checks the residents every 2 hours. The CNA C stated that she was not aware that Resident #1's pressure ulcers were uncovered but she had just come onto shift and had not had a chance to make her rounds. The CNA C stated that she had seen Resident #1's pressure ulcer uncovered before. The CNA C stated that she is not sure if Resident #1 had removed the dressing or if someone didn't cover the pressure ulcers. The CNA C stated that she had not witnessed staff not covering the pressure ulcers. The CNA C stated that if she had seen the pressure ulcers uncovered, she would report it to the LVN, the ADON, or DON. CNA C stated that she would check to make sure that the pressure ulcers were covered. Interview on 06/03/2024 at 8:50 PM with ADON revealed that Resident #1's orders did call for the pressure ulcers to be cleaned and covered. The ADON stated that she did not know why the pressure ulcers were uncovered. The ADON stated that the pressure ulcers are scheduled to be cleaned and covered for night shift. The ADON stated that night shift begins at 6 pm to 6 am. The ADON stated that she would assume that the staff had not had time to cleanse and cover the pressure ulcers yet but as long as it had gotten completed before the end of the night shift, it would be fine. ADON stated that usually the staff will make rounds every 2 hours, so they would report to the nursing staff if pressure ulcers were uncovered. Interview on 06/03/2024 at 9:18 PM with Resident #1 revealed that he is pain because of the open wounds and them not being covered. Resident #1 stated that he had not taken off any bandages. Resident #1 stated that the nursing staff do treat his wounds and usually covers them but stated he could not tell that they were uncovered until he moves around a little. Interview on 06/03/2024 at 9:10 PM with LVN B revealed that he was unaware of Resident #1's pressure ulcers because he is only PRN and had not worked in the facility for a while. The LVN B stated that he would get to the pressure ulcers when he finished medication pass. Interview on 06/04/2024 at 5:32 PM with ADON revealed that she is not sure why there is not a dressing on the left leg pressure ulcer. The ADON stated that the orders do state to put a dressing on all pressure ulcers for Resident #1. The ADON stated that all nursing staff are responsible for making sure that the dressing is on. The ADON stated, Resident #1 does take off the dressings sometimes. There was no dressing observed by Surveyor in the room on the bed or on the floor to show that the resident might have removed it from the pressure ulcer. The ADON stated that the negative potential outcome of the pressure ulcers being uncovered is that it could cause infection, bigger pressure ulcers could occur, and potentially be hospitalized . (continued on next page)

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(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	Interview on 06/04/2024 at 5:45 PM with DON revealed that she does agree with the physician's orders for pressure ulcers for Resident #1. The DON stated that she expects the staff to follow physician's orders. The DON stated that she did expect staff to let someone know when a pressure ulcer is uncovered so that staff could cover the pressure ulcer as soon as possible and not wait the whole shift. The DON stated that she and the ADON are responsible for training staff. The DON stated that she had provided training for pressure ulcers monthly by in-services. The DON stated that the negative potential outcome for not following physician's orders for Resident #1's uncovered pressure ulcers would be they could get worse and possibly get infected. Interview on 06/04/2024 at 6:01 pm with Administrator revealed that she expects the staff to follow physician orders and cover pressure ulcers. The Administrator stated that the DON is responsible for the training for the staff and the staff have been trained. The Administrator stated that the pressure ulcer could worsen or get infected if they are not treated according to physician orders. Requested policy for Care Plan from DON and care plan policy was not provided on 06/04/2024 at 5:15 PM. DON stated that she had contacted corporate, and they had stated that there is not a policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observations, interviews and record reviews, the facility failed to ensure Resident 1's Physician Ordered dressings for the left thigh, coccyx, and left hip, based on the comprehensive assessment of a resident the resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for (Residents #1) resident reviewed for pressure ulcer care, in that: 1. Resident #1's pressure ulcer on his left thigh was observed being uncovered with no dressings. Resident #1's pressure ulcer on coccyx (a small bone at the base of the spinal column) was observed with having a dressing hanging off the backside above the pressure ulcer with the pressure ulcers being exposed. Resident #1's pressure ulcer to the coccyx was observed with the dressing soaked with drainage from the pressure ulcer. These failures could place residents with wounds at an increased and unnecessary risk of complications such as pain, acquiring new pressure ulcers, worsening of existing pressure ulcers, and infection. Findings included: Findings include: Record review of Resident #1 face sheet revealed a [AGE] year-old male, admitted on [DATE] with a primary diagnoses of lung cancer, anemia, low potassium, high blood pressure, hyperlipidemia, atherosclerotic heart disease, nicotine dependence, cancer in bone, tachycardia, congestive heart failure, acid reflux. Record review of Resident #1's Admission MDS dated [DATE] revealed Resident #1 had a BIMS of 9 which indicated Resident #1 is moderately impaired cognition. Under Bladder and Bowel Resident #1 is listed as always being incontinent with urinary and bowel. Under skin conditions Resident #1 is listed as being a risk of developing pressure ulcers but is not listed as having any pressure ulcers upon admission. Record review of Resident #1's Care Plan date revealed: on 06/03/2024, Resident #1 was care planned for pressure ulcers care with interventions of: monitor ulcers for signs of infection, notify provider if no signs of improvement on current wound regimen, provide wound care per treatment orders. There is no care plan for Resident #1 removing his own dressings. Record review of Resident #1's Order Summary, date received 06/04/2024, revealed: On 05/27/2024 verbal orders were given for wound care to the coccyx. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure as needed for wound care. On 05/27/2024 verbal orders were given for wound care to the coccyx. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/27/2024 verbal orders were given for wound care to the left hip. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure as needed for wound care. On 05/27/2024 verbal orders were given for wound care to the left hip. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care. On 05/27/2024 verbal orders were given for wound care to the left thigh. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure as needed for wound care. On 05/27/2024 verbal orders were given for wound care to the left thigh. Cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care. Record review of Resident #1's Treatment Administration Record for June 2024, date received of 06/04/2024, revealed: Wound Care: coccyx, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. Treatment record indicated that June 1st and 2nd wound care was provided. There was nothing indicated for the 3rd. Wound Care: left hip, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. Treatment record indicated that June 1st and 2nd wound care was provided. There was nothing indicated for the 3rd. Wound Care: left thigh, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. Treatment record indicated that June 1st and 2nd wound care was provided. There was nothing indicated for the 3rd. Wound Care: coccyx, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. There was nothing indicated for PRN. Wound Care: left hip, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. There was nothing indicated for PRN. Wound Care: left thigh, cleanse with wound cleanser, pat dry with gauze, apply foam dressing, tape and secure every night shift for wound care, start date: 05/27/2024 at 6:00 PM. There was nothing indicated for PRN. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation had been made of Resident #1 on 06/03/2024 at 8:37 PM, revealed the ADON went with the Surveyor to show Resident #1's pressure ulcers. The ADON gathered a few supplies to cover Resident #1's pressure ulcers when completed with observation. Resident #1 was lying on his back in his room, sleeping. Resident #1 awakened to interview and allowed observations of his pressure ulcers. It was observed that Resident #1's pressure ulcer on his left thigh was uncovered, and with no dressings. Resident #1's pressure ulcer on his coccyx was observed with having a dressing hanging off the backside above the pressure ulcer with the pressure ulcer being exposed, with the dressing being dated 06/02/2024 with initials. Resident #1's pressure ulcer to his coccyx was observed with a dressing soaked with drainage from the pressure ulcer. The dressing had a watery brown drainage from the pressure ulcer on the dressing that was hanging off the top of the pressure ulcer. Resident #1 had blood on the backside and side of his gown and bedding. Observed the ADON following physician's orders per cleaning all wounds and covered with foam dressings with date and initials. Interview on 06/03/2024 at 8:32 PM with CNA A revealed she said that she checks the residents every 2 hours. The CNA C stated that she was not aware that Resident #1's pressure ulcers were uncovered but she had just come onto shift and had not had a chance to make her rounds. The CNA C stated that she had seen Resident #1's pressure ulcers uncovered before. The CNA C stated that she is not sure if Resident #1 had removed the dressing or if someone didn't cover the pressure ulcers. The CNA C stated that she had not witnessed staff not covering the pressure ulcers. The CNA C stated that if she had seen the pressure ulcers uncovered, she would report it to the LVN, the ADON, or DON. CNA C stated that she would check to make sure that the pressure ulcers were covered. Interview on 06/03/2024 at 8:50 PM with ADON revealed she said that Resident #1's orders did call for the pressure ulcers to be cleaned and covered. The ADON stated that she did not know why the pressure ulcers were uncovered. The ADON stated that the pressure ulcers are scheduled to be cleaned and covered for night shift. The ADON stated that night shift begins at 6 pm to 6 am. The ADON stated that she would assume that the staff had not had time to cleanse and cover the pressure ulcers yet but as long as it had gotten completed before the end of the night shift, it would be fine. ADON stated that usually the staff will make rounds every 2 hours, so they would report to the nursing staff if pressure ulcers were uncovered. Interview on 06/03/2024 at 9:18 PM with Resident #1 revealed that he said that he is pain because of the open pressure ulcers and them not being covered. Resident #1 stated that he had not taken off any bandages. Resident #1 stated that the nursing staff do treat his wounds and usually covers them but stated he could not tell that they were uncovered until he moves around a little. Interview on 06/03/2024 at 9:10 PM with LVN B revealed he said that he was unaware of Resident #1's wounds because he is only PRN and had not worked in the facility for a while. The LVN B stated that he would get to the pressure ulcers when he finished medication pass. Interview on 06/04/2024 at 5:32 PM with ADON revealed she said that she is not sure why there is not a dressing on the left leg wound. The ADON stated that the orders do state to put a dressing on all pressure ulcers for Resident #1. The ADON stated that all nursing staff are responsible for making sure that the dressings is on the pressure ulcers. The ADON stated, Resident #1 does take off the dressings sometimes. There was no dressing observed by Surveyor in the room on the bed or on the floor to show that the resident might have removed it from the pressure ulcer. The ADON stated that the negative potential outcome of the pressure ulcers being uncovered is that it could cause infection, bigger pressure ulcers, and potential to be hospitalized . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/2024 at 5:45 PM with DON revealed she said that she does agree with the physician's orders for pressure ulcers for Resident #1. The DON stated that she expects the staff to follow physician's orders. The DON stated that she did expect staff to let someone know when a pressure ulcer is uncovered so that staff could cover the pressure ulcer as soon as possible and not wait the whole shift. The DON stated that she and the ADON are responsible for training staff. The DON stated that she had provided training for pressure ulcers monthly by in-services. The DON stated that the negative potential outcome for not following physician's orders for Resident #1's uncovered pressure ulcers would be they could get worse and possibly get infected. Interview on 06/04/2024 at 6:01 pm with the Administrator revealed she said that she expects the staff to follow physician orders and cover pressure ulcers. The Administrator stated that the DON is responsible for the training for the staff and the staff have been trained. The Administrator stated that the pressure ulcers could worsen or get infected if they are not treated according to physician orders.

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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** 43150 Based on observation, interview and record review, the facility failed to establish and 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 3 of 4 Residents observed for infection control for practices (Resident #2, #3, #4) in that: 1. CNA A failed to wash her hands before or during providing incontinent care for Resident #2. CNA A failed to wash her hands for the 15 seconds per facility policy. 2. CNA A failed to wash her hands before, during, and after providing incontinent care for Resident #3. 3. CNA A and CNA B failed to wash their hands before, during, and after providing incontinent care for Resident #4. These failures could place residents at risk for infection through cross contamination of pathogens. The findings included: Resident #2: Record Review of Resident #2's face sheet revealed a [AGE] year-old male, admitted on [DATE] with a primary diagnoses of dementia, atherosclerotic heart disease (damage or disease in the heart's major blood vessels), retention of urine, high blood pressure, depression, upper respiratory infection, pneumonia, hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone). Records Review of Resident #2's Admission MDS dated [DATE] revealed Resident #2 had a BIMS of 6 which means Resident #2 had severe cognitive impairment. Record Review of Resident #2 Care Plan dated 04/24/2022 revealed: Resident #2 had a pressure ulcer on the right gluteal (buttocks) fold with limited mobility with the interventions of: assess/record/monitor wound healing (Tuesday, Thursday, Saturday) measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the doctor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #2's Care Plan dated 04/24/2022 revealed pressure ulcer on left gluteal fold with limited mobility. Resident #2's care staff to follow facility policies/protocols for the prevention/treatment of skin breakdown. Resident #2 had pressure ulcer on left gluteal fold with limited mobility with interventions of Administer Resident #2 treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing (Tuesday, Thursday, Saturday) measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the doctor. Educate Resident #2's family/caregivers as to causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Resident #2's nursing care staff to follow facility policies/protocols for the prevention/treatment of skin breakdown. Record Review of Resident #2's Care Plan dated 04/24/2022 revealed pressure ulcer on right abdominal fold with limited mobility with the interventions of administer Resident #2 treatments as ordered and monitor for effectiveness, assess/record/monitor Resident #2's wound healing (Tuesday, Thursday, Saturday) measure length, width and depth were possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the doctor, educate Resident #2's family/caregivers as to causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Record Review of Resident #2's Orders dated 01/17/2023 revealed: apply moisture barrier ointment to the right and left buttocks, coccyx, and right and left ischium (the curved bone forming the base of each half of the pelvis) after each incontinent episode. Record Review of Resident #2's Orders dated 01/17/2023 revealed: apply moisture barrier ointment to right and left buttocks, coccyx, and right and left ischium after every shift to prevent skin break down. Observed incontinent care with CNA A for Resident #2 on 06/04/2024 at 10:28 AM revealed Resident #2 was sitting in a wheelchair in the dining room when he was moved to his room by CNA A and he was soaking wet, stating, I guess I peed everywhere. The CNA A put on clean disposable gloves and did not wash her hands before providing incontinent care. The CNA A removed the urine-soaked pants off Resident #2 and put them to the side in a plastic bag. The CNA A removed the urine soaked brief and disposed of it in the trash. CNA A provided incontinent care. The CNA A did not change gloves or wash her hands. The CNA A turned Resident #2 to the left side and proceeded to complete incontinent care of the buttocks area. The CNA A placed the clean brief underneath Resident #2 and laid him on his back. The CNA A fastened the front side of the brief. The CNA A placed the new clean dry pants on Resident #2 and covered him with a blanket. The CNA A washed her hands in Resident #2's restroom by turning on the faucet, placing two squirts of soap in her hand, lathering the soap using friction for 10 seconds and then rinsing. The CNA A used a clean, dry paper towel to dry her hands and turned off faucet. The CNA A gathered all trash and took with her to throw away. Resident #3: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #3 face sheet revealed a [AGE] year-old female, admitted on [DATE] with a primary diagnoses of sepsis (a life-threatening complication of an infection), low blood pressure, kidney failure, cellulitis (a common and potentially serious bacterial skin infection), respiratory failure, chronic obstructive pulmonary disease (a group of lung diseases that block the airflow and make it difficult to breath), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood glow), anxiety disorder, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), anemic (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin), heart failure, acid reflux, osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wear down). Observed the CNA, A providing assistance with toileting Resident #3 on 06/04/2024 at 1:35 PM. The LVN A did not wash her hands but put on clean gloves to help Resident #1 with using the restroom. The CNA A placed on clean gloves and did not wash her hands before, during, or after providing incontinent care or assisting with toileting. The CNA A was observed assisting Resident #3 with cleaning her with wipes after Resident #3 had used the restroom in the toilet. The CNA A proceeded in taking one wipe and cleaning Resident #3. The CNA A then turned Resident #3 to the left side and began cleaning the buttocks area. The CNA A proceeded in grabbing a clean brief and placing it underneath the resident and then laying Resident #3 on her back. The CNA A fastened Resident #3's brief and pulled up her pants and covered her with the blanket. The CNA A did not wash her hands before leaving Resident #3's room. Resident #4: Record Review of Resident #4 face sheet revealed a [AGE] year-old female, admitted on [DATE] with a primary diagnosis of depression, type 2 diabetes, high blood pressure, urinary tract infection, osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down). Record Review of Resident #4's Admission MDS dated [DATE] revealed Resident #4 had a BIMS of 13 which means Resident #4 is cognitively intact. The MDS indicated that Resident #4 uses extensive assistance for toilet use with substantial and max assistance. The MDS listed Resident #4 as urinary and bowel incontinent. Record Review of Resident #4's care plan dated 11/15/2023 revealed that Resident #4 has bowel and bladder incontinence with impaired mobility and generalized weakness with interventions of: clean peri-area with each incontinence episode. Monitor and document intake and output as per facility policy. Observed the CNA A and CNA B providing incontinent care for Resident #4 on 06/04/2024 at 2:29 pm. CNA A did not wash her hands prior to gathering incontinent supplies. The CNA A and CNA B did not wash their hands prior to starting incontinent care for Resident #4. CNA A and CNA B did not wash their hands while gathering incontinent supplies for Resident #4. The CNA A and CNA B put on clean disposable gloves. Observed Resident #4's brief wet with urine. The CNA A and CNA B did not wash hands during incontinent care. The CNA B did not wash hands or change gloves before placing on clean brief. The CNA B did not perform hand hygiene after providing incontinent care for Resident #4. The CNA A did perform hand hygiene after providing incontinent care and disposing of gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/04/2024 at 4:18 PM with CNA A revealed that she knew that she should have washed her hands while caring for residents but failed to do it because she was nervous. The CNA A stated that she had been doing care for residents so long that she had just gotten into routine. The CNA A stated that she had been trained in infection control practices and handwashing through in-services and skills checks, monthly. The CNA A stated that she understood that she should have washed her hands. The CNA A stated that she just was not paying attention and did not think to wash her hands. The CNA A stated to make sure to wash hands and use gloves. The CNA A stated that the negative potential outcome is spread of infections. Interview on 06/04/2024 at 4:26 PM with the ADON revealed she said, that she and the DON are responsible for the training for the staff. The ADON stated that she expects staff to always wash their hands. The ADON stated that they have trained the staff for infection control and had staff to return demonstration. The ADON stated that the facility had given the staff the tools to provide adequate infection control practices and they are just not utilizing the tools. The ADON stated that the policy stated to wash hands while providing care and anytime going from dirty to clean. The ADON stated that they provide in-services and competency checks monthly. The ADON stated that the negative potential outcome of not washing hands is the spread of infection and germs. Interview on 06/04/2024 at 4:44 PM with CNA B revealed that she said that she understands where she went wrong and should have washed her hands before, during, and after care. The CNA B stated that she had been trained in handwashing by in-services, skill-checks, with return demonstration with either the ADON or DON, every month. The CNA B stated that policy states to wash hands before, during, and after resident care. The CNA B stated that the negative potential outcome for not washing hands is the spread of infection and germs. Interview on 06/04/2024 at 5:49 PM with the DON., the DON revealed she said that the policy states that staff should wash their hands before, during, and after providing care for residents and before preparing their supplies. The DON stated that she expects staff to follow policy and procedure guidelines and to wash their hands. The DON stated that she and the ADON are responsible for providing training for infection control practices/ handwashing. The DON stated that they provide competency checks for handwashing with return demonstration and in-services for infection control practices, monthly. The DON stated that the negative potential outcome for not using proper infection control practices/ hand washing would be the spread of germs. Interview on 06/04/2024 at 6:03 PM with the Administrator revealed she said that she expects the staff to wash their hands and use infection control practices. The Administrator stated that the staff have all been trained through competency checks and in-services approximately monthly. The Administrator stated that the staff should know after all the training that they should use infection control practices when providing care. The Administrator stated that the DON and ADON is responsible for overseeing the training. The Administrator stated that the negative potential outcome is the spread of infection and germs. Record review of the facility policy titled; Infection Control date revised 10 2018 revealed: Policy Statement: This facility's infection control policies are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation: 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, [NAME] or veteran, or prayer source. 2. The objectives of our infection control policies and practices are to: b). Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. .4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. Record review of the facility policy titled; Handwashing/ Hand Hygiene date Revised August 2019 revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: .2. All personnel shall follow the handwashing hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. .6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a). When hands are visibly soiled 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. b). Before and after direct contact with residents. d). Before performing any non-surgical invasive procedures. e). Before and after handling an invasive device (urinary catheters, IV access sites) g). Before handling clean or soiled dressing, gauze pads, etc. h). Before moving from a contaminated body site to a clean body site during resistant care. i). After contact with a resident's intact skin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j). After contact with blood or bodily fluids. k). After handling used dressings, contaminated equipment, etc. m). After removing gloves. n). Before and after entering isolation precaution setting. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used: a). Before aseptic procedures. b). When anticipating contact with blood or body fluids. c). When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. Procedure: Washing Hands. 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet. 5. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis. Using Alcohol-Based Hand Rubs: 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry. 3. Follow manufactures directions for volume of product to use.