

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Lakeside Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344</p> <p>Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy for 1 of 1 residents (Resident #3 reviewed for privacy issues in that:</p> <ol style="list-style-type: none"> 1. CNA A failed to provide full privacy for Resident #3 during peri care by not completely closing privacy curtains or providing a towel or sheet during peri care. 2. ADON failed to provide privacy by not providing a sheet or towel to cover the resident and not fully drawing Resident #3's curtain during peri care and wound care. <p>This failure could cause residents to feel uncomfortable, disrespected, and possible exposure to anyone passing by.</p> <p>Findings include:</p> <p>Resident #3:</p> <p>Record Review of Resident #3 face sheet dated 07/07/2024 originally admitted on [DATE] with a readmitted [DATE] reveals a [AGE] year-old female with a diagnosis of: metabolic encephalopathy (chemical imbalance in the blood that causes a problem with the brain), urinary tract infection, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), depression, high blood pressure, anemia, type 2 diabetes, fibromyalgia (a long-term condition that causes widespread pain and tiredness), Sjogren syndrome (an immune system illness that causes dry eyes and dry mouth), type 2 diabetes, acid reflux disease.</p> <p>Record review of resident #3 MDS with a date of 06/09/2024, reveals a BIMS score of 12 which indicates resident is moderately impaired.</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of peri care with CNA A for Resident #3 on 07/08/2024 at 1:07 PM. CNA A failed to provide complete privacy for Resident #3 during peri care. CNA A did not provide a sheet for maximum privacy during peri care. CNA A did not pull the curtains all the way during peri care causing Resident #3's body to be exposed during peri care. CNA A gathered peri care supplies and went into Resident #3's room to provide peri care. CNA A shut Resident #3's room door but did not close the curtain dividing the door from the resident all of the way. CNA A did not pull the privacy curtain to the full extent to cover the bed. CNA A removed Resident #3 removed clothing from the waist down to provide peri care and completed peri care while not providing a sheet for maximum privacy. Observed a camera at the end of Resident #3's bed for family to be able to view Resident #3. CNA A completed peri care with Resident #3.</p> <p>During an observation of wound care with ADON for Resident #3 on 07/08/2024 at 1:54 PM. ADON entered Resident #3's room to provide wound care and did shut the door but did not close privacy curtain all the way around the resident to provide optimum privacy. The curtain was only halfway drawn on the right side of the resident that divides the resident from the door. ADON removed Resident #3's clothing from the waist down. There was a camera where the family could view the entire procedure. While Resident #3's pants were pulled down and the brief was open, a CNA walked into the room. There was no sheet that had been provided to cover the resident. ADON and CNA completed peri care and ADON completed wound care and exposed Resident #3 the entire time.</p> <p>During an Interview with ADON on 07/08/2024 at 3:03 PM, she stated that she should have provided more privacy for the resident's by shutting the door, making sure blinds are closed, and closing the curtains. ADON stated that the policy stated that staff should provide privacy during care. ADON stated that the negative potential outcome for not providing privacy during care is that the resident is being exposed and it may make them feel bad or upset. ADON stated that she had been trained in privacy by in-services when needed or quarterly.</p> <p>During an Interview with DON on 07/08/2024 at 3:24 PM, she stated that she expects that when staff walks in a resident's room to provide resident care they should close the door, close the blinds, close all curtains and cover the resident to provide privacy. The DON stated that the negative potential outcome would be that resident's may not want other people to see their business and may also cause them to become embarrassed. DON stated that the facility provides training quarterly, monthly, and as needed by in-services.</p> <p>During an Interview with CNA A on 07/08/2024 at 3:46 PM, she stated that she did know to provide complete privacy for residents. She stated that she wasn't thinking about pulling the curtain closed, just providing peri care. CNA A stated that the negative potential outcome of not providing privacy is that someone could walk in and see the resident. CNA A stated that she had been trained in providing privacy for residents by in-services, monthly.</p> <p>Record review of facility policy, labeled, Resident Rights date Revised December 2016, revealed:</p> <p>Policy Statement: Employees shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation:</p> <p>a). a dignified existence</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b). be treated with respect, kindness, and dignity.</p> <p>t). privacy and confidentiality.</p> <p>Record review of facility provided in-services, labeled, Peri Care, dated June 20, 2024, revealed:</p> <ol style="list-style-type: none"> 1. Enters room and identifies self and patient/resident. 2. Explains the procedure addresses questions and other PPE as indicated. 3. Provide privacy 4. Washes hands, applies disposable gloves and other PPE as indicated. 5. Assembles supplies at bedside. 6. Raise bed to comfortable working height; assists the resident to a supine position.