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	09/12/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on the comprehensive assessment of residents for one of five residents (Residents #2) reviewed for wound care. The facility failed to follow physician's orders for wound care for Residents #2. The failure placed residents at risk of wound deterioration and infection. Findings included: Record review of Resident #2's clinical record reflected a face sheet, dated 09/12/24, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #2's diagnoses included ORIF Left hip (Surgical hip replacement), Epilepsy (seizure disorder), end stage renal disease (kidney disease), and major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities). Review of Resident #2's Quarterly MDS Assessment, dated 08/23/24, reflected the resident cognition was moderately impaired with a BIMS score of 08 . Review of Resident #2's physician's orders, dated 09/12/24, reflected: Order date: 08/16/24, Daily dry dressing changes to incisions LLE. No alcohol, betadine, peroxide, or ointments to incisions. Ok to shower and allow soapy water to run over incisions. rinse well and pat dry and apply new dry dressing. no soaking in any body of water. one time a day Daily and PRN. Review of Resident #2's September 2024 treatment administration record reflected there was documentation indicating Resident #2's wound to the left hip was treated on 09/06/24 by LVN C. Review of Resident #2's electronic medical records progress note dated 09/12/24 reflected no documentation related to Resident #2's wound to the left hip was treated on 09/05/24. Review of the Resident #2's weekly skin assessment dated [DATE] revealed she had other existing skin issue: surgical incision. (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 08:51 AM with CNA F, she stated on 09/07/24 at 06:30 AM she found Resident #2 on her bed with blood soaked through her dressing, fitted sheet, and draw sheet. She stated she reported it to the charge nurse LVN D. During an interview on 09/12/24 at 09:16 AM with LVN D, she stated at approximately 06:30 AM CNA F reported to her Resident #2 was oozing over her dressing and had blood on her sheets. She stated she observed Resident #2's wound, checked wound care orders, and gathered supplies to complete Resident #2's wound care. She stated she took a picture of the date and time of the wound's dressing that was dated 09/05/24 at 19:30 (07:30 PM). She stated the dressing had old and new blood. She stated she cleaned the wound which did not have pus and it was oozing serosanguinous and was not purulent (thick, milky discharge) but did have a foul odor. She stated the odor was from the wound dressing not the wound. She stated the odor had improved on 09/08/24. She stated the dressing was change by the night nurse on 09/05/24 and was not changed again until 09/07/24 by her. She stated she did not notify the physician but Resident #2 needed frequent dressing changes. She stated a fresh surgical wound should be changed and not wait for two days to change it, especially since there are specific doctor's orders. She stated she reported to the on call ADON on 09/07/24 at 06:49 AM Resident #1 dressing was not changed on 09/06/24. Record review of a photo on 09/12/24 taken by LVN D revealed Resident #2 wound dressing dated 09/05/24 at 1930 (time) with LVN E's initials. On 09/12/24 at 11:45 AM and 12:57 PM a call placed to LVN C with no answer. During an interview on 09/12/24 at 02:29 PM with the ADON, she stated the dressing change for Resident #2 not being done was reported to her on 09/07/24. During an interview on 09/12/24 at 02:30 PM with the DON, she stated due to low census the medication nurse did do the wound care between medication passes. She stated all nursing staff was notified on 09/05/24 in a group text. She stated if there was no documentation it was not done. She stated she was not sure why the dressing change was not done. She stated Resident #2's dressing should have been changed with a date, time and initials. She stated Resident #2's orders were for dressing changes daily and prn. She stated that all staff had been trained on how to document treatments. The DON stated monitoring was done daily by the DON and ADON. She stated the potential negative outcome could be not providing the residents with care, infection, and the wound could worsen. During an interview on 09/12/24 at 03:05 PM with the Admin, she stated all physician's orders should be followed and documented at the time the treatment was done. She stated training and monitoring was done by the DON or designee. She stated all staff should have been trained. She stated the potential negative outcome could be infection, poor healing at the site, but not at site could lead to sepsis if left unattended. Record review physician progress note dated 09/10/24 reflected exam today revealed patient has serosanguineous drainage from the left hip. Patient arrives to clinic in a wheelchair for ambulation with dry dressings over her left hip incision. On physical examination her wound is draining serosanguineous fluid of the left side. Follow up: patient will be admitted tot he hospital today through the emergency department. We will plan on irrigation debridement to the leg as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy titled Wound Care with a revision date October 2010, reflected: . Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given 2. The date and time the wound care was given . 4. The name and title of the individual performing the wound care . 10. The signature and title of the person recording the data .

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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** 41480 Based on interview, observation, and record review the facility failed ensure residents with wounds receive the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new pressure ulcers from developing or spreading for 1 of 2 Residents (Resident #1). The facility failed to follow physician's orders for Resident #1's pressure ulcer. This failure placed Residents at risks for infection and the development of new or worsening pressure injuries or wounds. Resident #1 Record review of Resident #1's clinical record reflected a face sheet, dated 09/12/24, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included hypotension (low blood pressure), multiple sclerosis (chronic autoimmune disease), schizoaffective disorder (mental illness), bipolar disorder (mental illness that causes extreme mood swings, energy changes and difficulty concentrating), major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities), seizures, and anxiety (feeling of fear and worry). Review of Resident #1's Quarterly MDS Assessment, dated 08/06/24, reflected the resident was cognitively intact with a BIMS score of 15 . Review of Resident #1's physician's orders, dated 09/12/24, reflected: Order date: 08/15/24, Wound Care: to coccyx (upper buttock) : Cleanse with wound cleanser, pat dry, apply triad, cover with bordered gauze or silicone dressing. Everyday shift for wound care. Review of Resident #1's September 2024 treatment administration record reflected there was no documentation indicating Resident #1's wound to her coccyx was treated on 09/10/24 . Review of Resident #1's electronic medical records progress notes from 09/09/24 through 09/12/24 reflected no documentation of Resident #1's wound to her coccyx. Review of the Resident #1's weekly skin assessment dated [DATE] revealed she had an existing pressure ulcer on the coccyx and treatment was done daily. During an interview on 09/12/24 at 11:23 AM with LVN A, he stated he was the charge nurse on station 2 on 09/10/24 and he did not do the wound care for Resident #1. He stated the medication nurse on station 1 did medications and all wound care. He stated LVN B was on station 1 on 9/10/24 and he did see him doing wound care on station 2 but was not sure if he did Resident #1's would care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 11:55 AM with LVN B, he stated he was the medication nurse on station 1 on 09/10/24. He stated he was not aware he was to do all the wound care on station 2. He stated he did assist with wound care as needed. He stated he did not do wound care for Resident #1 on 09/10/24. During an interview on 09/12/24 at 02:30 PM with the DON, she stated due to low census the medication nurse did do the wound care between medication passes. She stated all nursing staff was notified on 09/05/24 in a group text. She stated if there was no documentation it was not done. She stated she was not sure why the dressing change was not done. She stated Resident #2's dressing should have been changed with a date, time, and initials. She stated Resident #2's orders were for dressing changes daily and prn. She stated that all staff had been trained on how to document treatments. The DON stated monitoring was done daily by the DON and ADON. She stated the potential negative outcome could be not providing the residents with care, infection, and the wound could worsen. During an interview on 09/12/24 at 03:05 PM with the Admin, she stated all physician's orders should be followed and documented at the time the treatment was done. She stated training and monitoring was done by the DON or designee. She stated all staff should have been trained. She stated the potential negative outcome could be infection, poor healing at the site, but not at site could lead to sepsis if left unattended. Record review of facility's policy titled Wound Care with a revision date October 2010, reflected: . Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given 2. The date and time the wound care was given . 4. The name and title of the individual performing the wound care . 10. The signature and title of the person recording the data .

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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** 41480 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 2 of 2 residents (Residents #1 and #3) and 3 of 3 (LVN D, CNA G and CNA H) staff reviewed for infection control. LVN D failed to follow enhanced barrier precautions, change gloves, and wash her hands or use ABHR during Resident #1's and #3's wound care and Resident #3's transfer to bed. CNA G failed to follow enhanced barrier precautions before entering and exiting Resident #3's room. CNA H failed to follow enhanced barrier precautions before entering and exiting Resident #3's room and during the transfer of Resident #3 to bed. These failures could place residents at risk for spread of infection and cross contamination. Findings include: Resident #1 Record review of Resident #1's clinical record reflected a face sheet, dated 09/12/24, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included hypotension (low blood pressure), multiple sclerosis (chronic autoimmune disease), schizoaffective disorder (mental illness), bipolar disorder (mental illness that causes extreme mood swings, energy changes and difficulty concentrating), major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities), seizures, and anxiety (feeling of fear and worry). Review of Resident #1's Quarterly MDS Assessment, dated 08/06/24, reflected the resident was cognitively intact with a BIMS score of 15. Record review of Resident #1's care plan dated 06/06/24 reflected no care plan for wounds . Record review of Resident #1's physician orders dated 09/12/24 reflected Wound Care: to coccyx. Cleanse with wound cleanser, pat dry, apply TRIAD, cover with bordered gauze or silicone dressing. Every day shift for wound care, dated 08/15/24. During an observation on 09/12/24 at 10:49 AM revealed LVN D cleaned Resident #1 coccyx (upper buttock) wound with wound cleanser and gauze and patted dry with gauze. LVN D applied triad ointment and covered the wound with bordered gauze. LVN D removed gloves and repositioned resident. LVN D did not wash her hands or use ABHR when changing gloves between dirty and clean dressing and LVN did not wash hands or use ABHR after removal of gloves. LVN D did not wear proper PPE during wound care. Resident #3 (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 #1's clinical record reflected a face sheet, dated 09/12/24, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #3's diagnoses included anxiety (feeling of fear), dementia (memory loss), hypertension (high blood pressure), and atrial fibrillation (irregular heartbeat). Review of Resident #3's Annual MDS Assessment, dated 07/25/24, reflected the resident's cognition was severely impaired with a BIMS score of 05. Section M - skin condition reflected resident had an unhealed stage 3 pressure ulcer. Record review of Resident #3's care plan dated 08/04/24 reflected a focus area Resident #3 had stage 3 pressure ulcer to the left hip with interventions for an air mattress . Record review of Resident #3's physician orders dated 09/12/24 reflected Wound Care: right abd: cleanse with wound cleanse, pat dry, skin prep area, cover with tegaderm. Every day shift and as needed for wound care, dated 08/27/24. Wound Care: to left hip: cleanse with wound cleanse, pat dry, apply TRIAD, and cover with border gauze. Every day shift for wound care, dated 08/27/24. During an observation on 09/12/24 at 01:15 PM revealed LVN D put gloves on and LVN D did not wash her hands or use ABHR. CNA H put gloves on and CNA H did not wash her hands or use ABHR. CNA H and LVN D entered Resident #3's room to transfer the resident to bed. LVN D and CNA H did not wear proper PPE. LVN D came out to the treatment cart and picked up Sani wipes. LVN D re-entered the resident's room and cleaned the bed side table. LVN D removed her gloves and put on new gloves and gathered supplies. While LVN D was standing at treatment cart outside of Resident #3's room, CNA G entered the room and CNA G did not wash his hands or use ABHR. CNA G went to Resident #3's bedside. CNA G exited the room and CNA G did not wash his hands or ABHR. Observation of EBP sign posted beside door reflected Stop ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. After CNA G exited Resident #3's room, LVN D left the treatment cart with gloves on and went to another cart at the nurse's station. LVN D then went into the supply room. Observed LVN D walking in the hallway with gloves on carrying wound cleanser. LVN D held up the wound cleaner to the surveyor and stated, I got a new bottle. LVN D returned to the cart and gathered supplies and entered Resident #3's room. LVN D placed the supplies on the bedside table and removes her gloves. LVN D did not wash her hands or use ABHR. LVN D opened the gauze using her bare hands and sprayed the gauze with wound cleanser . LVN D put on gloves and LVN D did not wash her hands or use ABHR. LVN D picked up gauze off bedside table and cleaned the abdomen wound (Wound #1). LVN D removed gloves and used ABHR and put gloves on and applied skin prep and cover dressing to abdomen wound. LVN D opened a new dressing, put triad ointment in cup, put hand in pocket to get a marker, wrote on the dressing, put marker back in pocket, put wound cleaner on the gauze, opened a smaller dressing, put hand back in pocket to get a marker, wrote on the gauze and placed the marker on bedside table. LVN D removed her gloves then used ABHR and put on new gloves. LVN D cleaned left hip wound (Wound #2) then opened Q-tip and gauze. LVN D then patted left hip wound dry, applied triad ointment to left hip wound bed and covered with dressing . LVN D picked up a marker and wrote on the abdomen dressing on Resident #3 abdomen . LVN D removed gloves and used ABHR. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/12/24 at 10:49 AM and 01:15 PM revealed a sign on the wall beside resident #1 and #3 door that reflected, Stop ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, wound care: any skin opening requiring a dressing . During an interview on 09/12/24 at 01:35 PM with LVN D, she stated I should have changed my gloves when going from clean to dirty. I thought I did with as many glove changes as I did. She stated she did not see a problem with wearing gloves down the hallway and then touching supplies because they were all considered dirty until they opened them. She stated she did not recall touching supplies with her bare hands. When asked about wearing proper PPE she stated, I did not realize she (Resident #3) was in isolation. She stated the sign outside the resident door (Enhanced Barrier Precautions) was on everyone's door. When asked if she had been trained on enhanced barrier precautions she stated, Apparently not enough. When asked if she was required to wear a gown she stated, that's what the paper (sign posted outside Resident #3 door) says, but I have not seen anyone in this facility wear a gown. When asked about handwashing between glove changes and before entering or exiting a room LVN D stated Thank you. and walked away. During an interview on 09/12/24 at 02:00 PM with CNA G, he stated he did not wash his hands before entering or when exiting Resident #3 . He stated he had been trained on enhanced barrier precautions. He stated the potential negative outcome could be the spread of infections to other residents. During an interview on 09/12/24 at 02:30 PM with the DON, she stated LVN D should have changed her gloves between dirty and clean and either used ABHR or soap and water. She stated hands should have been washed or use ABHR before any treatment. She stated gloves were not to be worn in the hallways and LVN D should know that because she was a senior nurse. She stated gloves should have been changed between wounds (wound #1 and #2) . She stated staff should never put gloved hands in their pocket to get items, it should all be on the bedside table. She stated during wound care and transferring a resident the staff should have been wearing gloves and gown. She stated gloves and gown were required for any direct care of the resident. She stated all staff had recently been trained on enhance barrier protections. She stated the ADON/DON were responsible for monitoring and training staff. She stated the potential negative outcome could be spread of infections. During an interview on 09/12/24 at 03:05 PM with the Admin she stated gloves should be changed when going from dirty to clean. She stated supplies should not be touched by bare hands. She stated the new enhanced barrier protection does require gloves and gowns for direct care. She stated all staff had been trained. She stated the DON was responsible for staff training and in-services. She stated the potential negative outcome could be spread of infection. During an interview on 09/12/24 at 03:30 PM with CNA H, she stated she did not wash her hands or use ABHR before putting on gloves. She stated she did not wear a gown while transferring Resident #3 into bed. She stated there was no reason she did not wear a gown other than she forgot. She stated she had been trained on enhanced barrier protection and has read the stop sign outside Resident #3 door. She stated the potential negative outcome could be spread of germs and infection. Record review Hand Hygiene Competency Checklist, dated 07/22/24 for CNA H, reflected competency goals met. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk . 10. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE requires . Record review facility policy titled Wound Care, revised date October 2010, reflected the following: Purpose: the purpose of this procedure is to provide guidelines for the care of wounds to promote healing . Steps in the procedure . 4. Put on exam gloves. Loosen and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves . 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound . 14. Be certain all clean items are on clean field .