

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  01/08/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27430</p> <p>Based on observation, interviews and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administration of drugs that meet the needs of all residents for 1 of 5 residents (Resident #1) reviewed for pharmacy services.</p> <p>ADON failed to make sure that drugs and biologicals are prepared and given by the same person by preparing a medication and giving it to CNA to administer to Resident #1, on 12/30/2024 around 10:30 AM per anonymous complaint dated 12/31/2024.</p> <p>This failure could place residents at risk for not receiving medications correctly.</p> <p>Findings included:</p> <p>Record Review of Resident #1's facesheet dated 01/08/2025 revealed that Resident #1 was initially admitted to the facility on [DATE] with a readmission on 06/13/2024. Resident #1 had a medical history of acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), epilepsy (disorder in which nerves cell activity in the brain is disturbed, causing seizures), insomnia (makes it difficult to fall asleep or stay asleep), anxiety (intense, excessive, and persistent worry and fear about everyday situations), depression (loss of pleasure or interest in activities for long periods of time), dysphagia (swallowing difficulties), cerebral palsy (congenital disorder of movement, muscle, tone, or posture), and congenital hypertonia (overly toned muscles that cause muscles to be stiff and difficult to control).</p> <p>Record review of Resident #1s MDS dated [DATE] revealed, Section C- Cognitive patterns revealed a BIMS score of 10 which indicated Resident #1 had a moderate cognitive impairment. Section GG- Functional Abilities: A. revealed a score of 2 for eating, which indicated Resident #1 needed substantial/maximal assistance. Section K- Swallowing/Nutritional Status C. revealed coughing or choking during meals or when swallowing medications. K0520 revealed mechanically altered diet.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1 s care plan dated 08/19/2020 revealed problem: Resident #1 has an ADL self-performance deficit related to cerebral palsy. Goal to maintain current level of function in ADL's through the review date. Date initiated 07/23/2022. Interventions: Eating: Resident #1 requires extensive assist x 1 with eating. 04/20/21 Resident #1 requires extensive assist x 1 with eating. She has a regular diet, foods cut up into bite size pieces. She has difficulty with swallowing, so requires attention. She has ROM deficits in upper extremities requiring assist with feeding. Initiated on 08/19/2020. Revision on 10/06/2023.</p> <p>Record review of Resident #1s physician order dated 02/13/2024 for Resident #1 to receive ST skilled service 3 x week for 30 days for dysphagia management.</p> <p>Record review of Resident #1s Nutritional Review assessment dated [DATE]: 8. Current Diet/Supplement Order: Regular pureed diet with nectar thicken liquids. 9. Appropriateness of Diet Order: Appropriate. 10. Ability to Chew/Swallow: Ok. 13. Ability to feed self: Dependent. 24. Comments: Resident #1 is alert to person and place and can communicate needs.</p> <p>Record review of Resident #1's Nursing Monthly Summary dated 12/13/2024 revealed: Section A. Level of Consciousness/Orientation/Cognition: Resident #1 is alert and oriented to person and place, with episodic confusion. Section H. ADLs- Eating is total dependence of one person. Diet order: thickened liquids, pureed.</p> <p>Record review of Resident #1's December 2024 Medication Administration Record revealed an order for Tylenol Extra Strength oral tablet 500 mg. Give one tablet by mouth every 6 hours as needed for pain. There is no documentation on 12/31/2024 that the medication was given.</p> <p>During an interview on 01/08/2025 at 8:40 AM, the ADON stated that it had been a hectic day and she was running behind with the medication pass. ADON stated that her family member, CNA, came by and asked if she needed any help. ADON stated that she remembered it was during the morning med pass on 12/30/2024, and Resident #1 was crying out. ADON stated that she poured a Tylenol Extra Strength tablet into a medication cup and asked CNA to go administer the medication to Resident #1. ADON stated that CNA also does transportation for the facility and knows her residents very well. ADON stated it was just an OTC medication, and she would not have done that with any of the other medications. ADON stated that she would never to that again, it was just a spur of the moment decision. ADON revealed CNA is not certified to administer medications.</p> <p>During an interview on 01/08/2025 at 9:34 AM, Confidential Person A stated that she observed the ADON give a medication cup to CNA. Confidential Person A stated they did not know what was in the cup, but they knew a CNA should not be giving medications.</p> <p>During an observation on 01/08/2025 at 9:54 AM, Resident #1 was observed resting with eyes closed, head of bed up at 30 degrees, and had oxygen administering via nasal cannula. No signs or symptoms of distress.</p> <p>During a phone interview on 01/08/2025 at 10:40 AM, Regional RN stated, oh no, they can not do that, regarding the ADON giving CNA a medication to administer to Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/08/2025 at 11:16 AM, CNA stated that Monday 12/30/2024 had been a crazy day, and she was checking with other staff to see if she could help them with anything. CNA stated her family member, ADON was passing medications, and CNA asked her if she needed her to do anything. ADON poured a Tylenol Extra Strength tablet into a medication cup and asked her to go administer it to Resident #1. Resident #1 took the medication without incident. CNA stated that she was just trying to help out, and it was just an OTC medication. Regarding the risks to a resident if someone did not know the resident had an order for thickened liquids, CNA stated that she had been certified for [AGE] years, and as a CNA she knows that about her residents. CNA stated that Resident #1's head of bed is always elevated. CNA stated that she did not have her certification to administer medications. CNA stated that she would never do it again and stated that she would not have done that if it had not been her family member.</p> <p>During an interview on 01/08/2025 at 11:25 AM, Confidential Person B stated that they were concerned about an uncertified person giving medications, because they may not know what they are giving, or whether or not that resident has thickened liquids, or possibly the unlicensed person could give the medication to the wrong person.</p> <p>During an interview on 01/08/2025 at 11:46 AM, LVN A revealed the risks to a resident that is administered medications by an uncertified person includes not knowing what medication they are giving, what the side effects are, if there are parameters that need to be checked prior to administration, or there might be possible drug interactions with other medications. LVN A stated that if a person is not certified in medication administration, they should not be giving medications.</p> <p>During an interview on 01/08/2025 at 12:20 PM, ADON stated that a lot of things could happen to a resident with an uncertified person giving medications. ADON stated, I did it, but I will never do it again.</p> <p>During an interview on 01/08/2025 at 12:30 PM, Resident #1 was awake, made eye contact and smiled. Investigator asked how she was doing. It took a little while for her to get her words out. Resident #1 voiced she was doing ok. Resident #1 denied any concerns regarding the staff or her care. Resident #1 could not recall what medications she had on 12/30/2024.</p> <p>During an interview on 01/08/2025 at 1:47 PM, the Interim DON stated that the ADON had just told her about giving a medication to her family member, CNA, to administer to Resident #1. Interim DON stated, that is not good. Interim DON stated that the risks to a resident being given medication by an uncertified person could result in the resident choking or aspirating, or they may give the medication to the wrong person.</p> <p>During an interview on 01/08/2025 at 2:27 PM, LVN B, stated that the risks of an uncertified person giving medications include they could give the medication to the wrong person, or they may not give the resident the medication and take it themselves, the uncertified person may not know what the medication is for, or know what the side effects might be. LVN B stated there could be a lot wrong with an uncertified person administering medications.</p> <p>During an interview on 01/08/2025 at 3:15 PM, Physician stated that the risks of an uncertified person administering medications that they did not prepare, first you would be relying on what someone else was telling you the medication was. Physician stated, it is just not good practice.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Disciplinary Action Form dated 01/08/2025 for ADON. Safety violation: Unsafe Practice. Detailed description of offense: Not following the policy for Medication Administration. Employee comments: Will follow the facility policy. Action taken: Written Warning. Signed and dated by ADON and Interim DON.</p> <p>Record review of Disciplinary Action Form dated 01/08/2025 for CNA. Safety violation: Unsafe Practice. Detailed description of offense: Not following the policy for Medication Administration. Employee comments: Will follow the facility policy. Action taken: Written Warning. Signed and dated by CNA and Interim DON.</p> <p>Record review of in-service dated 01/08/2025: Medication Administration: Only licensed personnel or personnel permitted by the state to prepare, administer, and document the administration of medication can do so.</p> <p>The following policy reviewed: Administering Medications, 2001 Med-Pass, Inc. (Revised April 2019)</p> <p>Policy Statement: Medications are administered in a safe and timely manner, as prescribed.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so.</p>		