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	01/31/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder or had a urinary catheter received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 5 Residents (Resident #1) reviewed for catheter care in that: The facility failed to ensure Resident #1 had physician orders for a urinary catheter. This failure had the potential to affect residents by placing them at an increased risk of not receiving the appropriate care or services related to the urinary catheter. Findings include: Record review of the admission record for Resident #1, dated 01/31/25, revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: unspecified sequelae of cerebral infarction (long-term effects of a stroke in the brain), type 2 diabetes (blood sugar problems), essential hypertension (high blood pressure), and urinary tract infection (bladder infection). Record review of Resident #1's quarterly MDS assessment, dated 12/20/24 revealed Resident #1 had a BIMS score of 15 which indicated the resident's cognition was intact. The MDS revealed Resident #1 had an indwelling catheter. Record review of Resident #1's order summary report, dated 01/31/25, revealed no physician order for a foley catheter. Observation on 01/31/25 at 9:52 AM revealed Resident #1 in bed and a foley catheter bag was noted hanging on the side of the bed. Interview on 01/31/25 at 10:50 AM, Resident #1 stated she has had a urinary catheter for about 2 weeks. Resident #1 stated she was unsure why she received a catheter. Resident #1 stated staff cleaned her catheter when they changed her brief and emptied the bag at least twice daily. (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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/31/25 at 11:14 AM, LVN A stated this was her first day working at the facility and she was not familiar with Resident #1's care. LVN A stated the floor nurse was responsible for ensuring residents had physician orders for urinary catheters. LVN A stated there could be a potential for infection concerns or the urinary catheter could need to be irrigated and the staff would not know without physician orders for catheter care. Attempted phone interview on 01/31/25 at 11:25 AM with LVN B. No answer. Left a voice message with a call back number. Interview on 01/31/25 at 11:35 AM, the DON stated her first day working at the facility was this past Tuesday (01/28/25) and she was still trying to audit and get everything in place. The DON stated it was unknown why the urinary catheter was placed on Resident #1 but she believes hospice nurses ordered and placed the catheter. The DON stated she was unsure if hospice would keep the urinary catheter for Resident #1 as she was unsure what the actual diagnosis was for Resident #1's urinary catheter. The DON stated a potential negative outcome for the resident was urosepsis (a bladder infection that spreads to the kidneys and enters the bloodstream), infection, and septicemia (blood poisoning). Interview on 01/31/25 at 12:05 AM, the Interim ADM stated she expected the residents who had a urinary catheter to have a current physician's order for the catheter and catheter care. The Interim ADM stated the floor nurse was responsible for ensuring the residents on her hall had physician orders for urinary catheters if they had a urinary catheter. The Interim ADM stated the DON and ADON were also responsible for auditing the resident's charts to ensure the proper physician's orders were in place and being followed. The Interim ADM stated a potential negative outcome to the resident was not receiving catheter care or monitoring. Record review of Resident #1's progress note, dated 12/16/24 at 05:20 AM, created by LVN B: Foley cath changed to 18 fr [French] with 10 cc [ml] bulb. Small amt [amount] of bloody urine noted when inserted and sent to lab for UA [Urinary Analysis]. Resident tolerated procedure well Record review of Resident #1's progress note, dated 12/16/24 at 05:22 AM, created by LVN B: order to obtain UA with C/S [culture/sensitivity] after foley placed tonight. One time only for 1 day. 18FR [French] foley cath [catheter] changed per sterile technique. Resident tolerated well. Resident had very small amt [amount] of bloody urine noted. Small amt [amount] of urine sent to lab for UA. Record review of the facility policy and procedure titled, Catheter Care, Urinary, with a revised date of August 2022 revealed the following: Purpose: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Catheter Evaluation: 1. Review and document the clinical indications for catheter use prior to inserting. 2. Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place. Use a standardized tool for documenting clinical indications for catheter use