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	05/21/2025

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 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** 49927 Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #1) reviewed for care plans. Resident #1 did not have a care plan for Cognitive Loss/Dementia, Communication, Urinary Incontinence, Behavioral Symptoms, and Pressure Ulcers. Resident #1's care plan also did not include the physician's order for a wander guard or why the wander guard was ordered. Resident #1 did not have a care plan for her behaviors related to her diagnoses. This failure could place residents at risk of not receiving the care required to meet their individualized needs. Findings included: Record review of the face sheet, dated 05/05/2025, revealed Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included the following: benign intracranial hypertension (condition characterized by elevated pressure within the skull), mixed hyperlipidemia (elevated levels of both (bad) cholesterol and triglycerides, increasing cardiovascular risk), Type 2 diabetes Mellitus with Hyperosmolar hyperglycemic with Coma (life-threatening complication of diabetes (when blood glucose is too high)), Intermittent explosive disorder (repeated, sudden bouts of impulsive, aggressive, violent behavior or angry verbal outbursts), cognitive communication deficit, and unspecified Dementia, unspecified severity without behavioral disturbance, mood disturbance, and anxiety (memory loss that deteriorates over time). Record review of Resident #1's admission MDS assessment, dated 04/08/2025, revealed in Section C - Cognitive Patterns, Resident #1 had a BIMS score of 00, which indicated severe cognition impairment. The document also indicated in Section V - Care Area Assessment (CAA) Summary the following Care Planning Revision Areas: 02. Cognitive Loss/Dementia (dated 04/16/2025) 04. Communication (dated 04/16/2025) (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
	675093	A. Building B. Wing	05/21/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06. Urinary Incontinence and Indwelling Catheter (dated 04/16/2025) 09. Behavioral Symptoms (dated 04/16/2025) 11. Falls (dated 04/16/2025) 12. Nutritional Status (04/02/2025) 16. Pressure Ulcer (dated 04/16/2025) 17. Psychotropic Drug Use (dated 04/16/2025) Record review of the current care plan for Resident #1, undated, revealed the following problem areas: (Resident) request code status of: DNR, Date Initiated: 03/27/2025, Revision on: 03/27/2025; (Resident) has had an actual fall with no injury 3/26/25, 4/1 Fall with abrasion to left knee, Date Initiated: 03/27/2025. Revision on: 04/03/2025; (Resident) is on a Regular type (of) diet, (Resident) likes mostly everything, prefers to have orange or apple juice, milk, coffee, eggs, toast at breakfast, tea for lunch, fruit punch at dinner, BMI 35.9 (Resident) has a good intake. (Resident) can be confused at times and will usually continue eating if redirected. Further review revealed there were no additional problem areas found on Resident #1's care plan. Record review of Resident #1's active physician's order, dated 5/21/2025, revealed an order for Wander Guard (to left ankle), related to exit seeking. During an observation and interview on 05/20/2025 at 1:21 PM Resident #1 was observed in her room, laying in her bed. A wander guard was observed on Resident #1's ankle. Resident #1 was attempted to be interviewed. However, Resident #1 had trouble communicating verbally and was unable to communicate intelligibly. Resident #1 was observed to have a behavior of tapping her leg repeatedly. During an interview on 05/20/2025 at 3:05 PM LVN A stated Resident #1 had a cognitive impairment and had trouble communicating with staff. LVN A stated Resident #1 had behaviors of repeatedly tapping her hand on objects such as tables and chairs. LVN A stated Resident #1 had a physician's order for a wander guard. LVN A stated Resident #1's behaviors were related to her diagnosis of dementia. LVN A was uncertain if these areas of care were listed on Resident #1's care plan. LVN A stated she knew what Resident #1's needs were based on her physician orders and reports received daily from nursing staff. (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	05/21/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/2025 at 03:00 PM, the MDS nurse stated she had been responsible for completing and updating residents' care plans for approximately the last 6 months. The MDS nurse stated care plans were completed upon admission and updated immediately as changes arise, as well as reviewed quarterly for changes. The MDS nurse stated it has been a recent, combined effort by the MDS nurse and Interdisciplinary Team (IDT) to update residents' care plans. The MDS nurse stated the facility had been reviewing all residents' care plans to ensure they were accurate and updated. The MDS nurse stated they have been working from the beginning of the alphabet to ensure all care plans were reviewed for accuracy. The MDS nurse stated the IDT team reviewed a resident's diagnoses, medications, and areas of care to personalize each resident's care plan based on their current needs. The MDS nurse stated she was not aware Resident #1's care plan was not completed fully, to include all CAA areas indicated on Resident #1's MDS. The MDS nurse stated this was overlooked. The MDS nurse stated all CAA areas should have been included on Resident #1's care plan, as they applied to her current care. The MDS nurse stated Resident #1's physician order for Wander Guard should have also been included in Resident #1's care plan. The MDS nurse stated it was also the DON and ADON's responsibility to update any changes to a resident's care plan, as changes arise. She stated the facility did not have a DON or ADON at that time. The MDS nurse stated the facility had a system to review care planning tasks at their morning clinical meeting. The MDS nurse stated she would ensure Resident #1's care plan was updated that day, 05/21/2025. The MDS nurse stated if a care plan was not updated or completed properly, it would not be specific to the resident's current care needs. She did not feel it caused a negative impact to the resident, as she stated nursing staff should have been checking the resident's orders as well to ensure the resident's individual needs were being met. During an interview on 05/21/2025 at 3:20 PM, the ADM stated care plans were the responsibility of the entire IDT team. The ADM stated the MDS nurse was responsible for reviewing and completing care plans. The ADM stated care plans were completed upon admission and reviewed quarterly. The ADM stated any changes would have been added as soon as the change of condition was known. The ADM stated the MDS nurse and IDT team had been going through care plans recently, for all residents in the facility, to ensure they were accurate and completed. The ADM stated this was an ongoing task that had not been completed yet. The ADM stated he was responsible for ensuring the MDS nurse and IDT team were updating all residents' care plans. The ADM was not sure if all MDS CAA areas should have been listed on Resident #1's care plan. However, he stated Resident #1's care plan should have been personalized to address her individual needs. The ADM stated Resident #1's physician order for Wander Guard should have also been included in her care plan. The ADM stated care planning tasks were discussed during the facility's morning meetings, and any changes or updates were added, as needed, by each department head. The ADM stated a resident's care plan should have been complete and accurate; however, he stated physician's orders were also in place, so each resident's care would have been based on those orders as well as basic nursing knowledge. The AD stated any resident who did not have a current care plan was at risk of deficient practice by the facility. Record review of the facility's policy titled, Comprehensive Resident Centered Care Plan dated November 2016 with a review date of January 2022 and December 2023, reflected the following: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. (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	05/21/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation: 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.