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	06/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for narcotic medication being accounted for. 1. LVN A failed to document Resident #1's Oxycodone/Acetaminophen 10/325MG on the MAR after administration. 2. LVN B & RN C failed to document Resident #1's Oxycodone/Acetaminophen 10/325MG on the Narcotic Record Count Sheet after administration. 3. LVN B failed to notify the DON of a discrepancy with Resident #1's Oxycodone/Acetaminophen 10/325MG per facility policy. These failures could place residents at risk for not receiving prescribed medication. Findings include: Record review of Resident #1's, face sheet dated 06/26/2025 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included: unspecified fracture of right patella, subsequent encounter for closed fracture with routine healing (broken kneecap), muscle weakness (decreased strength), lack of coordination (inability to coordinate movement). Record review of a Resident #1's admission MDS, dated [DATE] did not reveal a BIMS score. Record review of Resident #1's physician orders, 06/26/2025, revealed an order for Oxycodone/Acetaminophen 10/325MG, give one tablet by mouth every 4 hours as needed for pain. Start date 05/29/2025. (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Individual Control Drug Record Narcotic Count Sheet dated 05/29/2025 for Oxycodone/Acetaminophen 10/325MG revealed the facility received 86 whole pills and discarded 5 broken pills on 05/29/2025 at time of admission. Record review of Resident's #1 MAR dated 06/26/2025 revealed Resident #1 was administered 10/325 MG Oxycodone/Acetaminophen on the following dates and times: On 05/29/2025 at 10:21 AM, LVN B documented she administered 1 Oxycodone/Acetaminophen 10/325MG to Resident #1. On 05/30/25 at 5:33PM. LVN B administered 1 Oxycodone/Acetaminophen 10/325MG to Resident #1. On 05/31/2025 at 1:00 AM, RN C administered 1 Oxycodone/Acetaminophen to Resident #1. Record review of Resident's #1 individual Control Drug Record Narcotic Count Sheet dated 05/29/2025 revealed Resident #1 was administered 10/325 MG Oxycodone/Acetaminophen on the following dates and times: On 05/29/2025 at 4:15 PM, LVN A administered 1 Oxycodone/Acetaminophen 10/325MG to Resident #1. On 06/02/2025 at 12:00 PM, LVN A administered 1 Oxycodone/Acetaminophen 10/325MG to Resident #1. On 06/10/2025 at 6:00 AM, LVN B and RN C, signed and documented dropped during count, 82 pills remain. During an interview on 06/26/2025 at 11:50 AM, the ADM stated he was told there was a discrepancy with the Oxycodone/Acetaminophen 10/325MG for Resident #1 when LVN B and RN C changed shift. He stated that LVN B reported she dropped the medication while counting and could not find two of the pills. He stated that LVN B documented to two missing pills on the individual narcotic and failed to report the incident to the ADON or DON. He stated LVN B was terminated for not following the facility policy and procedures for medication discrepancies. He stated LVN B should have reported the incident to the ADON or DON. He stated that RN C had documented the pills were wasted however, she did not witness the pills being wasted. He stated RN C was written up over the incident. He stated the facility started an in-service on the facility procedures for counting narcotics after the incident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2025 at 12:37 PM, the DON stated he was told by LVN A that there was a discrepancy on the individual narcotic count sheet for Resident #1's Oxycodone/Acetaminophen 10/325MG. He stated on the individual narcotic count sheet LVN B documented 2 pills dropped during count and decreased the total number of pills remaining by 2 from 84 to 82. He stated RN C signed as a witness to the wasted medication, but she did not see the medication be wasted. He stated RN C received a write up over the incident. He stated LVN B reported she had dropped the pills during the counting of the pills. He stated LVN B documented the pills were wasted but failed to report the incident to the ADON or DON. He stated the facility policy was that once the pills were wasted staff would need to nothing the ADON or himself. He stated staff should not sign medication as wasted if they did not witness the wasting of the medication. He stated to waste medication it requires to nurses to see the medication being wasted before signing it was wasted. He stated that Resident #1 had discharged before the incident happened and she did not miss any medication. He stated staff did not follow policy for reporting wasted medication. He stated he completed an audit of the medication carts and there were not any other discrepancies. He stated LVN B was terminated for not following facility policy. During an interview on 06/26/2025 at 2:00 PM, the ADON stated LVN A reported to her that LVN B dropped 2 pills and wasted them, and had RN C sign off that she wasted the pills with LVN B. That RN C did not see the pills being wasted. She stated the administrative staff called LVN B and RN C to ask why they did not follow protocol. She stated LVN B was asked why she did not report the medication she wasted. That LVN B told her she was busy; she forgot and didn't think about it. She stated RN C told her she did not see LVN B throw the pills away, but signed she witnessed them being wasted. She stated she told RN C she would receive a disciplinary action for signing pills wasted when she didn't see the pills wasted. She stated after the incident staff were in-serviced over the narcotics and medication counts. She stated she completed an audit with the DON and there were not any other discrepancies with narcotic medications. She stated at the time of the incident LVN B and RN C did not follow the facility policy for wasted narcotics. She stated if staff needed to waste pills, they would need a witness the verify the medication and verify together the medication was wasted and then to notify the ADON or DON of the incident. During an interview on 06/26/2025 at 2:36 PM, LVN A stated when she arrived for her shift on 06/11/2025 RN C reported two pills were dropped during count by LVN B and stated the pills were wasted. She stated that RN C told her she didn't see the pills being wasted but signed with LVN B the wasted two pills for Resident #1. She stated she had received training from the facility on narcotic medications and if a pill was dropped that staff were to notify the ADON or DON and have them waste the medication together. She stated staff should not sign that a medication was wasted if they did not see it being wasted. She stated if there are any discrepancies with narcotic medication staff should report it to the ADON or DON immediately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2025 at 3:04 PM, LVN B stated during count at change of shift she dropped some of the Oxycodone/Acetaminophen 10/325MG for Resident #1. She stated she documented on the individual narcotic count sheet that 2 pills were wasted dropped during count. She stated she had RN C sign with her the medication was wasted. She stated she did not notify the ADON or DON because in the past when something like that happened, she did not have to notify them. She stated she told RN C what happened, and two pills were wasted, and RN C signed with her. She stated she had been instructed before if something like that were to happen to notify the DON. She stated at that time the facility did not have a DON and she should have called the ADON. LVN B stated if she signed, she gave medication on the MAR for Resident #1 she gave it and was not sure why it was not on the narcotic count sheet. She stated she had not received training or any in-service for narcotic medication, counting or reporting discrepancies. During an observation on 06/26/2025 at 3:45 PM, the DON, ADON and ADM pulled the Oxycodone/Acetaminophen 10/325MG from the locked medication storage to count and verify the number of pills. The DON counted the pills, and 82 pills were accounted for. During an interview on 06/26/2025 at 3:55 PM, the ADM verified that LVN A documented she gave 1 Oxycodone/Acetaminophen 10/325MG to Resident #1 on 05/29/2025 and 06/02/2025 and documented it on the individual narcotic count sheet and failed to document it on the MAR. He verified LVN B documented on the MAR for Resident #1 that she gave Resident #1, one Oxycodone/acetaminophen 10/325MG on 05/29/2025 at 10:21 AM and another one on 05/29/2025 at 5:33 PM and failed to document it on the individual narcotic count sheet. He verified that RN C documented on the MAR for Resident #1 she gave Resident #1, one Oxycodone/acetaminophen on 05/30/2025 at 1:00 AM and failed to document it on the individual narcotic count sheet. He stated he was not able to upload documents in TULIP and provided copies of documents used for the PIR. During an interview on 06/26/2025 at 3:55 PM, the DON verified that LVN A documented she gave 1 Oxycodone/Acetaminophen 10/325MG to Resident #1 on 05/29/2025 and 06/02/2025 and documented it on the individual narcotic count sheet and failed to document it on the MAR. He verified LVN B documented on the MAR for Resident #1 that she gave Resident #1, one Oxycodone/acetaminophen 10/325MG on 05/29/2025 at 10:21 AM and another one on 05/29/2025 at 5:33 PM and failed to document it on the individual narcotic count sheet. He verified that RN C documented on the MAR for Resident #1 she gave Resident #1, one Oxycodone/acetaminophen on 05/30/2025 at 1:00 AM and failed to document it on the individual narcotic count sheet. He stated if we count for the three pills signed off on the MAR as administered to Resident #1 and the two signed off on the individual narcotic count sheet as administered along with the two signed as wasted there should be 79 pills remaining not 82. During an interview on 06/26/25 at 4:10 PM, LVN A stated she was not sure why she signed the medication for Resident #1 out on the individual narcotic count sheet and not in the MAR. She stated that if she signed it out on the count sheet, she gave it to Resident #1. During an interview on 06/26/25 at 4:45 PM, the DON stated each shift will have to fill out a count sheet for the medication cart to verify date and time and the number of narcotics signed out in the narcotic binder as well as the number of narcotics given in the MAR and turn it into him. He stated he started an in-service for staff over the new form to complete as well as documenting narcotics given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2025 at 5:18 PM, RN C stated that LVN B told her she dropped the pills for Resident #1. She stated LVN B told her they needed to sign the paper showing the medications were wasted because of the facility policy and she signed the paper. RN C stated she did not see LVN B waste the medication but signed the paper anyway. She stated LVN B told her she had not reported the incident to the ADON or DON, but she would. She stated she did not recall giving the Oxycodone/Acetaminophen 10/325MG to Resident #1 on 05/30/2025. She stated that she will usually make herself a note to sign medication out in the MAR and on the individual narcotic count sheet, because she forgets. She stated she knew she gave Resident #1 her pain medication during her stay at the facility but could not recall which days or times. She stated she had not received any training or in-service from the facility on narcotic medication, counting or reporting discrepancies. During an interview on 06/26/2025 at 7:40 PM Resident #1 stated when she admitted to the facility, she had her prescription of Oxycodone/Acetaminophen 10/325MG. She stated she had the bottle in a Ziplock bag and poured the pills out of the bottle in the bag. She stated she could not recall how many pills she admitted with maybe 20-25 but was not sure. She stated she was only at the facility for a few days before she was discharged . She stated while at the facility she received her pain medication when she asked for it. Record review of the facility PIR dated 06/18/2025 revealed the following documents: Record review of in-service dated 05/30/2025, subject: Narcotic count/sign out/computer, any narcotic you give must have the time on the book match the computer time given. No exceptions please report any missing or discrepancies. Call the ADM/ADON. Please sign book in and out. Signed on 05/30/2025 by LVN A, LVN B and RN C along with additional staff. Record review of in-service dated 06/11/2025, subject: Narcotic Discrepancy - Please call DON/ADON/ADM immediately following any narcotic discrepancies. Do not leave the building until resolved. Report as soon as discrepancy happens. Do not sign WASTED without seeing the medication and throwing it away. Signed by LVN A and RN C along with additional staff. Record review of personnel change form dated 06/12/2025 signed by LVN B revealed last day of employment for LVN B was 06/12/2025 and last day worked 06/10/2025. The document revealed LVN B failed to follow proper policy and procedures regarding medication administration and destruction. Record review of disciplinary action form dated 06/13/2025 for RN C date of offense 06/11/2025, narcotic waste, RN C signed waste but was not present upon disposing. Education provided. Record review of in-service dated 06/26/2025, subject: Narcotic sign out book MAR/TAR - Make sure all Narcotics PRN/Scheduled are signed out in the book as well as the MAR/TAR. No exceptions. Signed by LVN A and RN C along with additional staff. Record review of in-service dated 06/26/2025, subject: Verifying EMAR to Narcotic book - At shift change, the incoming and outgoing nurse will both verify every time a narc was given during the shift, that it is recorded in both the book and the EMAR. The verification count sheet will be filled out and signed by both nurses. LVN A and RN C both signed the in-service along with additional staff. Record review of the facility policy Controlled Substances dated (revised April 2019). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Policy Interpretations and Implementation: 10. Upon Administration: a. The nurse administering the medication is responsible for recording: (1) name of the resident receiving the medication (2) name strength and dose of the medication (3) time of the administration (4) method of administration (5) quantity of the medication remaining (6) signature of nurse administering the medication 11. Upon Disposition: b. Medication that are opened and subsequently not given (refused or only partly administered) are destroyed. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. 12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. b. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately.