

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 08/28/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure dignity was maintained for 1 of 14 residents (Resident #1) reviewed for respect and dignity. The Administrator failed to respect and ensure Resident #1's dignity when he made an obscene hand gesture towards the resident. This failure placed residents at risk for loss of self-worth and emotional distress and failed to ensure the residents' right to be treated with dignity and respect. Findings included: Record review of Resident #1's Transfer/Discharge Report dated 08/27/25 reflected the [AGE] year-old male resident was re-admitted to the facility on [DATE] with a diagnosis of paraplegia. Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident was admitted to the facility on [DATE]. He was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated cognitively intact). In an interview on 08/27/25 at 8:18 AM, the SW stated she began her employment at the facility in April 2025. She stated there was staff turnover around May 2025. She stated on 05/08/25 she was asked to conduct Safe Surveys with the residents due to complaints about the Administrator's inappropriate comments to staff and the residents. She stated the Administrator was suspended 2-3 days while the investigation was conducted by the RNC, but she did not know the specifics. She stated none of the residents she interviewed reported any complaints or concerns regarding the Administrator. In a telephone interview on 08/27/25 at 8:48 AM, the former DON stated Resident #1 informed her the Administrator made an obscene gesture, the middle finger which the resident found to be disrespectful. She stated the obscene gesture and unprofessional comments the Administrator had made to staff and residents to the RDO. She stated about a week after she made the comments the RNC came to investigate. She stated the RNC suspended the Administrator a few days while she conducted the investigation. She stated the RNC did not report the allegations to the State Agency but should have been as required. The former DON stated Resident #1 was not interviewed by the RNC about the specific allegations regarding the Administrator and she believed. She stated the RNC terminated her employment and brought the Administrator back the day after her termination. She stated she believes her termination was retaliation for reporting the Administrator. Record review of the former DON's Disciplinary Action Form dated 05/12/25 revealed, a statement from the former DON, which read, in part, this is done in retaliation to me reporting Administrator, who not only verbally abuse - but also emotionally abused a resident. The form was signed by the former DON and RNC on 05/12/25. Record review of an email from the former DON to the RDO dated 04/30/25 at 7:42 PM which read, in part, I am writing to you today to inform you about something that has been going on in the facility since the Administrator has arrived to the facility. Today a resident by the name of Resident #1 came into my office to explain to me that he felt like he was being mistreated by the administrator. This is not the first time that the resident has voiced to me ill treatment from the Administrator. In this particular instance, the resident came into my office and informed me that yesterday (04/29/25) while he was in the smoking room, the Administrator came up to him in front of an employee and stated Hey Resident #1, I have something for you. At that time the Administrator went into his pocket and pulled out his fist and flipped him off. The resident then informed me that former Housekeeper A saw him do this. He said he felt like this was inappropriate and at no time have he and the Administrator had a relationship in which they would joke around with each other the resident went on to tell me that he and the Administrator do not have a relationship in which it would ever be ok to do those things. In a telephone interview on 08/27/25 at 9:27 AM, the RNC stated the RDO received an email from the former DON alleging the Administrator had verbally abused Resident #1. She stated she suspended the Administrator 3 days, maybe more, while she interviewed the staff who all denied the allegations. She stated she did not interview Resident #1 about the allegations, but she had the SW conduct Safe Surveys and none of the residents, including Resident #1 reported any issues. She stated the decision was made to treat the incident internally and not report the incident to the State Agency. When the RNC was asked by the Investigator if the facility policy was followed regarding reporting, she stated that's a tricky one because everyone denied the allegations. Record review of the RNC's investigation conducted on 05/08/25 reflected a copy of the email from the former DON to the RDO dated 04/30/25, the Safe Surveys conducted by the SW with the residents on 05/08/25 and the RDO's interviews with staff: - The Administrator denied the allegation. - An interview with former Housekeeper B on 5/8/2025 at 2:49 PM reflected, Have you ever been witness to any administrative staff saying or doing anything to a resident/or other staff member that would be considered out of a professional role? If so, can</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure an allegation of abuse was reported immediately to the State Agency as required for 1 of 14 residents (Resident #1) reviewed for abuse reporting. Resident #1 alleged the Administrator made an obscene hand gesture. The allegation was not reported to the State Agency. This failure resulted in the residents' right to be free from abuse not protected, eliminated the opportunity for a timely investigation by the State Agency and placed all the residents at risk for abuse and psychological harm, which resulted in substandard quality of care. Record review of Resident #1's Transfer/Discharge Report dated 08/27/25 reflected the [AGE] year-old male resident was re-admitted to the facility on [DATE] with a diagnosis of paraplegia. Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident was admitted to the facility on [DATE]. He was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated cognitively intact). In an interview on 08/27/25 at 8:18 AM, the SW stated she began her employment at the facility in April 2025. She stated there was staff turnover around May 2025. She stated on 05/08/25 she was asked to conduct Safe Surveys with the residents due to complaints about the Administrator's inappropriate comments to staff and the residents. She stated the Administrator was suspended 2-3 days while the investigation was conducted by the RNC, but she did not know the specifics. She stated none of the residents she interviewed reported any complaints or concerns regarding the Administrator. In a telephone interview on 08/27/25 at 8:48 AM, the former DON stated Resident #1 informed her the Administrator made an obscene gesture, the middle finger which the resident found to be disrespectful. She stated the obscene gesture and unprofessional comments the Administrator made to staff and residents to the RDO. She stated about a week after she made the comments the RNC came to investigate. She stated the RNC suspended the Administrator a few days while she conducted the investigation. She stated the RNC did not report the allegations to the State Agency but should have been as required. The former DON stated Resident #1 was not interviewed by the RNC about the specific allegations regarding the Administrator and she believed the RNC terminated her employment and brought the Administrator back the day after her termination. She stated she believes her termination was retaliation for reporting the Administrator. Record review of the former DON's Disciplinary Action Form dated 05/12/25 revealed, a statement from the former DON, which read, in part, this is done in retaliation to me reporting Administrator, who not only verbally abuse - but also emotionally abused a resident. The form was signed by the former DON and RNC on 05/12/25. Record review of an email from the former DON to the RDO dated 04/30/25 at 7:42 PM which read, in part, I am writing to you today to inform you about something that has been going on in the facility since the Administrator has arrived to the facility. Today a resident by the name of Resident #1 came into my office to explain to me that he felt like he was being mistreated by the administrator. This is not the first time that the resident has voiced to me ill treatment from the Administrator. In this particular instance, the resident came into my office and informed me that yesterday (04/29/25) while he was in the smoking room, the Administrator came up to him in front of an employee and stated Hey Resident #1, I have something for you. At that time the Administrator went into his pocket and pulled out his fist and flipped him off. The resident then informed me that former Housekeeper A saw him do this. He said he felt like this was inappropriate and at no time have he and the Administrator had a relationship in which they would joke around with each other the resident went on to tell me that he and the Administrator do not have a relationship in which it would ever be ok to do those things. In a telephone interview on 08/27/25 at 9:27 AM, the RNC stated the RDO received an email from the former DON alleging the Administrator had verbally abused Resident #1. She stated she suspended the Administrator 3 days, maybe more, while she interviewed the staff who all denied the allegations. She stated she did not interview Resident #1 about the allegations, but she had the SW conduct Safe Surveys and none of the residents, including Resident #1 reported any issues. She stated the decision was made to treat the incident internally and not report the incident to the State Agency. When the RNC was asked by the Investigator if the facility policy was followed regarding reporting, she stated that's a tricky one because everyone denied the allegations. Record review of the RNC's investigation conducted on 05/08/25 reflected a copy of the email from the former DON to the RDO dated 04/30/25, the Safe Surveys conducted by the SW with the residents on 05/08/25 and the RDO's interviews with staff: - The Administrator denied the allegation. - An interview with former Housekeeper B on 5/8/2025 at 2:49 PM reflected: Have you ever been witness to any administrative staff saying or doing</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure allegations of abuse were promptly and thoroughly investigated for 7 of 14 residents (Resident #1, #3, #4, #6, #8, #9, and #12) reviewed for abuse prevention. 1) Resident #1 alleged the Administrator made an obscene hand gesture. Resident #1 was not interviewed regarding the allegation and the incident was not reported to the State Agency as required. 2) Residents #3, #4, #6, #8, #9, and #12 alleged staff members were rude and/or yelled at them. The residents' allegations were documented on the Safe Surveys conducted on 05/08/25, the facility did not initiate an investigation on any of the residents' statements. These failures placed all the residents at risk for abuse and psychological harm, which resulted in substandard quality of care. Findings included: Record review of Resident #1's Transfer/Discharge Report dated 08/27/25 reflected the [AGE] year-old male resident was re-admitted to the facility on [DATE] with a diagnosis of paraplegia. Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident was admitted to the facility on [DATE]. He was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated cognitively intact). In an interview on 08/27/25 at 8:18 AM, the SW stated she began her employment at the facility in April 2025. She stated there was staff turnover around May 2025. She stated on 05/08/25 she was asked to conduct Safe Surveys with the residents due to complaints about the Administrator's inappropriate comments to staff and the residents. 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In this particular instance, the resident came into my office and informed me that yesterday (04/29/25) while he was in the smoking room, the Administrator came up to him in front of an employee and stated Hey Resident #1, I have something for you. At that time the Administrator went into his pocket and pulled out his fist and flipped him off. The resident then informed me that former Housekeeper A saw him do this. He said he felt like this was inappropriate and at no time have he and the Administrator had a relationship in which they would joke around with each other the resident went on to tell me that he and the Administrator do not have a relationship in which it would ever be ok to do those things. In a telephone interview on 08/27/25 at 9:27 AM, the RNC stated the RDO received an email from the former DON alleging the Administrator had verbally abused Resident #1. 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Record review of the RNC's investigation conducted on 05/08/25 reflected a copy of the email from the former DON to the RDO dated 04/30/25, the Safe Surveys conducted by the SW with the residents on 05/08/25 and the RDO's interviews with staff: - The Administrator denied the allegation. - An interview with former Housekeeper B on 5/8/2025 at 2:49 PM reflected, Have you ever been witness to any administrative staff saving or doing anything to a resident/or other staff member that would be considered out</p>		