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	11/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the resident's free of physical and chemical restraints that were not medically indicated for 1 of 15 residents (Resident #1) observed for physical restraints in that; The facility failed to ensure Resident #1 had a physician order, consent and evaluation for a chest restraint used for positioning and mobility. This failure could place residents at risk of injuries or entrapment. Findings include: Review of Resident #1's admission record, dated 10/09/25, revealed he was a 25 -year-old male admitted on [DATE] with the following diagnoses: spastic quadriplegic cerebral palsy (a type of cerebral palsy that affects all four limbs, causing stiffness, tightness, and difficulty with movement) and a history of falling. Review of Resident #1's quarterly MDS assessment, dated 08/29/25 revealed staff performed an assessment for mental status and Resident #1's cognitive skills for daily decision making were moderately impaired. The MDS further revealed Resident #1 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with positioning, mobility and transfers. The MDS revealed Resident #1 did no use a trunk restraint, limb restraint, chair that prevents rising or other restraint in his chair. Record review of Resident #1's comprehensive care plan, undated, revealed he did not have a care plan for restraints or a care plan for the chest harness used. The care plan further revealed Resident #1 was totally dependent on staff for activities of daily living and transfers. Record review of Resident #1's order summary report dated 10/09/25 revealed no physician order for a chest harness or chest restraint. Record review Resident #1's medical record revealed no consent or completed evaluation of need for a chest harness or chest restraint. Record review of a facility document titled, Social Services Assessment for Resident #1, dated 06/17/25, revealed: Section B - Physical Functional Status:3. Are restraints currently being used with this resident?Answer - yes3b. If yes, describe type and reason for restraint use:Answer - [Resident #1] utilizes a stability device across his wheelchair to prevent slipping out of his chair. Observation on 10/09/25 at 10:33 AM revealed Resident #1 sitting up in his wheelchair in the TV area. Resident #1 was noted to have a specialized chair and a chest harness was noted across Resident #1's chest and strapped to the back of the chair. A buckle was noted on the chest harness and was currently buckled. During an interview on 10/09/25 at 4:20 PM, LVN A stated Resident #1 used the chest harness to help prevent him from falling. LVN A stated she did not think Resident #1 could remove the chest harness by himself. LVN A stated Resident #1 would be able to answer yes or no questions from the surveyor. During an observation and interview on 10/09/25 at 4:21 PM, Resident #1 was sitting in his wheelchair in front of the nurse's station by LVN A. Resident #1 was asked if staff put the chest harness on him daily and Resident #1 nodded yes. Resident #1 was asked if he could unbuckle the chest harness and Resident #1 shook his head no. During an interview on 10/09/25 at 4:23 PM, the ADM and the DON stated the chest harness on Resident #1 was used as a position changing device. The ADM stated the chest harness was made specifically for Resident #1's chair and it was his understanding that the chest harness was not a restraint. The ADM stated Resident #1 would fall if he did not have the chest harness due to Resident #1's spasticity (when muscles become abnormally stiff and tight, leading to involuntary muscle spasms, jerking, and difficulty with movement). Attempted phone interview on 10/09/25 at 5:20 PM with the physician for Resident #1 revealed no answer. During an interview on 10/09/25 at 5:25 PM, the DON stated all of the nursing staff were responsible for ensuring residents had a physician order for a position changing device. The DON stated he was ultimately responsible if a resident had a restraint. The DON stated Resident #1 did not have a restraint, he had a position changing device. The DON stated if a resident had any type of restraint, it would need a risk assessment, consent and physician order. The DON stated the residents would also need physician orders to check placement and the skin around the restraint. The DON stated Resident #1 would fall if the chest harness was not used for him. During an interview on 10/09/25 at 5:37 PM, the ADM stated he was ultimately responsible for ensuring residents had a physician order, consent and assessment for any restraint used. The ADM stated the facility did not consider the chest harness for Resident #1 to be a restraint. The ADM stated Resident #1 used the chest harness as a position changing device. The ADM stated a potential negative outcome to the residents if they did not have a physician order for a restraint was a risk of being physically harmed because it was a device. Record review of the facility's policy titled, Use of Restraints with a revised date of April 2017, reflected the following: Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after