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 02/04/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident maintained acceptable parameters of nutritional status, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise, for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to implement interventions to ensure that Resident #1 did not have a significant weight loss of 16.8 pounds, a 10% body weight loss, between 12/03/2026 and 01/16/2026. This failure could place residents at risk for decreased nutritional status, malnutrition, and a decline in health.Record review of Resident #1's face sheet dated 02/04/26 reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included: compression fracture of lumbar vertebra (fracture of a spinal bone in the lower back), Type 2 Diabetes Mellitus (a disease resulting in inadequate control of glucose in the blood), osteoporosis (a disease that weakens bones), and cognitive communication deficit (an impairment in communication effectiveness caused by decreased cognitive processes). Record review of Resident #1's admission MDS assessment, dated 12/09/25, reflected a BIMS score of 15, which indicated the resident's cognition was intact. Further review of MDS, Section D - Mood, indicated the resident did not have a poor appetite. Section GG - Functional Abilities - indicated Resident #1 completed the task of eating independently and required set up and clean up assistance prior to and following the activity. Section K - Swallowing/Nutritional Status, indicated the resident had an admission weight 158 pounds. Record review of Resident #1's Comprehensive Care Plan, initiated on 12/09/25 and revised on 01/13/26, reflected:Problem: [Name] Resident #1 has nutritional problem or potential nutritional problem (diabetes) watches her sugar intake by not eating sugary foods, like fruits, cakes, or cookies. On an LCS Regular diet with thin liquid consistency. Love Spanish foods, dislikes Chinese foods. At breakfast she prefers yogurt, milk, bacon and sausage, BMI 25.4.Goal: [Name] Resident #1 will maintain adequate nutritional status as evidenced by maintaining weight within (3) % of (145.8), no s/sx of malnutrition and consuming at least (75/100) % of at least (3) meals daily through the review date.Interventions:Provide and serve diet as ordered.Provide, serve diet as ordered. Monitor intake and record q meal.RD to evaluate and make diet change recommendations PRN. Record review of Resident #1's Physician's Orders dated 02/04/26 reflected the resident had a diet order for Regular diet, regular texture with thin consistency, for LCS. Further review reflected an order for Mirtazapine Tablet 7.5 MG by mouth at bedtime for appetite stimulant with a start date of 01/28/26. Record review of Resident #1's MAR for January - February 2026 reflected the resident was started on Mirtazapine 7.5 MG on 01/28/26 and had received daily doses since that date. Record review of Resident #1's weight record reflected the following weights:12/03/25 - 158.0 pounds01/04/26 - 145.8 pounds [-5.0% change, -12.2 Lbs.], [-7.7% change, -12.2 Lbs.]01/16/26 - 141.2 pounds [-7.5% change, -16.8 Lbs.], [-10% change, -16.8 Lbs.] Record review of Resident #1's admission nutritional assessment dated [DATE], completed by the DM, reflected the resident's admission weight was 158 (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pounds. Resident #1 was on an LCS Regular diet with thin liquids and an HS snack. Further review reflected the resident consumed meals independently in the resident room and had an oral intake of 50-75%. Interventions: continue current diet regimen prescription. Monitoring and Evaluation: monitor monthly weights, intake and follow up PRN. Record review of Resident #1's meal intake record for December 2025 and January 2026 reflected the resident consumed 51-100% of meals. The intake record reflected Resident #1 consumed 50% or less of a meal on the following dates: 12/18/25, 12/22/25, 12/31/25, 01/01/26, 01/02/26, 01/06/26, 01/10/26, 01/13/26, 01/20/26, 01/23/26, 01/24/26, and 01/28/26. During an observation and interview on 02/04/26 at 11:21 AM Resident #1 stated she was admitted to the facility on [DATE] from another nursing facility following a fall at home that resulted in a fracture in her lower back. The resident stated she was diabetic and had recently started insulin. Resident #1 stated she had lost over sixteen pounds since admission. The resident stated her weight loss was due to having to select foods on her tray that won't run my sugar up. The resident stated she was a picky eater and stated she did not care for some of the foods the facility served. Resident #1 stated she had been weighed once or twice a month since admission. The resident stated she did not recall whether or not she had seen a dietician since she admitted in early December. Resident #1 stated she brought her own protein shakes to the facility and was not offered liquid supplements at the facility. The resident stated she was getting a sandwich as a snack in the morning and in the evening and stated, I had to ask for those. Resident #1 stated she would like to meet with the DM for food choices and diet changes. The resident stated she had not spoken to the ADM or DON about her diet concerns. During an observation and interview on 02/04/26 at 12:37 PM, Resident #1 was served a lunch tray by the ADM. Observation of Resident #1's meal tray card reflected regular tray and consisted of a chicken sandwich on a bun with French fries, lettuce, tomato, mandarin oranges, and tea. Observed Resident #1 taste of the chicken sandwich and French fries. Resident #1 stated, the chicken could be warmer, and the fries are too salty. During an observation and interview on 02/04/26 at 1:10 PM, Resident #1 stated she ate most of her lunch. Observation of the tray revealed 75% of the food was consumed. The resident stated she ate all of the chicken and left a few pieces of the bun and stated she ate all of the mandarin oranges and left a few French fries. Resident #1 stated, It wasn't too bad. During an interview on 02/04/26 at 1:12 PM, CNA A stated she was responsible for passing the lunch trays. She stated Resident #1 had not complained to her about any of her meals since being admitted to the facility. CNA A stated Resident #1 usually consumed between 75-100% of her meals and was getting a sandwich in the morning and evening. CNA A stated if a resident complained of food, she would let the kitchen know and offer the resident an alternative. During an interview on 02/04/26 at 1:19 PM, LVN B stated the CNA's on day shift were responsible for getting resident weights each month. LVN B stated she thought the policy for newly admitted residents was to be weighed upon admission and monthly. She stated the CNA's turned in weights to the DON, who would then notify the physician of changes, if necessary. She stated Resident #1 had not complained to her about her meals and was receiving snacks twice daily. During an interview on 02/04/26 at 1:42 PM, the DON stated Resident #1 was admitted in early December and had a hospital stay of approximately one week shortly after admission. The DON confirmed Resident #1's admission weight of 158 pounds but stated he questioned the accuracy of that weight due to it being recorded as a standing weight and the other weights being recorded as a wheelchair weight. He stated the transportation aide was responsible for obtaining resident weights and she was out of the facility today to transport residents. The DON stated the transportation aide turned in weights to him to enter into the electronic health record, then he or the ADON would notify the physician of weight changes. He stated newly admitted residents were usually weighed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upon admission, weekly for four weeks, then monthly. He stated he was unsure why Resident #1 was not weighed weekly upon admission but stated she had a hospital stay shortly after admitting to the facility, which may have contributed to the resident being missed on weekly weights. The DON stated the DM and RD would be notified if a resident had significant weight changes. He stated a care plan meeting was held for Resident #1 last week and the resident's weight loss was addressed, and an order was obtained from the physician for an appetite stimulant. The DON stated he was unsure why the significant change in Resident #1's weight was overlooked upon the weight change on 01/04/26. He stated he was unsure why the resident was not weighed upon readmission to the facility from the hospital in December. He stated he was unsure if the resident had weight loss in the hospital, but she should have been weighed upon readmission to the facility to determine if her weight had changed. During a phone interview on 02/04/26 at 3:20 PM, the RDN stated she had been servicing the nursing facility for 25 years. She stated her experience with newly admitted residents was that they were weighed weekly for the first month. She stated if a new admission had a weight change in the first month, the nursing facility would reach out to her for a virtual visit if it was between her on-site visits. She stated she had not been consulted by the facility regarding Resident #1's weight loss. The RDN stated she worked alongside the DM to monitor residents for changes and interventions if needed. She stated she had seen Resident #1 shortly after admission to the facility, but the resident had not shown any weight loss at that time. The RDN stated she did not have a note in the computer for the admission visit but stated her notes showed that the resident reported her usual weight was between 145-150 pounds. She stated the resident was on a regular diet for LCS, which meant the resident was served less sugary foods to avoid elevating her blood sugars. She stated she had seen the resident on 01/08/26 and noted some weight loss but felt that the resident's admission weight was inaccurate due to Resident #1's reporting of her normal weight of 145-150 pounds. She stated no recommendations were made at that time. The RDN stated she did not type a note in the electronic health record for the visit on 01/08/26. She stated she would change the diet order to a consistent carbohydrate diet today which meant the resident would be served a meal consisting of approximately 50 to 60 grams of carbohydrates and would provide more choices to the resident for her diabetic preferences. The RDN stated Resident #1 was on her list to be seen in the facility at her next visit, which was scheduled for 02/05/26. During an on-site interview on 02/04/26 at approximately 3:45 PM, the MD stated he was familiar with Resident #1 and had seen her weekly since admission. He stated he was made aware of Resident #1's weight loss last week after a care plan meeting. The MD stated he had written an order for the resident to have an appetite stimulant and would be seeing Resident #1 while he was at the facility today. He stated he would look for any additional recommendations by the RD and follow the resident's subsequent weight changes. During the follow up interview on 02/04/26 at 4:31 PM, the DON stated the facility policy for obtaining weights of newly admitted residents was that the resident was weighed upon admission and again the following day, upon readmission, and weekly for two weeks. The resident would then be changed to monthly or PRN for a significant weight change. He stated he was responsible for determining significant changes in weights and the electronic health record would notify of the significant change upon entering weights. The DON stated if a resident showed a significant change in weight the physician would be notified, and the facility would follow the policy for obtaining weights and implement any new orders. The DON stated he was not aware that resident #1's weight had changed as significantly as it had since admission. He stated he did not feel the admission weight for Resident #1 was accurate, but the resident's weight should have been weighed again and monitored according to policy to determine if there was actual weight loss. He stated the resident was (continued on next page)

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