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	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 3 of 22 residents (Residents #4, #42 and #45) reviewed for advanced directives. The facility failed to ensure Residents #4, #42 and #45, who were listed as a DNR (Do Not Resuscitate), had Out-of-Hospital Do Not Resuscitate (OOH-DNR) forms that did not have missing required information. These failures could place residents at risk of not having their end-of-life wishes honored and incomplete records.Findings included: Resident #4 Record review of Resident #4's admission record, dated 06/25/2026, revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (lung disease), muscle weakness, diabetes (high blood sugar), Hypertension (high blood pressure), and chronic kidney disease. Advance Directive section revealed - DNR. Record review of Resident #4's physician order summary dated 06/25/2026 revealed an order for DNR dated 11/21/2025. Record review of Resident #4's care plan, dated 03/25/2026, revealed care plan for DNR. Record review of Resident #4's Out of Hospital Do Not Resuscitate form dated 11/13/2025 revealed under the final section All persons who have signed above, must sign below acknowledging that this document had been properly completed, revealed no signature of Person's signature. Resident #42 Record review of Resident #42's admission record, dated 06/25/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include cerebral palsy (neurological disorder), muscle weakness, and lack of coordination. Advance Directive section revealed - DNR. Record review of Resident #42's physician order summary dated 06/25/2026 revealed an order for DNR dated 07/13/2020. Record review of Resident #42's care plan, dated 05/11/2026, revealed care plan for DNR. Record review of Resident #42's Out of Hospital Do Not Resuscitate form dated 06/23/2017 revealed under the final section All persons who have signed above, must sign below acknowledging that this document had been properly completed, revealed no signature of attending physician. Resident #45 Record review of Resident #45's admission record, dated 06/25/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include prostate cancer, muscle weakness, dementia (decline in cognitive abilities), depression and hypertension (high blood pressure). Advance Directive section revealed - DNR. Record review of Resident #45's physician order summary dated 06/25/2026 revealed an order for DNR dated 07/18/2024. Record review of Resident #45's care plan, dated 06/22/2026, revealed care plan for DNR. Record review of Resident #45's Out of Hospital Do Not Resuscitate form dated 12/01/2023 revealed, under the Physician's statement, no date. During an interview on 06/25/2026 at 09:52 a.m., the DON stated the SW was responsible for completing resident DNR forms. He stated the SW was currently out of the facility. He stated that the DNR was not valid if missing information. He stated the purpose of a DNR was for residents to be able to express their wishes in the event the cannot. He stated he was not aware the DNRs were missing information. He stated he was not sure if staff were trained. He stated he had no idea what the potential negative outcome could be, but it could be legal. During an interview on 06/25/2026 at 10:36 a.m., the ADM stated the missing signature on Resident #4's DNR was a mistake. He stated when he showed Resident #4 the (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
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DNR where she missed signing, Resident #4 agreed to sign it. He stated he would call the doctor and get the signature and date for Resident #42 and #45's DNRs. He stated the purpose of the DNR was to clearly state someone's code status. He stated the SW was responsible for completing the DNR forms and she was not available for interview. He stated he was not aware the DNRs were not completed correctly. He stated the potential negative outcome could be improper identification of code status. Record review of the facility policy titled Advance Directive revised date September 2022 reflected the following: Policy Statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Record review of a blank Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Texas Department of State Health Services Instructions for Issuing an OOH-DNR Order revealed the following: . The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interviews and record reviews, the facility failed to provide comfortable and safe temperature levels for 1 of 1 dining rooms and 1 of 2 Halls (Hall 2) and a clean and comfortable environment for the 1 of 3 Hallways (front hallway). The facility failed to ensure the temperature for the dining room and Hall 2 did not go above 81 degrees Fahrenheit. The facility failed to ensure the front hallway did not have sticky handrails or a clean appearance on the walls and doors. These failures could place residents at risk for living in an unsafe, unclean, uncomfortable, and unhomelike environment which could cause a decline in resident psychosocial well-being.The findings included: During an observation on 06/23/26 at 2:27 PM, the handrail in the front hallway by the business office was noted to have a sticky substance on it. A door in front of Station 2 nursing station labeled Soiled Utility was observed to have black markings on the bottom half of the door. Parts of the wall above the handrail was observed with black markings. The bottoms half of the walls in the front hallway were noted to have black markings from the handrail down to the floor. During the initial pool process on 06/23/26 at 3:20 PM, Hall 2 was observed with the surveyor's thermometer; the inside temperature was 83.2 degrees Fahrenheit. The door was observed open at the end of the hallway and workers were noted with hoses going out the door. No fans or air conditioners were noted in Hall 2 at this time. During an observation on 06/23/26 at 3:34 PM, the hallway leading to the dining room and back door were observed with black markings on the two sides of the hallway frame. The black markings started around the middle and went down towards the floor. During an observation on 06/23/26 at 4:31 PM, the thermostat on the wall in the dining room read 83 degrees Fahrenheit. During a confidential family interview at an undisclosed date and time, one of the family members stated they liked to feed their resident in the front sitting area of the nursing home. The family member stated the dining room was too hot for them to eat in there comfortably. The family member stated it has been hot like this at the nursing home for a while now and it was mainly in the dining room and on Station 2 in the evenings. The family member stated their resident resided on Station 2 and they had to buy several fans for the bedroom to help the resident stay cool. During a confidential resident interview on 06/24/26 at an undisclosed time, the resident stated their room was on Station 2 and it had been getting hot in the evenings. The resident stated they had to buy a fan for their bedroom so they can keep cooler at night. The resident stated staff had been told about the heat and they said the AC was on. During an observation on 06/24/26 at 4:41 PM, the thermostat on the wall in the dining room read 83 degrees Fahrenheit. During an interview on 06/25/26 at 10:43 AM, the MS stated a compressor had been replaced for the AC in the back by the dining room a few weeks ago. The MS stated he felt like the AC had gone back to normal after the compressor was fixed. The MS stated the AC was mainly an older system and when the temperatures start to rise outside, they rise some on the inside. The MS stated none of the residents had complained to him about the heat, only the staff. The MS stated people were constantly going in and out of the dining room door to smoke and the AC won't cool down with the door open. The MS stated the facility had to turn off the AC on Station 2 the other day (06/23/26) and the door remained open at the end of the hall for repairs to be made. The MS stated he did not supply extra fans or AC units to the residents during the time the AC was off and the door at the end of Station 2 Hall was opened. The MS stated the hallways only have 1 vent for the hallway and the resident rooms each have a vent for the AC. The MS stated the hallways do get a little hot if the residents keep the doors to their rooms closed. The MS stated he felt like the AC for the facility was sufficient if all the residents kept their doors open. The MS stated a risk to the residents was overheating. During an interview on 06/25/26 at 11:02 AM, the HSK Director stated the bottom parts of the walls were cleaned with a flat mop daily. The HSK Director stated the bottom half of the walls in the hallways were a different texture and the black markings do not always come off. The HSK Director stated the handrails were cleaned throughout the day. The HSK Director stated she (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	walked through the halls and the resident rooms every day to monitor how her staff were cleaning. The HSK Director stated the staff were trained to clean all areas at the facility, including the walls and the doors. The HSK Director stated a potential risk to the residents was a possible infection with the handrails being dirty. During an interview on 06/25/26 at 1:27 PM, the ADM the facility had a waiver for the central air and heat exchange. The ADM stated the thermostats in the hallways and in the dining room did not have a vent near it and had poor airflow. The ADM stated he did not believe the thermostat reading in the dining room was accurate. The ADM stated the facility did hydration rounds for the residents when the door was open on Station 2 and the AC was off on Tuesday (06/23/26). The ADM stated the facility does its best to maintain the resident rooms to be in regulation for temperature. The ADM stated a potential risk to the residents with the temperature being above 81 degrees Fahrenheit was dehydration. The ADM stated just because the walls have a change in color does not mean the wall was dirty. The ADM stated he expected the staff to clean the handrails and the walls daily. The ADM stated the walls had multiple layers of paint and that could also be a reason why some areas were discolored. The ADM stated he did not believe there was a specific risk to the residents because the facility was clean in his opinion. During an observation on 06/25/26 at 3:57 PM, the thermostat in the dining room read 82 degrees Fahrenheit. The surveyor had a hand thermometer that read 82.5 degrees Fahrenheit by the drinks station in the dining room, and the reading was confirmed by the DM. Record review of the facility document titled, Maintenance Log, dated from 02/25/26 to present, no work orders were noted related to the temperatures.Record review of the facility policy titled, Homelike Environment, with a revised date of February 2021, reflected the following: Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.Policy Interpretation and Implementation:.2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:a. clean, sanitary and orderly environment.h. comfortable and safe temperatures (71 degrees Fahrenheit - 81 degrees Fahrenheit.Record review of the facility policy titled, Cleaning and Disinfection of Environmental Services, with a revised date of August 2019, reflected the following: Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA bloodborne pathogens standard.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles and stored in locked compartments for 2 of 4 carts (Station 1 Treatment Cart, and Station 2 Nurse Aide Medication Cart) reviewed for medication storage. 1. LVN F failed to ensure the Station 1 Treatment Cart was secured when unattended. 2. MA D failed to ensure the Station 2 Medication Aide Cart did not contain loose pills. These failures could place residents at risk of not receiving prescribed medications as ordered, having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversion.1. During an observation on 06/23/2026 at 2:26 PM, the treatment cart was in front of the business office unlocked and unattended. No staff or residents were observed around the treatment cart at that time. During an interview on 06/23/2026 at 2:29 PM LVN F stated she went to help a resident and was assisting him to his room. LVN F stated she was supposed to keep her cart locked when she walked away. LVN F stated she was trained to lock her cart but could not remember when. LVN F stated a risk to the residents was they could drink something or squirt something in their mouth. 2. During an observation and interview on 06/23/2026 at 3:39 PM, the Station 2 Medication Aide Cart was observed with MA D. Five (5) loose pills were found in the drawers of the medication cart. MA D placed the pills in a dispensing cup and gave them to the DON for identification. The DON identified the medication as potassium chloride 10 mEq (1 tablet), gabapentin 600 mg (1 tablet), Eliquis 2.5 mg (1 tablet), haloperidol 5 mg (1 tablet), and Lasix 40 mg (1 tablet). The DON took the identified medications to be destroyed. MA D stated the medication cart should not contain loose pills. She stated she was responsible for the cart while she was on duty. MA D stated she usually checked the cart every weekend for loose or expired medications. She stated she was trained on proper medication storage in her medication aide education and at the facility through in-services conducted by nursing administration. MA D stated the medication carts were audited by the pharmacy consultant and checked randomly by nursing administration for secure storage and cleanliness. She stated a potential negative outcome for loose medication on the cart was that a resident could miss a dose of medication or the pharmacy may not refill the medication early. During an interview on 06/25/2026 at 11:10 AM, the ADM stated he was not aware there were loose pills on the cart or that a treatment cart was observed unlocked and unattended. He stated the ADM and DON were responsible for ensuring medications were properly stored and secured. The ADM stated all staff had been trained on medication storage through in-services and pharmacy consultant audits. He stated his expectation of staff was that all medications are properly and securely stored. The ADM stated a potential negative outcome for loose and unsecured medications was injury to a resident up to death due to a resident getting a wrong medication or dose. During an interview on 06/25/2026 at 1:58 PM, the DON stated he was unaware of loose medications on the cart until the medication cart audit was completed. He stated medications should not be loose in the cart and the cart should be secured at all times when unsupervised. He stated the MA's and nursing staff were responsible for assuring medications were properly stored on the carts. The DON stated all staff were trained on proper medication storage through in-services and carts were monitored by the pharmacy consultant conducting cart audits monthly during onsite visits. He stated a potential negative outcome for unsecured medications on the carts was a resident could miss a dose or get a wrong dose. Record review of the facility's policy titled Storage of Medications (Revised November 2020), revealed the following: Policy Statement The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medication.2. Drugs and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	biologicals are stored in the packaging, containers or other dispensing systems in which they are received.6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in used. Unlocked medication carts are not left unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food safety. -The facility failed to ensure foods were properly stored in the refrigerator, freezer and pantry.-The facility failed to ensure the food preparation table, ice chest, walls and fire extinguisher were cleaned. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During the initial tour of the kitchen on 06/23/26 beginning at 9:13 AM the following items were observed:- 1 bag of red grapes in the refrigerator in a gallon-sized bag dated 6/19/26 to 6/25/26 that was not fully sealed.- 1 bag of hamburger buns (8 buns) in the pantry dated 6/16/26 to 6/22/26.- 1 large container of brown sugar in the pantry dated 6/8/26 to 8/8/26 that was not fully sealed.- 1 box/bag of cookies in the freezer not fully sealed.- a dried, white substance could be seen and felt on the side of the food preparation table. - the ice machine in the dining room was observed with black unknown substance on white area inside where the ice was dispensed. During an interview on 06/23/26 at 9:30 AM, the DM stated the facility had received a food order that morning and she had made space in the refrigerator, so the grapes were not fully sealed because she did not check to see if they were when she put them in the bag earlier. The DM stated the cookie box/bag was opened from the wrong side and that was most likely the reason they were not fully sealed in the freezer. The DM stated she had not gone through the pantry yet and that was why the hamburger buns were still on the shelf. The DM stated one of the cooks had used the brown sugar for breakfast and that was why the brown sugar was not fully sealed. The DM stated she did not know what was on the side of the food preparation table and stated the kitchen was cleaned daily. The DM stated the ice machine was last cleaned when the Health Department was in the facility on 4/28/26. The DM stated she was responsible for keeping up with the cleaning of the ice machine. During an observation on a return visit to the kitchen on 06/23/26 at 11:55 AM, a black substance was observed on the bottom half of the wall by the back door and sink and the fire extinguisher by the microwave was noted to have a thick layer of dust. During an interview on 06/25/26 at 10:09 AM, the DM stated she did not know the last time the fire extinguisher had been cleaned, maybe about 6 months ago. The DM stated the walls in the kitchen were last cleaned about 2 months ago when a part of the kitchen was painted. The DM stated she was responsible for ensuring the kitchen was cleaned and food was properly sealed or removed from the shelves if no longer good to use. The DM stated she provided an in-service about once a month for the kitchen staff and she went over any issues and reminders about cleaning. The DM stated a potential risk to the residents was a fly or something could get into the food and the residents could get sick. During an interview on 06/25/26 at 1:27 PM, the ADM stated he expected the food to be stored the proper way to keep food safe and hygienic for the residents. The ADM stated the dietician did a recent inspection of the kitchen on 6/17/26 and he did not know why some food was not stored properly. The ADM stated a potential negative outcome for the residents was a risk for cross-contamination. Record review of the facility policy titled, Food Receiving and Storage, with a revised date of November 2022, reflected the following: Policy Statement: Food shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation:.Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled and dated. Record review of the facility policy titled, Sanitization - Kitchen with a revised date of November 2022, reflected the following: Policy Statement: The food service area is maintained in a clean and sanitary manner.Policy Interpretation and Implementation:1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.2. All utensils, counters, shelves, and equipment are kept clean.10. Ice machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 2 of 2 dumpsters (dumpsters #1 and #2) and 1 of 1 (Oil Container #1) oil disposal container, in that:The door for dumpster #1 was left open.Dumpster #2 had no plug and was leaking an unidentified substance on the concrete.There was an unidentified substance build-up on top of the oil container #1 and the lid was opened.These failures could place residents at risk of exposure to germs and diseases carried by vermin and rodents.The findings included: Observation on 06/24/2026 at 11:03 a.m., revealed the facility's dumpster area, which was behind the kitchen had 2 commercial-size dumpsters (#1 and #2). Dumpster #1 had no drain plug. Dumpster #1 had unknown liquid substance draining from the bottom onto concrete in front of the dumpster. Dumpster #2 observed with lid open. Observed oil container #1 with unknown substance build-up on top of container and lid open. Observation on 06/25/2026 at 10:11 a.m., revealed dumpster #1 with an unknown liquid substance draining from the bottom onto the concrete in front of the dumpster. The oil container #1 lid was opened. During an interview on 06/25/2026 at 11:30 a.m., the MS stated that anyone who used the dumpster was responsible for making sure the lid and doors were closed. He stated the dumpster should have a plug. He stated he was not aware the dumpster did not have a plug. He stated kitchen staff did not use the oil disposal container located outside. He stated he was not sure who maintained the oil disposal container. He stated tried to contact a company for removal but was not able to find anyone to service the oil disposal container. He stated the dumpsters were provided by the city. He stated he was not sure what a potential negative outcome would be. During an interview on 06/25/2026 at 11:49 a.m., the ADM stated all staff were responsible for making sure the dumpster doors were closed. He stated staff were trained in properly disposing of trash and oil. He stated the dumpsters were serviced by the city. He stated unless the dumpster was severely damaged the city would not replace the dumpsters. He stated the city would not put a plug in the dumpsters due to it causing the dumpsters to rust out too fast. He stated he had tried multiple times to have the dumpsters serviced but was denied. He stated he was not sure if the kitchen staff used the oil disposal container. He stated the oil disposal should be serviced when you could not put any more oil in it. He stated he was not sure who serviced the oil disposal container, but it should have a sticker on the container. He stated maintenance and the ADM was responsible for having the oil disposal container serviced. He stated he was not aware the lid was left open on the dumpsters or oil disposal container. He stated he was not aware of any negative outcomes. During an interview and observation on 06/25/2026 02:18 p.m., the DM stated all staff were responsible for making sure the dumpster lids were closed. She stated the kitchen staff dumped oil in the oil disposal container weekly. She stated she had tried to close the lid on the oil disposal container but it would not close due to the build-up on top of the container. She stated she was not sure who serviced the oil disposal container. She stated she was told there was a company sticker with company information on the container. Observed white sticker on front of oil disposal container with no company information. She stated all kitchen staff were trained in properly disposing garbage and oil. She stated she was not aware of any potential negative outcome since the dumpsters and oil disposal container was located outside the facility. Record review of the facility policy titled, Food-Related Garbage and Refuse Disposal, revised date October 2017, reflected the following: Policy Statement: Food-related garbage and refuse are disposed of in accordance with current state law.Policy Interpretation and implementation:1. All food waste shall be kept in containers.2. All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use.5. Garbage and refuse containing food waste will be stored in a manner that is inaccessible to pests.6. Storage areas will be kept clean at all times and shall not constitute a nuisance. 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests in the 1 of 1 kitchen, 1 of 1 dining room, 1 of 2 common areas and 1 of 3 Halls (Hall 2) reviewed for physical environment. The facility failed to provide an effective pest control program for flies in the facility. This failure could place residents at risk for vector-borne diseases.The findings included: During an observation on 06/23/26 at 09:15 AM, during initial tour of the kitchen, a fly was seen in the food pantry area and cooking areas.During an observation on 06/23/26 at 9:36 AM, a resident was observed sitting at a table with a coffee cup in front of her. A fly was observed crawling over the lip of the cup and on the inside of the cup. During an observation on 06/23/26 at 11:41 AM during the puree process in the kitchen, several flies were noted in the kitchen area and were observed landing on the kitchen counters and food preparation areas. During an observation on 06/23/26 at 12:36 pm during the food serving line in the kitchen, several flies were noted landing on the steam table and drinks cart. During a confidential interview at an undisclosed date and time, a confidential resident stated a lot of flies have been noticed at the facility. The confidential resident stated the ADM had been talked to about the flies and fly swatters were supplied to the residents. The confidential resident stated the flies were eating them up. The confidential resident stated pest control had not been seen at the facility for flies. During an observation and interview on 06/23/26 at 4:18 PM, a family member was seen waving flies off of a resident in the sitting area by the dining room. Three to four flies were observed around the resident at that time. The family member stated the flies were in and out of the facility all the time. The family member stated she did not like it when the flies landed on the resident's face. During an observation on 06/24/26 at 2:44 PM, a resident was observed in the sitting area by the dining room, and 3-4 flies were flying and landing on him. During an interview on 06/25/26 at 10:43 AM, the MS stated he has not noticed the flies in the facility. The MS stated no one has told him about the flies being a problem. The MS stated pest control was in charge of things like that. The MS stated it was hot outside and there was an increase in flies everywhere. The MS stated the residents were going in and out of the dining room through the back door and that was why the facility had flies. The MS stated he did not know of a risk for the residents regarding flies. During an interview on 06/25/26 at 1:27 PM, the ADM stated pest control goes out to the facility to provide service, but he was not sure if flies were covered. The ADM stated the door was left open on Station 2 on Tuesday (06/21/26) and that could be how the flies got into the facility. The ADM stated the flies were horrible everywhere right now. The ADM stated they did what they could to keep the flies out of the facility and have even provided some of the residents with a fly swatter. The ADM stated he did not believe the flies were excessive at the facility. The ADM stated a potential risk to the residents was possible cross-contamination due to the fly process of landing on things. Record review of the facility document for Pest Control revealed on 02/26, ants were treated in Rooms 44-47 around the sinks and bed. A signature was noted on 6/8/26 with location, issue, witnessed by and additional description left blank. Record review of the facility policy titled, Pest Control, with a revised date of May 2008, reflected the following: Policy Statement: Our facility shall maintain an effective pest control program.Policy Interpretation and Implementation:1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.6. Maintenance services assist, when appropriate and necessary, in providing pest control services.

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	675093	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their own established smoking policy for 1 of 18 residents (Resident #59) and 1 of 1 smoking area reviewed for smoking.The facility failed to follow the smoking policy and ensure Resident #59 had a safe smoking evaluation completed.The facility failed to follow smoking policy allowing residents to smoke in non-designated smoking areas.This failure could place residents at risk of an unsafe smoking environment and an increased risk of injury related to smoking. Findings included:Record review of the admission record for Resident #59, dated 06/25/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: hemiplegia and hemiparesis following cerebral infarction (one-sided weakness after a stroke), muscle weakness (generalized), and lack of coordination.Record review of the admission MDS assessment for Resident #59, dated 06/16/26, revealed a BIMS score of 15, indicating Resident #59's cognition was intact.Record review of the care plan for Resident #59, undated, revealed no Problem area related to smoking.Record review of the electronic medical record assessments for Resident #59 revealed no smoking assessments.During an observation and interview on 06/23/26 at 2:32 p.m., Resident #59 stated he was able to go out to smoke by himself and he was able to keep his smoking supplies on him. A pack of cigarettes was observed in Resident #59's front shirt pocket.During an observation and interview on 06/25/26 at 8:58 a.m., Resident #59 was observed in his room with a pack of cigarettes in his front shirt pocket. Resident #59 stated he did not remember a staff member going out to smoke with him to see how he smoked.During an interview on 06/25/26 at 9:50 a.m., the ADM stated he could not locate a smoking assessment for Resident #59 in electronic medical record. The ADM stated the SW completed the smoking assessments in the facility and she was currently out of the facility and not available by phone. The ADM stated he would look on her desk to see if he could locate a paper copy of a smoking assessment for Resident #59.During an interview on 06/25/26 at 1:27 p.m., the ADM stated the SW was responsible for ensuring a smoking safety screen was performed on a resident upon admission. The ADM stated PCC auto populates a safety smoking screen upon admission for every resident. The ADM stated he did not know why the safety smoking screen was missed for Resident #59. The ADM stated the safety smoking screen could have been done on paper due to poor internet at times, but he could not locate one and the SW was not available by phone. The ADM stated the SW was last trained by the previous SW a week or two prior. The ADM stated a potential risk to the residents was that it could put an unsafe smoker with access to smoking supplies.During an observation on 06/24/2026 at 10:30 a.m. observed unknown resident smoking on back patio by the exit door in the no smoking area.During an observation on 06/24/2026 at 11:06 a.m. observed no smoking signs above the windows on the back patio. Observed ashtray on back patio between the windows with no smoking signs. Observed red trash can on back patio in the no smoking area.During an observation on 06/25/2026 10:09 a.m. observed resident smoking on back patio by the exit door in the no smoking area.During an interview on 06/25/2026 at 11:49 a.m., the ADM stated the designated smoking area was out the dining room door on the back patio to the left of the metal gate. He stated the facility has several residents who were allowed to smoke unsupervised. He stated the facility has had meetings with the residents about the designated smoking area. He stated the last meeting was held on 03/20/2026. He stated all smoking materials should be on the left side of the metal gate. He stated there were signs posted for smoking and non-smoking areas. He stated he made rounds daily and moves any smoking items found in non-designated areas to the back patio. He stated the residents placed the ashtrays in the non-designated smoking areas. He stated, There is not a 24/7 smoking tenant to monitor smoking. He stated maintenance cleaned the back patio area daily. He stated he was not aware of a potential negative outcome but believed smoking had to be 25 feet from any exit door. Record review of the facility policy titled, Smoking Policy - Resident, revised date August 2022, reflected the following: (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement - This facility shall establish and maintain safe resident smoking practices.Policy Interpretation and Implementation.1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Electronic cigarettes are permitted in designated areas only. Smoking is not allowed inside the facility under any circumstances.6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: .d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation) .8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed, and documented, that it was appropriate for the PRN order to be extended beyond 14 days for 2 of 22 resident (Resident #6 and #45) reviewed for PRN psychotropic medications, in that: Resident #6 continued to have a PRN order for Lorazepam 2 MG/ML after 14 days without a stop date. Resident #45 continued to have a PRN order for Lorazepam 1 MG after 14 days without a stop date. This failure could result in residents receiving antipsychotic medications when contraindicated and could result in residents experiencing adverse drug reactions.The findings include: Resident #6 Record review of Resident #6's face sheet, dated 06/25/2026, reflected a [AGE] year-old-female who was admitted to the facility on [DATE] with diagnoses to include Alzheimer's (cognitive loss), diabetes (high blood sugar), and hypertension (high blood pressure). Record review of Resident #6's quarterly MDS, dated [DATE], reflected Resident #6's BIMS score was 00 which indicated Resident #6 had severely impaired cognitive impairment. The MDS further reflected Resident #6 had diagnoses of Alzheimer's disease and anxiety disorder. Record review of Resident #6 care plan, dated 03/04/2026, reflected a problem for anxiety with interventions to administer medications as ordered. Record review of Resident #6's physician order summary dated 06/23/2025reflected the following orders: Lorazepam oral concentrate 2mg/ml, give 0.25 ml by mouth every hour as needed for agitation/anxiety, dated 09/09/2025 with no end date. Lorazepam oral tablet 0.5mg, give 0.5mg by mouth every 6 hours as needed for agitation/anxiety, dated 09/09/2025 with no end date. Record review of Resident #6's PRN MAR reflected the following: Lorazepam Oral Concentrate 2 mg/ml give 0.25 ml by mouth every hour as needed for agitation/anxiety. Start Date 09/10/2025. Medication administered on 06/01/2026, 06/03/2026 and 06/17/2026. Lorazepam Oral Tablet 0.5mg by mouth every 6 hours as needed for agitation/anxiety. Start Date 09/09/2025. Medication administered on 06/09/2026, 06/13/2026 and 06/14/2026. Resident # 45 Record review of Resident #45's admission record, dated 06/25/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include prostate cancer, muscle weakness, dementia (decline in cognitive abilities), depression and hypertension (high blood pressure). Record review of Resident #45's comprehensive MDS, dated [DATE], reflected Resident #45's BIMS score was a 08 which indicated Resident #45 had moderate cognitive impairment. Record review of Resident #45 care plan, dated 03/04/2026, reflected a problem for anxiety with interventions to administer medications as ordered. Record review of Resident #45's physician order summary dated 06/23/2025reflected the following orders: Lorazepam Oral Tablet 1 MG (Lorazepam) Give 1 mg by mouth every 4 hours as needed for anxiety, dated 11/14/2024 with no stop date. Record review of Resident #45's PRN MAR reflected the following: Lorazepam Oral Tablet 1 MG (Lorazepam) Give 1 mg by mouth every 4 hours as needed for anxiety, start date 11/14/2026. No medication was administered for the month of June. During an interview on 06/26/2026 at 09:52 a.m., the DON stated Residents #6 and #45 were on hospice services and did not need a stop date for the prn psychotropic medications. He stated he did not have additional documentation to support the need for the past 14 days. He stated he was not aware prn psychotropics needed a stop date if the resident was on hospice services. He stated all nursing staff had been trained on prn psychotropic. He stated the nursing staff was responsible for making sure PRN psychotropic medications had stop dates. He stated he added stop dates to Resident #6 and #45 lorazepam prn orders. He stated he had also started an in-service for nurses to make sure the order has a 14 day stop date for all prn psychotropic medications. He stated the potential negative outcome could be unnecessary prn psychotropic medications. During an interview on 06/26/2026 at 10:40 p.m., the ADM stated PRN psychotropic medications were for residents with behaviors. He stated he was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not aware Residents #6 and #45 did not have a stop date on the prn psychotropic medications. He stated the DON and nursing staff were responsible for making sure the order has a 14 day stop date when the order is received. He stated all staff had been trained on PRN psychotropic medications. He stated the potential negative outcome could be residents being over medicated. Record review of the facility policy titled Psychoactive Medications revised date 07/22 reflected the following: Policy: Residents will not receive medications that are not clinically indicated to treat a specific condition.15. Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record.16. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of the medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an assessment accurately reflected a resident's status for 1 of 18 residents (Resident #59) reviewed for accuracy of MDS assessments. -The facility failed to accurately assess Resident #59 for tobacco use on his annual MDS assessment. This failure could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services.Findings included: Record review of the admission record for Resident #59, dated 06/25/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: hemiplegia and hemiparesis following cerebral infarction (one-sided weakness after a stroke), muscle weakness (generalized), and lack of coordination.Record review of the admission MDS assessment for Resident #59, dated 06/16/26, revealed a BIMS score of 15, indicating Resident #59's cognition was intact. The MDS further revealed in Section J that Resident #59 was marked No for Current Tobacco Use.Record review of the care plan for Resident #59, undated, revealed no problem area related to smoking.Record review of the electronic medical record for Resident #59 revealed no safe smoking assessments.During an observation and interview on 06/23/26 at 2:32 PM, Resident #59 stated he was able to go out to smoke by himself and he was able to keep his smoking supplies on him. Observed a pack of cigarettes in Resident #59's front shirt pocket. Resident #59 stated he wanted to come to this facility because of their smoking policy and his previous facility was changing their smoking policies and he did not like that.During an interview on 06/25/26 at 9:53 AM, the MDS Coordinator stated she had completed the admission MDS for Resident #59. The MDS Coordinator stated she was not aware that Resident #59 smoked. The MDS Coordinator stated she checked the resident's chart for a safe smoking assessment and did not see one. The MDS Coordinator stated due to the location of her office and the door to her office being closed most of the time, she was not able to see which residents went outside to smoke. The MDS Coordinator stated she relied on a smoking assessment to be performed for her to know if a resident smokes or not. The MDS Coordinator stated it had been a long time since she was last trained on MDS accuracy. The MDS Coordinator stated a risk to the resident was their care could be missed. The MDS Coordinator stated odds were the care plan was also not completed correctly due to the MDS being inaccurate and that was where the nursing department got their information on how to care for a resident. During an interview on 06/25/26 at 1:27 PM, the ADM stated the MDS Coordinator was responsible for ensuring the MDS was an accurate snapshot in time of care for a resident. The ADM stated the MDS Coordinator was last trained last week sometime, maybe Tuesday (6/16/26) or Wednesday (06/17/26) but he could not remember exactly. The ADM stated he did not know why the MDS Coordinator missed the smoking status for Resident #59. The ADM stated a risk to the resident was that it could inaccurately represent a picture of the resident at that time. Record review of the facility policy titled, Comprehensive Assessments, with a revised date of March 2022, reflected the following: Policy Statement: Comprehensive assessments are conducted to assist in developing person-centered care plans. Policy Interpretation and Implementation:1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025 revealed the following:Section J: Health Conditions.J1300: Current Tobacco Use:Item Rationale - Health-related Quality of Life-The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life.Steps for Assessment -Ask the resident if they used tobacco in any form during the 7-day look-back period.If the resident states that they used tobacco in any form during the 7-day look-back period, code 1, yes. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record and interview staff for any indication of tobacco use by the resident during the look-back period.

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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** Based on observation, interview, 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 include 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 18 residents (Resident #59) reviewed for care plans. The facility failed to develop a care plan for Resident #59 related to smoking. This failure could place residents at risk of not receiving the care required to meet their individual needs. Findings included: Record review of the admission record for Resident #59, dated 06/25/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: hemiplegia and hemiparesis following cerebral infarction (one-sided weakness after a stroke), muscle weakness (generalized), and lack of coordination. Record review of the admission MDS assessment for Resident #59, dated 06/16/26, revealed a BIMS score of 15, indicating Resident #59's cognition was intact. Record review of the care plan for Resident #59, undated, revealed no problem area related to smoking. Record review of the electronic medical record for Resident #59 revealed no smoking assessments. During an observation and interview on 06/23/26 at 2:32 PM, Resident #59 stated he was able to go out to smoke by himself and he was able to keep his smoking supplies on him. A pack of cigarettes was observed in Resident #59's front shirt pocket. During an interview on 06/25/26 at 11:37 AM, the DON stated all of the staff pitched in on the care plans. The DON stated the care plans were a work in progress. The DON stated a smoking care plan was missing for Resident #59 because the care plans were a work in progress. The DON stated there was no risk to the resident if he was safe to smoke unsupervised. During an interview on 06/25/26 at 1:27 PM, the ADM stated he expected the care plan to be an accurate reflection of the care for a resident. The ADM stated he did not know why Resident #59 was missing a care plan for smoking. The ADM stated a risk to the resident was there could be possible negative outcomes towards the resident. Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, with a revised date of March 2022, 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to review and revise the person-centered, comprehensive care plan for 2 (Resident #43 and Resident #49) of 22 residents reviewed for comprehensive care plan revisions.1. The facility failed to ensure Resident #43's comprehensive care plan was updated with the most current information for the resident's smoking status. 2. The facility failed to ensure Resident #49's comprehensive care plan was updated with the most current information for the resident's smoking status. These failures could put residents at risk of not receiving the appropriate care, services, or treatments needed to maintain health.1. Record review of the admission record for Resident #43, dated 06/23/2026 revealed a [AGE] year-old female with an original admission date of 01/16/2022. Resident #43 had diagnoses which included: atherosclerotic heart disease (a heart condition affecting blood supply to the heart), congestive heart failure (a heart condition where the heart is too weak to pump blood efficiently), bipolar disorder (a mental health condition that causes extreme shifts in mood, energy and activity levels), and Type II diabetes mellitus (a metabolic condition affecting blood sugar levels). Record review of the quarterly MDS assessment for Resident #43, dated 06/12/2026, revealed a BIMS score of 15, indicating the resident was cognitively intact. Record review of the Smoking Safety Screen for Resident #43, dated 04/13/2026, revealed Resident #43 was safe to smoke without supervision. Record review of the care plan for Resident #43, undated, revealed, [Resident #43] is a supervised smoker. [Resident #43] will smoke with supervision, with an initiation date of 09/26/2024 and revised date of 03/24/2026. During an interview on 06/23/2026 at 9:46 AM, Resident #43 stated she was unsupervised while smoking at the facility. She stated she was aware of smoking times for residents who smoked with a staff member, but she preferred to go out to smoke alone when other smokers were not present. Resident #43 stated she kept her smoking supplies with her in her room and a safe smoking assessment was done on her within the past year. 2. Record review of the admission record for Resident #49, dated 06/24/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: urinary tract infection (bacterial infection in the urinary system), muscle weakness, and other lack of coordination. Record review of the admission MDS assessment for Resident #49, dated 12/28/2025, revealed Resident #49 had a BIMS score of 14 indicating his cognition was intact. The MDS further revealed Resident #49 currently used tobacco. Record review of the Smoking Safety Screen for Resident #49, dated 04/27/2026, revealed Resident #49 was safe to smoke with supervision. Record review of the care plan for Resident #49, undated, revealed, Focus: Smoker: [Resident #49] is a smoker. He is safe to smoke unsupervised, with an initiation and revised date of 01/08/2026. During an interview on 06/25/2026 at 11:10 AM, the ADM stated he was not aware Resident #43's care plan had not been updated to reflect that the resident was safe to smoke unsupervised. The ADM stated the care plan was utilized by all direct-care staff and IDT members and should reflect the most current status of the resident During an interview on 06/25/2026 at 11:37 AM, the DON stated all of the staff pitched in on the care plans. He stated any IDT member could make changes to the care plan. The DON stated the care plans were a work in progress. The DON stated originally Resident #49 was safe to smoke without supervision and now he was not. He stated he was unsure why Resident #43's care plan had not been updated to reflect that she no longer required supervision to smoke. The DON stated a potential negative outcome for failure to update and revise care plans was that staff may not be aware of changes that were made to a resident's plan of care. During a follow up interview on 06/25/2026 at 1:27 PM, the ADM stated the care plans were revised as needed and quarterly. The ADM stated Resident #49's smoking status recently changed and that was why his care plan had not been updated yet. The ADM stated a possible risk to the residents was they could have possible negative outcomes. During an interview on 06/25/2026 at (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:21 PM, the ADM stated the facility did not have a specific policy for the revision of care plans. He stated the only policies relating to care plans had been provided to the survey team by the facility. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered (Revised March 2022) revealed: PolicyA 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.Policy Interpretation and Implementation.11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.12. The interdisciplinary team reviews and updates the care plan:a. when there has been a significant change in the resident's condition;.d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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	675093	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 residents (Resident #49) reviewed for smoking. The facility failed to ensure Resident #49's smoking items were kept at the nursing station and he received adequate supervision while smoking. This failure could place the residents at risk of inadequate supervision, accidents, and burns which could result in injury.Findings Included: Record review of the admission record for Resident #49, dated 06/24/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: urinary tract infection (bacteria in urinary system), muscle weakness, and other lack of coordination. Record review of the admission MDS assessment for Resident #49, dated 12/28/25, revealed Resident #49 had a BIMS score of 14 indicating his cognition was intact. The MDS further revealed Resident #49 currently used tobacco. Record review of the Smoking Safety Screen for Resident #49, dated 04/27/26, revealed Resident #49 was safe to smoke with supervision. Record review of the care plan for Resident #49, undated, revealed, Focus: Smoker: [Resident #49] is a smoker. He is safe to smoke unsupervised, with an initiation and revised date of 01/08/2026. During an observation on 06/23/26 at 9:40 AM, Resident #49 was observed propelling his wheelchair out to the smoking area with a pack of cigarettes in one hand. During an observation and interview on 06/23/26 at 9:48 AM, Resident #49 was observed putting trash from the cigarette box into a metal ash tray in front of him. Resident #49 finished his cigarette and was observed putting out his cigarette on top of the cigarette box trash in the metal ash tray. Resident #49 stated he was allowed to put trash in the metal ash tray or in the red trash can and the staff take it out to the dumpster. Resident #49 stated he was allowed to keep his cigarettes and lighter on him. No staff members were observed in the smoking area during this time. Interview on 6/25/26 at 11:37 AM, the DON stated Resident #49 last had a smoking evaluation 04/27/26 and it showed that he was safe to smoke with supervision. The DON stated he did not know how Resident #49 was supplied cigarettes and a lighter. The DON stated maybe it was missed because he was originally ok to smoke unsupervised and now, he was not. The DON stated all of the staff were responsible for ensuring Resident #49 was supervised for smoking. The DON stated a potential risk for the resident was burns. Interview on 06/25/26 at 1:27 PM, the ADM stated the last smoking assessment for Resident #49 was performed by him on 04/27/26 and it showed that Resident #49 was safe to smoke with supervision. The ADM stated the smoking assessment was completed 9 days after Resident #49's first smoking assessment that showed he was safe to smoke without supervision. The ADM stated he did not know why he completed another smoking assessment on 04/27/26 that showed a difference in Resident #49's smoking status. The ADM stated according to the most recent smoking assessment for Resident #49, his cigarettes and lighter should be kept locked in the nursing cart. The ADM stated he did not know why Resident #49 had his smoking supplies on him and stated maybe the resident purchased the supplies by himself. The ADM stated no burns or burn marks on clothing had been seen on Resident #49. Record review of the facility policy titled, Safety and Supervision of Residents with a revised date of July 2017, reflected the following: Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and Implementation:.Resident Risks and Environmental Hazards1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:.d. Smoking. Record review of the facility policy titled, Smoking Policy - Residents with a revised date of August 2022, reflected the following: Policy Statement: This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation:.6. Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Smoking status is evaluated upon admission. If a smoker, the evaluation includes:.d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation).14. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco.except under direct supervision.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 2 residents fed by gastrostomy tube (g-tube) (Resident #42), in that: The facility failed to ensure Resident #42's feeding pump was hooked up and infusing at the time ordered by the physician. This failure could result in weight loss and dehydration in residents with a g-tube.The findings included: Record review of the admission record for Resident #42, dated 06/24/26, revealed a [AGE] year-old-male was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include: athetoid cerebral palsy (condition caused by early brain damage), muscle wasting and atrophy (muscles shrink and weaken) and gastrostomy status (g-tube). Record review of the comprehensive MDS assessment for Resident #42 dated 11/05/25 revealed Resident #42 was assessed by staff, and his mental status was severely impaired- he never/rarely made decisions. The MDS further documented Resident #42's Nutritional Approach While a Resident was feeding tube and the proportion of total calories the resident received through a tube feeding was 51% or more. Record review of the current care plan for Resident #42, undated, revealed a problem area for: [Resident #42] is at risk for dehydration related to NPO status, PEG feedings and dependent on staff for all nourishment and hydration. Date Initiated 07/08/2020. Resident #42's care plan revealed another problem area for: [Resident #42] requires nutrition via PEG tube. Jevity 1.5 at 85 mL/hr x 15 hours with H2O at 68 mL/hr x 15 hours via pump. To start at 1500[3pm] and Off at 0600[6am]. NPO diet. Revised on 01/14/2026. Record review of the order summary report for Resident #42, dated 06/24/26, revealed an order for: Jevity 1.5 at 85 mL/hr X 15 hours with H2O at 68 mL/hr X 15 hours via pump. TO START at 1500 AND OFF at 0600. in the evening Place on feeding with a start date of 06/24/26. Record review of the Weight Summary for Resident #42 revealed the following: 4/5/26 - 106.2 LBS, 5/4/26 - 108.0 LBS, and 6/4/26 - 105.2 LBS. During an observation on 06/24/26 at 3:07 PM, Resident #42 was not in his room and his feeding pump was observed next to the bed and was off. During an interview on 06/24/26 at 3:41 PM, LVN C stated Resident #42 normally returned from the Day Center after 4pm daily. During an observation on 06/24/26 at 4:16 PM, 2 CNA's were observed putting Resident #42 back in bed via Hoyer-lift. The feeding pump was next to the bed and was turned off at that time. During an interview on 06/24/26 at 4:18 PM, the ADM stated Resident #43 usually returned to the facility between 4:15 PM and 5:15 PM daily, it depended on what time the bus dropped him off. During an observation and interview on 06/24/26 at 4:42 PM, LVN C was observed in Resident #42's room with a gown and gloves on. LVN C stated she had just changed the dressing for Resident #42's g-tube site and was hooking him up to his feeding at this time. Attempted phone interview on 06/25/26 at 8:40 AM, the Dietician did not answer. A voicemail was left with a call back number. During an interview on 06/25/26 at 9:01 AM, the ADON stated she was covering the shift for Station 2. The ADON stated the city bus was the main transportation for Resident #42. The ADON stated depending on how many stops they had, sometimes the bus dropped Resident #42 off late to the facility. The ADON stated he was always back to the facility by 6 PM. The ADON stated she has not noticed any weight loss or dehydration signs for Resident #42. The ADON stated he looks pretty much the same. The ADON stated the facility had an hour before and an hour after the time that was ordered to put Resident #42 on his feeding. The ADON stated she did not know a possible risk to Resident #42 with his feeding being hooked up late. During an interview on 06/25/26 at 11:37 AM, the DON stated Resident #42 normally got back to the facility from the Day Center a little after 4 PM daily and that was why he did not get hooked up to his feeding at 3 PM. The DON stated Resident #42 had not had a lot of weight fluctuations recently. The DON stated staff were trained to follow physician's (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders regarding g-tube nutrition, but he did not know the last time. The DON stated a possible risk to the residents was that it could lead to weight loss or a UTI. During an interview on 06/25/26 at 1:27 PM, the ADM stated he expected a resident to be fed according to proper nutrition and to follow the dietician's recommendations. The ADM stated he felt like Resident #42 was getting the proper nutrition and hydration, even though Resident #42 was not getting the total 15 hours of formula and hydration as ordered. The ADM stated a possible negative outcome for the resident was losing weight if they received all nutrition through the g-tube. Record review of facility's policy titled, Enteral Tube Feeding via Continuous Pump, with a revised date of November 2018, reflected the following: Purpose: The purpose of this procedure is to provide a guideline for the use of a pump of enteral feedings.Preparation:1. Verify that there is a physician's order for this procedure. Record review of the facility's policy titled, Resident Hydration and Prevention of Dehydration, with a revised date of October 2017, reflected the following: Policy Statement: This facility will strive to provide adequate hydration and to prevent and treat dehydration.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 22 residents reviewed for unnecessary medication (Resident #10).The facility did not monitor Resident #10 for side effects of the anticoagulation medication Apixaban.This failure could place the residents at risk for adverse consequences of medication.Findings included:Record review of Resident #10's face sheet, dated 06/24/2026, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnosis to include quadriplegia (paralysis all 4 extremities), seizures (episode of abnormal [NAME] activity), and hypertension (high blood pressure).Record review of Resident #10's Quarterly MDS Assessment, dated 04/24/2026, revealed Resident #10 had a BIMS score of 15, which revealed the resident's cognition was intact. Section N - Medications revealed Resident #10 received anticoagulant during the last 7 days. Record review of the physician orders dated 06/24/2026 revealed Resident #10 was prescribed 5mg apixaban by mouth two times a day. The orders did not address monitoring the anticoagulant.Record review of a care plan dated 01/07/2026 revealed Resident #10 was on anticoagulant therapy with interventions to monitor/document/report signs or symptoms of anticoagulant complications.Record review of MAR dated 06/24/2026 revealed Resident #10 received 5mg apixaban two times a day as ordered from 06/01/2026 to 06/23/2026. Record review of Resident #10 electronic medical record did not indicate the nurses documented monitoring of side effects of anticoagulant daily with medication administration.During an interview and record review on 06/25/2026 at 09:52 a.m., the DON stated the purpose of monitoring anticoagulation medication was to make sure there was no uncontrolled bleeding. He stated he was not aware the resident did not have an order for monitoring. He reviewed Resident #10's EMR and stated there was no order for monitoring. He stated the order was not added when the order for apixaban was ordered. He stated all staff have been trained to add anticoagulant monitoring when medication was ordered. He stated he was responsible for checking new orders. He stated the potential negative outcome could be uncontrolled bleeding.During an interview on 06/25/2026 at 10:20 a.m., the ADM stated the purpose of anticoagulant monitoring was to ensure that if something happened the resident did not bleed out. He stated he was not aware Resident #10 did not have an order for anticoagulant monitoring but was aware that medication needed monitoring. He stated the DON was responsible for making sure orders were put in the EMR. He stated he was not sure what monitoring system was in place, but he was sure nursing had a system. He stated the potential negative outcome could be resident injury or death.Record review of the facility policy titled, Anticoagulation - Clinical Protocol, revised date 11/2018 reflected the following: .5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 10.34 percent based on 3 errors out of 29 opportunities, which involved 2 (Resident #8 and Resident #43) of 3 residents reviewed for medication administration. 1. MA E failed to give Resident #43's dose of the medication Chlorhexidine Gluconate at the ordered time, due to not having the medication available, resulting in a missed dose. 2. MA E failed to give Resident #8's doses of the medications Apixaban and Propranolol Hydrochloride at the ordered time, resulting in a late dose for each medication. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and a decline in health.1. Record review of Resident #43's admission Record dated 06/23/2026 revealed a [AGE] year-old female with an original admission date of 01/16/2022. Resident #43 had diagnoses which included: atherosclerotic heart disease (a heart condition affecting blood supply to the heart), congestive heart failure (a heart condition where the heart is too weak to pump blood efficiently), bipolar disorder (a mental health condition that causes extreme shifts in mood, energy and activity levels), and Type II diabetes mellitus (a metabolic condition affecting blood sugar levels). Record review of Resident #43's Quarterly MDS assessment, dated 06/12/2026, revealed a BIMS score of 15, indicating the resident was cognitively intact. Record review of Resident #43's current physicians orders revealed an order with a start date of 04/11/2025 for Chlorhexidine Gluconate Solution give 30 ml by mouth two times a day for mouth wash. During a medication administration observation and interview on 06/24/2026 at 8:21 AM for Resident #43, MA E was unable to give the medication Chlorhexidine Gluconate mouth wash due to the medication being unavailable on the medication cart or in the medication room. She stated she was unsure why the medication was not in the facility. MA E stated the medication should be available for dispensing and had been ordered but must not have been delivered yet by the pharmacy. MA E stated she would check with the pharmacy for the status of the reordered medication once she completed her medication pass. She stated if reordered medications were not delivered timely by the pharmacy, the policy was to inform the charge nurse who would check with the pharmacy. During an interview on 06/24/2026 at 8:28 AM, Resident #43 stated she had used Chlorhexidine Gluconate mouthwash, and it was prescribed by her doctor. She stated the MA or nurse brought the mouthwash to her during medication pass. Resident #43 stated she did not recall the date she last used the prescribed mouthwash and stated, sometimes I tell the nurse I don't want it that day because I don't really like it. Resident #43 stated she preferred a different mouthwash and was planning to tell her doctor she wanted to change to the preferred mouthwash the next time she saw him. 2. Record review of Resident #8's admission Record dated 06/23/2026 revealed a [AGE] year-old female with an original admission date of 07/18/2022. Resident #8 had diagnoses which included: atrial fibrillation (a common heart arrhythmia), muscle weakness, and hypertension (high blood pressure). Record review of Resident #8's Quarterly MDS assessment, dated 05/18/2026, revealed a BIMS score of 09, indicating the resident had moderate cognitive impairment. Record review of Resident #8's current physicians orders revealed an order with a start date of 03/08/2024 for Apixaban oral tablet 2.5 mg. Give one tablet two times a day related to atrial fibrillation. Further review revealed an order with a start date of 10/12/2022 for Propranolol HCL tablet 20 mg. Give one tablet by mouth in the morning related to hypertension. Record review of Resident #8's June 2026 MAR revealed Apixaban oral tablet 2.5 mg and Propranolol HCl tablet 20 mg were each ordered to be administered at 7:00 AM. During a medication administration observation and interview on 06/24/2026 at 9:25 AM for Resident #8, MA E dispensed one Apixaban 2.5 mg tablet and one Propranolol HCl 20 mg tablet and administered the medications to Resident #8, which resulted in both doses being late. MA E stated the medications showed late due to being outside the one-hour window from the time the medication was ordered. She stated the medications were given a little over an hour late due to (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting behind on medication pass this morning. She stated, per policy, she would let nursing administration know about the error so notification could be made to the provider. During an attempted interview on 06/25/2026 at 1:56 PM, a telephone call was placed to the facility medical director. There was no answer and a voicemail was left requesting a returned call. During an interview on 06/25/2026 at 3:58 PM, the DON stated he was not aware until after the observed medication pass that physicians orders had not been accurately followed. He stated all staff were trained on accurate medication administration. The DON stated the facility utilized rounds and competency checks for monitoring and training of accurate medication administration. He stated nursing administration was responsible for ensuring accurate and timely medication administration. He stated the pharmacy consultant conducted monthly competency checks for medication administration. He stated medication errors were reported to the provider and noted in the health record. The DON stated a potential negative outcome for failure to follow physicians orders during medication administration was a resident could be injured or suffer harm. During an interview on 06/25/2026 at 3:58 PM, the ADM stated he was not aware that physicians' orders for medications had not been accurately followed until after the medication observation was conducted. He stated nursing administration was responsible to assure staff were administering medications accurately and according to physicians' orders. The ADM stated all nursing staff and MAs were trained on accurate medication administration. The ADM stated the medical director would assist the facility to establish more efficient medication administration times to avoid potential negative outcomes. During a telephone interview on 06/26/2026 at 5:12 PM, MA E stated it was the responsibly of the MA's and nurses to assure medications were available in the facility and given on time, according to physicians orders. She stated when a medication was ordered at a certain time, she had one hour before that time and one hour after that time to be in compliance with the medication administration policy. She stated she did administer Resident #8's medications a little late during the medication pass observation. MA E stated occasionally medications were late due to having to go from one side of the facility to the other and changing carts, which was time consuming. She stated she passed all the scheduled medications in the facility, and she got behind sometimes when she got interrupted or had to wait on a resident to administer their medications. MA E stated the facility utilized liberal med pass, on some medications, meaning she had a longer window to pass those medications, which made it easier for her to administer medications on time. She stated the charge nurses also administered some of the medications, such as insulin, PRN narcotics and eye drops. MA E stated the MAs were allowed to order some medications on the computer system. She stated if the medications were not delivered by the next day, the MA would inform the charge nurse who would then follow up with the pharmacy. MA E stated she was trained on accurate medication administration during her MA training and at the facility through observations and in-services conducted by nursing administration. She stated a potential negative outcome for failure to administer medications according to physicians orders was that a resident could have changes in blood pressure, have an increased in pain, or have heartburn if a medication was not given before a meal. During a telephone interview on 06/30/2026 at 4:54 PM, the medical director stated his expectation for ordered medication was that the medication was given within one hour prior to or one hour following the scheduled administration time. He stated he did not have concerns for a resident receiving Propranolol or Apixaban medications approximately 1.5 hours late. He stated a potential negative outcome for failure to administer medications according to physicians' orders would depend on the medication, but it was important to follow the orders for timing and accuracy of all medications. Record review of the facility policy titled Administering Medications (Revised April 2019) revealed: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .4. Medications are administered in accordance with prescriber orders, including any required time frame.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #42) reviewed for infection control. RN A failed to wear proper PPE (a gown) when providing wound care and administering tube feeding through a PEG tube) for Resident #42 who was on EBP. These failures could place residents at risk for the spread of infection and cross contamination.Record review of Resident #42's admission record dated 06/25/2026, revealed a [AGE] year-old male with an original admission date of 07/16/2012. Resident #42 had diagnoses which included: athetoid cerebral palsy (a neurological condition caused by brain damage before or during birth), gastrostomy (a surgical procedure that creates a small opening through the abdominal wall into the stomach), and muscle weakness. Record review of Resident #42's Quarterly MDS assessment, dated 05/08/2026, revealed - Section C - BIMS score not performed as resident was rarely understood. Section - K - Swallowing and Nutritional Status revealed resident had a feeding tube. Record review of Resident #42's current physicians orders revealed an order with a start date of 05/21/2026 for Wound Care: PEG Tube: Cleanse area surrounding PEG tube with NS or wound cleanser, pat dry and apply treatment as ordered. Further review revealed an order with a start date of 06/24/2024 for tube feeding to run 15 hours per day via pump. An order with a start date of 02/04/2025 revealed: Enhanced Barrier Precautions for G-Tube/Wounds. Gloves and Gown to be worn when providing: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting. Record review of Resident #42's care plan dated 05/22/2026, revealed: [Resident #42] requires nutrition via PEG tube. During an observation and interview on 06/23/2026 at 4:17 PM of wound care and PEG (a feeding tube placed through the abdominal wall into the stomach) tube feeding administration for Resident #42, RN A was observed entering the room for Resident #42 with supplies for wound care. A cart with PPE was observed in the hallway next to Resident #42's door. An Enhanced Barrier Precaution sign was observed hanging next to the door of Resident #42's room. RN A donned gloves prior to providing ordered wound care to the area surrounding the PEG tube site. RN A did not don a gown prior to providing wound care. RN A then provided Resident #42's tube feeding via PEG tube, according to orders. RN A donned gloves and provided the tube feeding without donning a gown prior to the procedure. RN A stated she should have worn a gown prior to providing wound care and tube feeding administration for Resident #42. She stated she was rushing and failed to put her gown on. RN A stated she was trained on EBP through in-services conducted by nursing administration, and she last received training on 06/17/2026. RN A stated the purpose of EBP was to prevent the spread of infection and PPE should be utilized when doing direct care of any resident who has a device such as a catheter or feeding tube or wounds. RN A stated a potential negative outcome for failure to wear proper PPE while performing direct care on a resident who was on EBP was cross-contamination and infection. During an interview on 06/25/2026 at 11:10 AM, the ADM stated he was made aware that a staff member conducted direct care on a resident on EBP without utilizing a gown. He stated the purpose of EBP was to protect residents and staff from the spread of infection. The ADM stated all staff were trained on EBP upon hire and through ongoing training in the facility. He stated, as ADM, he was ultimately responsible to ensure staff were following proper EBP protocol and nursing administration was responsible to ensure the protocol was being followed as well. The ADM stated a potential negative outcome for failure to use proper PPE for a resident who was on EBP was the spread of infection that could cause harm to residents or staff. During an interview on 06/25/2026 at 1:58 PM, the DON stated he was made aware by RN A that she failed to wear proper PPE while performing direct care for Resident #42. He stated the purpose of EBP was to help prevent the spread of MDRO's. He stated nursing administration was (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	06/25/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible to ensure staff were following proper EBP protocol, including utilizing PPE. The DON stated all staff were trained on EBP through in-services conducted at the facility. He stated a potential negative outcome for failure to follow EBP protocol was the spread of infection. Record review of the facility sign posted outside Resident #42's door, titled Enhanced Barrier Precautions, undated, revealed: Everyone must:Clean their hands, including before entering and when leaving room. Providers and staff must also:Wear gloves and a gown for the following High-Contact Resident Care Activities.Device care or use:central line, urinary catheter, feeding tube, tracheostomyWound Care; any skin opening requiring a dressing Record review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022, revealed: Policy Statement Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used an as infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:.g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); andh. wound care (any skin opening requiring a dressing).