STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676325	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Nursing and Rehabilitation Center	8707 Lakeside Parkway San Antonio, TX 78245

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 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 that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Residents #2) reviewed for comprehensive care plans in that: The facility failed to care plan Resident #2's abductor wedge that was needed for her after hospitalization care. This failure could place residents at risk for not receiving care interventions.The findings included A record review of Resident #2's admission record dated 6/3/2026 revealed an admission date of 8/16/2022 and readmission on [DATE] with diagnoses which included generalized muscle weakness. A record review of Resident #2's quarterly MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old female admitted for LTC with ADL. Resident #2 was assessed with a BIMS score of 03 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #2's care plan dated 6/3/2026 revealed no focuses, goals, nor interventions for Resident #2's need for an abduction wedge for her legs. A record review of Resident #2's nursing progress notes for the period 5/15/2026 through 6/5/2026 revealed the following:*On 5/15/2026 Resident #2 was assessed with pain when applying weight to her left leg, NP A received a report and prescribed x-ray images for the left hip which was diagnosed as a left hip fracture on 5/16/2026.*On 5/16/2026 Resident #2 was ordered to be transferred to the hospital for evaluation and treatment and was admitted for after hospital care on 5/19/2026. A record review of Resident #2's hospital records dated 5/17/2026 revealed the Orthopedic Surgeon performed a surgical repair for Resident #2's left hip and ordered for Resident #2 not to rotate her left leg, cross her legs, or flex her hip, orthopedic surgery operative note . post operative plan: the patient will be weightbearing as tolerated to the injured lower extremity. They will be under posterior hip precautions (no internal rotation past neutral, no hip flexion beyond 90 degrees, and no crossing legs) for the first 6 weeks. We will see the patient back in clinic in 2 weeks for a wound check. left hip replacement, abductor pillow in place. A record review of Resident #2's facility therapy department in-service titled Safe positioning in bed dated 5/20/2026 revealed, maintain posterior hip precautions - no hip flexion, no crossing legs, no internal rotation, log rolling; move trunk, hips, and shoulders, as one unit for all turns, use of abduction pillow at all times in supine, abduction knee separator in sitting, . avoid pulling on upper extremities or pelvis. During an interview an observation on 6/3/2026 at 2:40 PM revealed Resident #2 was seated in her wheelchair visiting with her Representative. Resident #2 wore an abductor-wedge in between her legs. Resident #2's Representative stated she participated in a care plan meeting, however the discussion in the meeting never reviewed the details of Resident #2's need for an abduction wedge in between her legs. Resident #2's Representative stated Resident #2 was given the wedge after her surgery at the hospital and was admitted to the facility with the same wedge. Resident #2 Representative stated she believed the facility received the order from the surgeon and knew how to use the abduction web wedge. During an interview and observation on 6/3/2026 at 3:10 PM revealed CNA B attended Resident #2's at her bedside CNA B demonstrated (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's wedge as she laid in bed CNA B stated she had received training from the physical therapy department on applying the wedge and removing the wedge. During an interview on 6/3/2026 at 3:20 PM LVN C stated she was the charge nurse for Resident #2 and stated Resident #2 had a need for an abductor wedge between her legs because Resident #2 has been recovering from a left hip fracture with surgical repair. LVN C stated Resident #2 should not rotate or flex her left leg and the intervention from the therapy department was for Resident #2 to wear the abductor wedge in between her legs. LVN C stated she reviewed Resident #2's medical record and recognized Resident #2 had no care plan interventions detailing the care and use of the abductor wedge. LVN C stated the potential negative outcome could possibly be she received an abductor wedge without an order. During an interview on 6/3/2026 at 4:10 PM the Therapy Director stated Resident #2 was admitted from the hospital on 5/19/2026 after a surgical repair to her left hip and an abductor wedge between her legs was applied at the hospital and was wearing the abductor wedge between her legs. The Therapy Director stated the abductor wedge was used to keep Resident #2's left leg in a straight alinement to the hip socket and restricted Resident #2 from twisting her left leg and prevented Resident #2 from crossing her legs. The Therapy Director stated the potential for harm could be if the wedge was not used Resident #2 could possibly twist her leg, cross her legs, or flex the hip joint which could cause damage to the surgical repair of the hip. The therapy director stated upon admission Resident #2 was assessed by the therapy department as having a need for the abductor wedge and developed and implemented an in-service education for all the nursing staff and began training specific for Resident #2. The Therapy director stated all staff have received the training. The Therapy Director stated she was a member of the IDT team and had met with the IDT team to discuss Resident #2's admission and needs for therapy services which included the use of the abductor wedge. The Therapy Director stated she also attended the care plan meeting on 5/27/2026 and had reviewed Resident #2's care plan and she had not recognized Resident #2 did not have care plan interventions for which reflected the in-service education for the staff. The Therapy Director stated the potential negative outcome could be Resident #2 could be receiving therapies without a care plan. During an interview on 6/3/2026 at 4:45 PM the DON stated she would have to review the details surrounding the abductor-wedge and had no comment at the time. During an interview on 6/4/2026 at 4:45 PM the Administrator stated the expectation was for Residents #2's abduction wedge, which was assessed by the therapy department and the staff was educated, should have been reflected on the care plan. A record review of the facility's undated Care and Treatments policy revealed, it is the policy of this facility that the interdisciplinary team shall develop and complete a comprehensive person-centered care plan for each resident that includes measurable objectives End time frames to meet a residence medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement A baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective in person centered care that meet professional standards of quality care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure, in accordance with accepted professional standards and practices, complete, accurately documented, readily accessible, and systemically organized medical records for each Resident, for 1 of 4 residents (Resident # 2) reviewed for accurate records. The facility failed to obtain an order Resident #2's physician for the use of the abductor wedge. This failure could place residents at risk for receiving care interventions without physicians' orders. The findings included: A record review of Resident #2's admission record dated 6/3/2026 revealed an admission date of 8/16/2022 and readmitted on [DATE] with diagnoses which included generalized muscle weakness. A record review of Resident #2's quarterly MDS assessment dated [DATE] revealed that resident #2 was a [AGE] year-old female admitted for LTC with ADL. Resident #2 was assessed with a BIMS score of 03 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #2's hospital records dated 5/17/2026 revealed the Orthopedic Surgeon performed a surgical repair for Resident #2's left hip and ordered for Resident #2 not to rotate her left leg, cross her legs, or flex her hip, orthopedic surgery operative note . post operative plan: the patient will be weightbearing as tolerated to the injured lower extremity. They will be under posterior hip precautions (no internal rotation past neutral, no hip flexion beyond 90 degrees, and no crossing legs) for the first 6 weeks. We will see the patient back in clinic in 2 weeks for a wound check. left hip replacement, abductor pillow in place. A record review of Resident #2's physician's orders dated 6/3/2026 revealed no orders for Resident #2's abduction-wedge. A record review of Resident #2's facility therapy department in-service titled Safe positioning in bed dated 5/20/2026 revealed, maintain posterior hip precautions - no hip flexion, no crossing legs, no internal rotation, log rolling; move trunk, hips, and shoulders, as one unit for all turns, use of abduction pillow at all times in supine, abduction knee separator in sitting, . avoid pulling on upper extremities or pelvis. During an interview an observation on 6/3/2026 at 2:40 PM revealed Resident #2 was seated in her wheelchair visiting with her Representative. Resident #2 wore an abductor-wedge in between her legs. The Representative stated she believed the facility received the order from the surgeon and knew how to use the abduction web wedge. During an interview and observation on 6/3/2026 at 3:10 PM revealed CNA B attended Resident #2's at her bedside CNA B demonstrated Resident #2's wedge as she laid in bed CNA B stated she had received training from the physical therapy department on applying the wedge and removing the wedge. During an interview on 6/3/2026 at 3:20 PM LVN C stated she was the charge nurse for Resident #2 and stated Resident #2 had a need for an abductor wedge between her legs because Resident #2 has been recovering from a left hip fracture with surgical repair. LVN C stated Resident #2 should not rotate or flex her left leg and the intervention from the therapy department was for Resident #2 to wear the abductor wedge in between her legs. LVN C stated she reviewed Resident #2's medical record and recognized Resident #2 had no physicians' orders detailing the care and use of the abductor wedge. LVN C stated the potential negative outcome could be Resident #2 received an abductor wedge without an order or care plans for the abductor-wedge. During an interview on 6/3/2026 at 4:10 PM the Therapy Director stated Resident #2 was admitted from the hospital on 5/19/2026 after a surgical repair to her left hip and an abductor wedge between her legs was applied at the hospital and was wearing the abductor wedge between her legs. The Therapy Director stated the abductor wedge was used to keep Resident #2's left leg in a straight alinement to the hip socket and restricted Resident #2 from twisting her left leg and prevented Resident #2 from crossing her legs. The Therapy Director stated the potential for harm could be if the wedge was not used Resident #2 could possibly twist her leg, cross her legs, or flex the hip joint which could cause damage to the surgical repair of the hip. The therapy director stated upon admission Resident #2 was assessed by the therapy department as having a need for the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abductor wedge and developed and implemented an in-service education for all the nursing staff and began training specific for Resident #2. The Therapy director stated all staff have received the training. The Therapy Director stated she was a member of the IDT team and had met with the IDT team to discuss Resident #2's admission and needs for therapy services which included the use of the abductor wedge. The Therapy Director stated the potential negative outcome could be Resident #2 could be receiving therapies without physician orders. During an interview on 6/3/2026 at 4:45 PM the DON stated she would have to review the details surrounding the abductor-wedge and had no comment at the time. During an interview on 6/4/2026 at 4:45 PM the Administrator stated the expectation was for Residents #2's abduction wedge, which was assessed by the therapy department and the staff was educated, and Resident #2 should have had a physician order for the abductor-wedge. A record review of the facility's undated Medical Records policy revealed, It is the policy of this facility to ensure every resident has an accurate record. The resident record will contain: . the resident Service plan, physician orders, .