

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Lakeside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the residents for 1 of 3 residents (Resident # 15) reviewed for call light.</p> <p>The facility failed to ensure. Resident # 15's call light was within reach.</p> <p>This failure could place residents at risk of achieving independent functioning, dignity, and wellbeing.</p> <p>Findings include:</p> <p>Record review of Resident 15's face sheet dated 6/18/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident # 15 had diagnoses which included: Guillain-Barre syndrome, (is a rare neurological disorder that occurs when the body's immune system attacks the peripheral nervous system), Paraplegia (is a specific pattern in which you can't deliberately control or move your muscles) and Pulmonary hypertension (condition that occurs when blood pressure in the lungs is higher than normal).</p> <p>Record review of Resident # 15's Quarterly MDS, dated [DATE], reflected a BIMS score of 13, which indicated cognition was intact.</p> <p>Record review of Resident # 15 Quarterly MDS, dated [DATE], reflected under section G, 0130, option # 1 which stated, the patient required assistance X 2.</p> <p>Record review of Resident # 15 care plan dated 1/11/23, revised 5/4/24 revealed that Resident # 15 had an alteration in muscle function related to Guillain [NAME] Syndrome, intervention Be sure call light is with in reach.</p> <p>Observation on 6/18/24 at 10:15 a.m. revealed the call light was not visible for Resident # 15. Resident #15's call light was located inside the nightstand drawer.</p> <p>In an interview with Resident # 15 on 6/18/24 at 10:35 a.m., he stated, I don't like to bother the CNA's .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/18/24, at 10:18 am, LVN B stated that she was the assigned nurse for Resident #15 and mentioned that the call light was located inside the nightstand drawer. She noted that the lack of accessibility of a call light could possibly have a negative impact if Resident # 15 required assistance.</p> <p>During an interview with the DON on June 21, 2024, at 9:05 a.m., she expressed that it was her expectation for call lights to be within arm's length of all residents. She emphasized that the absence of a call light could result in a fall if a resident required assistance. The DON was unaware that Resident #15's call light was not visible. She mentioned that her ADON's were responsible for ensuring that all residents' call lights were within reach, and she monitors this randomly.</p> <p>Record review of the facility's policy titled Call Light/Bell , undated, reflected Place call light with in residents reach.</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307</p> <p>Based on record review and interview, the facility failed to ensure the right to receive written notice of a room change before the change was made for 2 of 2 resident (Resident #41 & Resident #80) reviewed for resident room changes.</p> <p>The facility did not provide evidence that Resident #41 and Resident #80 was given a written notice of a room change before the resident was moved.</p> <p>This deficient practice could affect residents in the facility that are moved without required notification.</p> <p>The findings included:</p> <p>Record review of Resident #41's comprehensive MDS assessment, dated 06/14/2024 reflected a [AGE] year-old female admitted on [DATE] a primary diagnosis of Other encephalopathy (damage or disease that affects the brain) and assessed to have severe cognitive impairment.</p> <p>Record review of Resident #41's face sheet, dated 06/21/2024 listed Resident #41's RP as Resident #41's primary contact.</p> <p>Record review of Resident #80's quarterly MDS assessment, dated 06/03/2024, reflected a [AGE] year-old female admitted on [DATE] with a primary diagnosis of Acute and chronic respiratory failure with hypoxia (not getting enough oxygen into your blood) and was assessed to not have cognitive impairment.</p> <p>Record review of Resident #80's progress notes, dated 05/20/2024 at 11:27 AM, authored by ADON C, reflected Spoke w/ resident about room change. Resident acknowledged understanding and agreed.</p> <p>Interview on 06/18/2024 at 11:40 AM, Resident #41's RP stated she was the primary responsible party for Resident #41 and stated in the last month (May 2024) the facility moved both Resident #41 and her roommate, Resident #80 from room [ROOM NUMBER] to their current room at the end of the hall. Resident #41's RP stated she was not notified of this room change prior to when the change was made and was later notified this communication was made to Resident #41's other family who was not listed as the RP. Resident #41's RP stated had she been notified of the room change then it would have been rejected outright. Resident #41's RP stated she became aware of Resident #41's room change when she visited and could not find Resident #41. Resident #41's RP stated she never received a written notification of the room change and was informed after the room change was made by the DON that the change was made to accommodate a different resident in a different room who would be better equipped in room [ROOM NUMBER] due to its proximity to the nurse's station and a recent fall incident.</p> <p>(continued on next page)</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/18/2024 at 11:54 PM, Resident #80 stated she was requested to move to her current room from room [ROOM NUMBER] approximately 1 month ago (May 2024) to which she initially declined as the DON stated Resident #41 was not going to be transferring with her. Resident #80 stated after her initial declination to move rooms, the DON then returned to request her to move to room [ROOM NUMBER] but then stated Resident #41 was going with her. Resident #80 stated at no point was she provided a written notification of the room change. Resident #80 stated she was requested to move to her current room to accommodate a different resident who recently experienced a fall and was requiring more direct nursing care based on the proximity of room [ROOM NUMBER] to the nurse's station.</p> <p>Interview on 06/20/2024 at 9:52 AM, ADON C stated she was the assigned ADON for Resident #80 and Resident #41's hall. ADON C stated she completed the notification of the room change to Resident #80 and Resident #41 verbally, during which neither disagreed. ADON C stated she did not provide a written notification as she was not instructed to, and only made the room change notification to Resident #80 and Resident #41 based on the instruction provided that day from the DON. ADON C stated she was not familiar with why Resident #80 and Resident #41 were being moved and was only told by the DON of the need to move them.</p> <p>Interview on 06/20/2024 at 10:07 AM, the SW stated she was not part of the room change for Resident #80 and Resident #41. The SW stated the facility protocol during room changes was to verbally request the room change, and if the resident was to refuse, then a 5-day written notification was to be issued, however this was never needed to be utilized as a resident had never refused before. The SW confirmed the staff who made the verbal notification to Resident #80 and Resident #41 was ADON C.</p> <p>Interview on 06/20/2024 at 10:40 AM, the DON stated she and the ADM were both present when the notification of the room change was made to Resident #41 and Resident #80 and stated Resident #80 did not disagree and that was evidenced by the fact that the room change was inevitably made. The DON stated there was no record of the DON and ADM being present for the verbal notification and stated written notifications of room changes were not part of facility protocol as they were only used when a resident was to disagree to the room change. The DON stated the SW would primarily be the one to provide the written notification of the room change but during the room change with Resident #41 and Resident #80 a verbal notification was instead made by herself and the ADM.</p> <p>Interview on 06/20/2024 at 10:54 AM, the ADM stated he did not have record of a written notification of the room change for Resident #41 and Resident #80 due to both residents not objecting to the room change and the room change was made the same day when both he and the DON made a verbal request for Resident #41 and Resident #80 to move from #101. The ADM stated he did not see a potential concern with not providing a written notification because he did not see a potential abusive scenario where a resident would be moved without their consent. The ADM stated his facility protocol regarding room changes was only to issue written 5-day notifications was when a resident was to disagree and stated Resident #80 never disagreed to the room change and further stated Resident #41's RP never complained of the room change to any staff at any time. A request for a facility policy was requested at this time.</p> <p>Facility policy specific to room changes was not provided prior to exit. A request was made to the ADM on 06/20/2024 at 10:54 AM.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>48366</p> <p>Based on interview and record review, the facility failed to demonstrate their response and rationale regarding the resident's council's grievances after group meetings concerning issues of resident care and life in the facility and provide a private space for residents' monthly council meetings for 1 of 1 resident council, in that:</p> <p>The facility failed to demonstrate their response and rationale for such response to the resident council's grievances.</p> <p>The facility failed to provide the resident council with a private space for their monthly meetings.</p> <p>This failure could place residents that participate in a resident council at risk of not having the right to their concerns and grievances followed through with.</p> <p>The findings included:</p> <p>During confidential interviews on 06/19/24 at 02:02 PM, residents stated grievances were not always followed up on and they were concerned the grievances they wrote were not being addressed. They stated they felt they could not make grievances without being reprimanded by staff. They expressed they were not aware they could have resident council meetings without staff.</p> <p>During an interview 06/20/24 on 03:01 PM, the AD revealed she has had meetings for resident council with staff members. She further revealed it was the president's preference to have AD present at all meetings, but other residents did not request the AD to be present at all meetings. She further revealed the resident council meeting was held in the dining room or the conference room.</p> <p>During an interview on 06/21/24 at 10:30 AM, the Activities Director revealed they have had resident council meetings in the dining room due to growing numbers of resident council members. The AD further revealed she put signs up for staff to not walk by the resident council meeting, but it did not stop staff from walking by. She pointed out the nurse's station was near the dining room, and they could not control nurses being present at the nurse's station while the resident council meeting was going on.</p> <p>During an interview on 06/21/24 at 10:56 AM, the ombudsman revealed staff members have always been present at the resident council meetings and she did not know if residents were aware they could have resident council meetings without staff members. She suggested that the AD put signs up to let staff members know to not walk into the dining room to provide privacy to the resident council meeting. She further revealed the facility's grievance system was broken and needed work. She had received complaints from residents about grievances not going anywhere and not being addressed.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/21/24 11:18 AM, the AD revealed sometimes old business and old grievances that have been resolved were not discussed. She further revealed she asked residents if they wanted to discuss old grievances being resolved and some residents in the resident council said no. She revealed it may be important to discuss when grievances had been resolved so residents knew grievances had been addressed. She assumed residents would speak up if they wanted to hear the grievance solutions and did not consider the residents may stay quiet and still want to hear the solutions.</p> <p>Attempts to interview the resident council president were not successful as she was at medical appointments per facility staff.</p> <p>Record review of the facility's Grievance Log for the last 6 months revealed April 2024 was the only one that had Resident Council for 4 out of 6 grievances, reported on 04/17/24 and resolved 04/17/24 with resolution noted to be satisfactory.</p> <p>Record review of the facility's Complaint/Grievance Follow-up Report for these 4 grievances, dated 04/17/24, revealed the person notified of resolution for these complaints was the [resident council president].</p> <p>Record review of the facility's policy titled Grievances, revised 12.2023, reflected, It is the policy of this facility to establish a grievance process that allows the resident(s) a way to execute their right to voice concerns or grievances to the facility or other agency/entity without fear of discrimination or reprisal. And The Grievance Official or designee responds to the individual expressing the concern within (3) three working days of the initial concerns to acknowledge receipt and describe steps taken toward resolution.</p> <p>There were no policies about resident council.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on interviews and record reviews, the facility failed to develop a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality for 1 (Residents #451) of 8 residents reviewed for baseline care plans.</p> <p>Resident #451's baseline care plan, dated 06/18/24, did not reflect any interventions for focus of at risk for falls.</p> <p>This deficient practice could affect residents admitted to the facility and result in missed or inadequate care.</p> <p>The findings included:</p> <p>Record Review of Resident #451's Admission Record, dated 06/18/24, reflected a [AGE] year-old male admitted [DATE] with diagnoses to include fracture of left femur, difficulty in walking, abnormalities of gait and mobility, cognitive communication deficit, and need for assistance with personal care.</p> <p>Record Review of Resident #451's Admission MDS assessment, dated 06/12/24, reflected a BIMS score of 13 out of 15, indicating cognitively intact. His MDS assessment further reflected all questions pertaining falls in section J were not answered.</p> <p>Record Review of Resident #451's care plan, dated 06/18/2024, revealed no interventions for problem At risk for falls r/t (SPECIFY), initiated 06/09/2024, and for problem Has acute/chronic pain r/t, initiated 06/09/2024.</p> <p>Record Review of Resident #451's Fall Risk Evaluation, dated 06/08/24, Resident had 1-2 falls in the last 3 months with a medium risk for falls.</p> <p>Record Review of Resident #451's hospital records, dated 06/05/24, revealed resident was admitted for left femur fracture and left hip contusion following a fall from a previous group home.</p> <p>During an interview on 06/20/24 at 05:00 PM the DON revealed any new admission will have fall interventions in place and staff knew to do this. The DON would not confirm there were no fall interventions on Resident #451's care plan when showed the electronic copy of Resident #451's care plan.</p> <p>Interview and observation of Resident #451 on 06/18/24 at 04:29 PM revealed some fall interventions in place to include: call light within reach, bed in lowest position, room was free from clutter. Resident #451 revealed he has not fallen while in the facility and the staff checked in on him regularly.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of the facility's policy Fall Management System, undated, reflected, Residents with high risk factors identified on the Fall Risk Evaluation will have an individualized care plan developed that includes measurable objectives and timeframes.</p> <p>Record Review of the facility's policy Care Planning, undated, reflected nothing about the baseline care plans.</p> <p>A policy for baseline care plans was requested from the DON on 06/21/24 at 10:27 AM and on 06/22/24 at 10:17 AM. There was not a policy available.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #28) reviewed for pharmacy services.</p> <p>Resident #28 was provided a medication, Prilosec, outside of the ordered time range.</p> <p>This failure could place residents at risk of not receiving the therapeutic effects of their prescribed medications.</p> <p>The findings included:</p> <p>Record review of Resident #28's face sheet, dated 6/20/24, reflected a [AGE] year-old female with an initial admitted [DATE] and diagnoses including: Acute Pancreatitis (condition where the pancreas becomes inflamed (swollen) over a short period of time, Cirrhosis of the Liver (a type of liver damage where healthy cells are replaced by scar tissue) and Hepatic Failure (loss of liver function).</p> <p>Record review of Resident # 28's Quarterly MDS assessment, dated 1/3/24, revealed Resident # 28 was assessed with a BIMS score of 15 which indicated intact cognition.</p> <p>Record review of resident #28's Care Plan dated 8/12/23 revealed the resident had GERD (Gastroesophageal Reflux Disease) with interventions give the resident their medications as ordered.</p> <p>Record review of Resident # 28's Physician orders for June 2023 revealed that Resident # 28 was prescribed Prilosec 20 mg daily at 0630 for GERD (Gastroesophageal Reflux Disease).</p> <p>Record review of medication administration history for Resident # 28, dated 6/20/24, revealed that Prilosec was administered on 6/20/24 at 810 a.m.</p> <p>Observation on 6/20/24 at 915 a.m. revealed that Resident # 28's medication order for Prilosec 20 mg on the electronic medication administration record was red, indicating that the medication was not given as ordered.</p> <p>Interview with CMA A on 6/20/24 at 8:05 am, revealed that medication Prilosec 20 mg for Resident # 28 was scheduled at 6:30 a.m. but administered at 810 a.m because , Resident # 28 does not like to take medication before eating breakfast.</p> <p>Interview with Resident # 28 on 6/20/24 at 10:00 a.m. revealed she has told all nurses that she does not want any medications before breakfast.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/2024 at 10:45 AM, the DON stated that the expectation for certified medication assistants was to administer medications per physician orders and notify the charge nurse of any deviation.</p> <p>The DON stated if a nurse makes a medication error, such as providing medications out of a one-hour window when scheduled, they should inform the DON, physician, and RP. The DON stated the risk of the resident receiving medications outside of physician orders could cause possible side effects. She stated her ADONs currently monitor this task at random, and she oversees this task.</p> <p>A record review of the facility's Policy Medication Administration , dated May 2007, revealed, Any irregularly in pouring or administrating must be reported to the physician .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>47611</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles for, 1 of 4 medication carts observed, in that:</p> <p>The Nurse Medication Cart in the 300 hall contained eleven loose medication pills.</p> <p>This failure could place residents who receive medications at risk for not receiving the intended therapeutic effects of medications.</p> <p>The findings were:</p> <p>Observation on 06/19/2024 at 9:57 a.m. of the 300 Hall Nurse Medication Cart revealed there were eleven loose medication pills inside one of the drawers.</p> <p>During an interview with Nurse E on 06/19/2024 at 9:57 a.m., Nurse E confirmed there were eleven loose medication pills inside a drawer of the Nurse Medication Cart.</p> <p>During an interview with the DON on 06/19/2024 @ 10:27 a.m., she stated medication carts should not have loose medications. They were the responsibility of the nurse that accepted responsibility for the cart, also the medications carts were supposed to be checked bi-weekly by the ADON's and any loose medications were to be identified, followed by a medication count then cross-checked by residents, then disposed of per facility policy.</p> <p>Record review of the facility policy titled Medication Access and Storage revealed, Policy Statement: Medication storage areas are kept clean, well lit, and free of clutter.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48366</p> <p>Based on observations, interviews, and record review, the facility failed to prepare puree food by methods that conserve nutritive value, flavor, and appearance for 1 of 1 kitchen observed for puree preparation.</p> <p>The facility failed to follow the puree diet recipe for Pureed Buttered [NAME] Bread for 06/20/24 lunch.</p> <p>This failure could affect residents on puree diet at risk of receiving inadequate diet that could affect their health.</p> <p>Findings included:</p> <p>Record Review of Week At a Glance week 2 revealed Pureed Buttered [NAME] Bread to be served for pureed diets.</p> <p>Record Review of recipe Pureed Buttered [NAME] Bread, Copyright 2024, reflected Ingredients: white sliced bread, melted margarine, and milk and instructions to add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato consistency.</p> <p>During an observation, interview, and record review on 06/20/24 at 10:11 AM, [NAME] F prepared Pureed Buttered [NAME] Bread not according to the recipe. The recipe was not present while [NAME] F was preparing this recipe. Observation revealed [NAME] F did not add margarine or milk during this preparation. [NAME] F revealed she added chicken broth and water to the pureed white bread menu item. She further revealed the product was not a mashed potato consistency because the foods became hardened when on the steam table due to the liquids evaporating by the time foods were served.</p> <p>During an observation and interview on 06/20/24 at 11:48 AM, the CDM revealed they did not use the Pureed Buttered [NAME] Bread that was made during the pureed foods observation. The CDM further revealed the Pureed Bread that was going to be served for 06/20/24 lunch had ingredients to include bread, margarine, and broth. The CDM stated he would contact the RD to see if broth was okay to use instead of the milk.</p> <p>During an interview on 06/20/24 at 02:06 PM, the CDM revealed the RD stated it was okay to use broth or a liquid with nutritive value instead of milk in pureed recipes due to some residents having an allergy to milk. He further revealed the kitchen did not use the prepared pureed bread that was observed by this surveyor for 06/20/24 lunch.</p> <p>A policy for following recipes was requested from the DON on 06/21/24 at 10:27 AM. There was not a policy available.</p>		

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NAME OF PROVIDER OR SUPPLIER Lakeside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307</p> <p>Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 32 residents (Resident #50) reviewed for safe comfortable environment.</p> <p>The facility failed to ensure Resident #50's room was free of two cracks in the floor, running the length of the room.</p> <p>This deficient practice could place residents at risk of falling due to a tripping hazard created from the floor crack.</p> <p>The findings included:</p> <p>Observation and interview on 06/18/2024 at 12:13 PM, Resident #50's room was revealed to contain two cracks, each measuring approximately 1.5 millimeters in width or slightly larger than the thickness of pencil lead and measuring approximately 12 feet long of one crack and the other measuring approximately 8 feet long. Resident #50 stated she has had this crack in her room for as long as she had been in the room and did not prefer to have the crack in the floor. Resident #50 stated she has expressed the concern to her nursing staff but could not identify individual staff and stated she had not seen maintenance in her room since she had been in this room. Resident #50 stated she has never tripped on the crack and did not believe the crack had grown. Resident #50 stated the crack went underneath her roommate's bed as well but was only visible on her side of the room in front of her bed.</p> <p>Record review of Resident #50's comprehensive MDS assessment, dated 06/14/2024, reflected an [AGE] year-old female admitted on [DATE] with a primary diagnosis of Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (A group of thinking and social symptoms that interferes with daily functioning), and was assessed to have severe cognitive impairment.</p> <p>Interview on 06/20/2024 at 9:30 AM, LVN D stated she has worked at the facility for a few weeks as a medication aide and has never observed the crack in Resident #50's room.</p> <p>Interview on 06/20/2024 at 9:36 AM, LVN E stated she was the charge nurse for Resident #50's hall and had never seen a crack in Resident #50's room at any time.</p> <p>Interview on 06/20/2024 at 9:52 AM, ADON C stated she was the ADON assigned to Resident #50's hall and had never observed a crack in the room and stated if any staff member had observed it, it was facility protocol to submit a work order request in their digital work order logbook.</p> <p>Interview on 06/20/2024 at 10:07 AM, the SW stated she had never received a concern from Resident #50 regarding broken flooring but also that she had never observed it in her room during her routine visits to Resident #50.</p> <p>(continued on next page)</p>		

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

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 06/20/2024 at 10:33 AM, the MS stated he has not received work orders related to Resident #50's room related to floor repair or cracks in the floor. The MS stated he last visited Resident #50's room on 04/12/2024 for a telephone repair and during that visit he did not observe any floor cracks. The MS stated any staff who visit the room could submit a work order. During observation of the crack in Resident #50's room, the MS stated the floor crack was significant and required it to be submitted as an outside vendor request.</p> <p>Observation and interview on 06/20/2024 at 11:42 AM, the ADM stated he was not familiar with any cracks in Resident #50's room and stated he had not received any concerns from Resident #50 related to the state of the bedroom floor. During observation of Resident #50's floor, he stated this was the first time he had observed it before and stated he believed the crack in the floor to not have been observed previously as the bed was potentially rotated in a position that obscured the full length of the crack. The ADM stated even in a 90-degree rotation of the bed, he did not believe staff would have noticed the crack even as the crack was observed to extend past where the bed had covered or would have covered in a 90 degree rotation. The ADM stated the risk of the broken floor to be a potential tripping hazard along with a potential infection control concern as water or contaminates could be harbored in the crack. Policy specific to physical environment and building upkeep was requested at this time.</p> <p>Facility policy specific to physical environment and building upkeep was not provided prior to exit. A request was made to the ADM on 06/20/2024 at 11:42 AM.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>48366</p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain an effective pest control program for 1 of 1 dining room for pests, in that:</p> <p>An unknown number of gnats were surrounding the beverage station (to include cranberry juice, water, coffee, mugs, and glasses) in the dining room for 06/18/24 lunch.</p> <p>This deficient practice could place residents at risk of residing in an environment with pests.</p> <p>Findings included:</p> <p>Observation on 06/18/24 at 11:59 AM revealed an unknown number of flying black living things, surrounding mugs and glasses that were upside down and present in the beverage station. It was further revealed the residents were getting their beverages from this station for 06/18/24 lunch.</p> <p>Observation and interview 06/18/24 12:09 PM with the Activities Director revealed there were bugs around the beverage station. She stated she would get the maintenance director or the dietary department to clean the beverage area.</p> <p>Observation on 06/18/24 at 12:16 PM revealed 8 residents received mugs or glasses from the beverage station that had these black flying bugs around their respective glass and mugs. These glasses and mugs were observed to not be sent to the kitchen for cleaning.</p> <p>Interview on 06/18/24 at 12:16 PM with the Activities Director revealed kitchen was bringing out cleaned mugs and glasses.</p> <p>Interview and observation on 06/18/24 at 12:16 PM with the Housekeeping Supervisor revealed the pest control company came to the facility earlier in the day to clean the area where containers of liquids were available to residents. The Housekeeping Supervisor was observed waving a towel as to try to hit these bugs away from this area.</p> <p>Interview on 06/18/24 at 12:17 PM, Resident #24 and Resident #24's POA revealed there were gnats around the dining room a lot and unaware of why. They expressed dislike when gnats were surrounding them when they were in the dining room.</p> <p>Interview on 06/20/24 at 09:29 AM, the CDM revealed housekeeping oversaw making sure the beverage station was cleaned. Housekeeping were supposed to let them know when anything kitchen related like cups need to be cleaned. He further revealed the kitchen washed all the glasses and mugs from the drink station on 06/18/24.</p> <p>Interview on 06/21/24 at 10:54 AM, the Maintenance Director revealed there were problems with gnats in the dining room and the pest control company targeted this area along with other areas in the facility.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of [Pest Control Company] service log reflected service date of 06/18/24 for general type of pest to service locations to include the dining area. This was confirmed by the Maintenance Director.</p> <p>Record Review of the facility's policy on section: Physical Environment with a subject of Maintains Effective Pest Control Program, undated, reflected An effective pest control program is defined as measures to eradicate and contain common household pests .</p>