

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 07/31/2025
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 6 residents (Resident #89) reviewed for privacy, in that: The facility failed on 7/30/2025 when CNA A and RA B did not completely close Resident #89's privacy curtain while providing incontinent care. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy. The findings include: Record review of Resident #89's face sheet, dated 07/30/2025, revealed an admission date of 12/09/2023 and, a readmission date of 10/03/2024, with diagnoses which included: Dementia (decline in cognitive abilities), Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood),Dysphagia (Difficulty swallowing), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood). Record review of Resident #89's Quarterly MDS assessment, dated 04/25/2025, revealed the resident had a BIMS score of 09, indicating she was moderately cognitively impaired. Resident #89 was always incontinent of bladder and frequently incontinent of bowel and, required total assistance with her ADLs. Record review of Resident #89's care plan, dated 12/20/2023, revealed a problem of has bowel and bladder incontinence r/t Activity Intolerance, Dementia, Disease Process, Impaired Mobility, w/c bound, and Overactive Bladder., with an intervention of TOILET USE: The resident requires extensive assist from (2) staff for toileting. Observation on 07/30/2025 at 10:20 a.m. revealed CNA A and RA B did not completely close the privacy curtains while they provided incontinent care for Resident #89, exposing the resident who could be seen if somebody entered the room. Further observation revealed Resident #89's roommate was in the room. The privacy curtain was folded on itself on one end and was too short to be completely closed. During an interview with CNA A and RA B on 07/30/2025 at 11:11 a.m., when CNA A stated the privacy curtains was not completely closed while they provided care for Resident #89 but it should have been to protect the resident privacy. Neither CNA had noticed the privacy curtain was too short to completely close and were going to notify Maintenance. They stated they received resident rights training within the last year. During an interview with the DON on 07/30/2025 at 3:55 p.m., when DON stated privacy must be provided during nursing care and Resident #89's privacy curtains should have been closed completely. DON stated the staff had received training on resident rights within the year and the training was provided by the ADONs and herself. The DON stated they also check the staff skills annually and as needed. Review of Facility's policy, titled Resident Rights, undated, revealed They also will have the right to privacy, maintain privacy curtains for dressing and when providing care.</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
---	-------	-----------

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 07/31/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

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 07/31/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident Minimum Data Set (MDS) assessment accurately reflected the resident's status for 2 (Resident #48 and Resident #84) of 5 residents reviewed for accuracy of assessments. 1.The facility failed to ensure Resident #48 was coded on his annual MDS assessment dated [DATE] as receiving an antipsychotic medication. 2.The facility failed to ensure Resident #84 was coded on his quarterly MDS assessment dated [DATE] as receiving an antipsychotic medication. This failure could place residents at risk for improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1.Review of Resident #48's admission sheet with an original admission date of 8/31/24 and a re-admission date of 7/16/25, showed a [AGE] year-old male resident with diagnoses including Dementia, Depression, Anxiety, Post Traumatic Stress Disorder, Cholecystitis (inflammation of the gallbladder, often caused by gallstones), Parkinson's Disease (a movement disorder of the nervous system), and Hypertension (high blood pressure). Review of Resident #48's order summary included an order for Nuplazid (Pimavanserin) 34 MG dated 8/30/24, with directions to give 34 MG one time a day for hallucinations. Nuplazid is an atypical antipsychotic indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. Review of Resident #48's annual MDS assessment dated [DATE] documented the resident with a BIMS of 11, indicating moderate cognitive impairment. Further review of the assessment showed in Section N - Medications, N0415. High-Risk Drug Classes: Use and Indication 1. Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days A. Antipsychotic, a blank box under the Is taking column for antipsychotic medication. Review of Resident #48's care plan with a revision date of 9/2/24, documented the resident is on antipsychotic medication use r/t hallucinations with interventions/tasks including Document episodes of behavior; Document non-pharmacological interventions; Pimavanserin as ordered per Medical Doctor (MD); and Quarterly Abnormal Involuntary Movement Scale (AIMS) assessment to be completed. 2.Review of Resident #84's admission sheet with an original admission date of 1/17/23 and a re-admission date of 10/3/23, showed a [AGE] year-old male with diagnoses including Type 2 Diabetes Mellitus, Hypertension, Anxiety, Bipolar Disorder, and Benign Prostatic Hyperplasia (enlarged prostate). Review of Resident #84's order summary included an order for Latuda (Lurasidone) 40 MG dated 4/10/25, with directions to give 1 tablet by mouth one time a day for Bipolar. Latuda is an atypical antipsychotic indicated for the treatment of schizophrenia and bipolar depression. Review of Resident #84's quarterly MDS assessment dated [DATE] documented the resident with a BIMS of 14, indicating intact cognition. Further review of the assessment showed in Section N - Medications, N0415. High-Risk Drug Classes: Use and Indication 1. Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days A. Antipsychotic, a blank box under the Is taking column for antipsychotic medication. Review of Resident #84's care plan with a revision date of 5/20/24, documented the resident receives Lurasidone Psychotropic medication r/t Bipolar disorder with interventions/tasks including Administer medications (Latuda) as ordered. Monitor/document for side effects and effectiveness. During an interview with the MDS Coordinator on 7/30/25 at 2:24 PM, the MDS Coordinator stated she opens the MDS assessment in the scheduled time frame and the interdisciplinary team reviews the medical record and completes their portion of the assessment. The MDS Coordinator stated when the assessment was complete, a registered nurse with Resource Utilization Group (RUG) training will sign the assessment. The MDS Coordinator stated after the assessment has been signed, she will lock and transmit it. The MDS Coordinator stated it was important for the MDS to be accurate, because they use the assessment for quality measures, to perform the care of the patient, and to revise the care plan. During an interview with the DON on 7/30/25 at 4:00 PM, the DON stated her expectation for the MDS assessments is that they are accurate, and if they are inaccurate, her expectation was that they be fixed. During an interview with the DON on 7/31/25 at 9:08 AM, the DON stated they use the Resident Assessment Instrument (RAI) Manual as a reference for the MDS assessments. Review of the RAI Manual (Resident Assessment Instrument) dated October 2024, documented in section N0450: Antipsychotic Medication Review Coding Tips and Special Populations, Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section regardless of why the</p>		

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 07/31/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. 1 container of an orange juice cup was sitting on top of a box of orange juice and was partially opened. 2. A box of graham cracker tart shells was open and the individual shells were not covered. 3. A box of vanilla ice cream cups was open, not dated and contained cups that had opened and spilled out into the cardboard box. 4. A box of strawberries in the freezer was open and the plastic wrap around the strawberries was torn, exposing the strawberries to the air. 5. An individually wrapped glazed donut was in a plastic baggie with smeared marks at the top where the Date and Contents line was located. 6. An undated and unlabeled bag of red juice was located under the juice dispenser and was not connected to the dispenser. 7. The facility failed to store a mop in the proper position in the utility closet. These deficient practices could place residents who received meals and snacks from the kitchen at risk for food borne illness. The findings were: 1. Observation on 07/28/25 at 9:12 am in the kitchen revealed a small container of orange juice sitting on top of a cardboard box of orange juice that had the cardboard lid partially opened and juice had leaked out onto the side of the container. 2. Observation on 07/28/25 at 9:12 am in the kitchen revealed a box of graham cracker crust tart shells that was open, not dated and exposed to the air.3. Observation on 07/28/25 at 9:12 am in the kitchen freezer revealed a box of vanilla ice cream cups that was open, not dated and contained cups that had opened and spilled out into the cardboard box. This appeared to indicate that at some point the containers were not kept frozen and melted so that the contents spilled out. 4. Observation on 07/28/25 at 9:12 am in the kitchen, revealed a box of strawberries in the freezer that was open and the plastic wrap around the strawberries was torn, exposing the strawberries to the air.5. Observation on 07/28/25 at 9:12 am in the kitchen, revealed a baggie of an individually wrapped glazed donut with illegible ink smears on the label part of the bag for date and contents.6. Observation on 07/28/25 at 9:12 am in the kitchen, revealed an undated and unlabeled open bag of red juice located under the juice dispenser laying on a shelf that was not connected to the dispenser. A kitchen employee grabbed the container off the shelf when she noted surveyor was looking at it and said she was going to take it to the trash. 7. Observation of the utility closet in the kitchen on 07/29/25 at 10:00 am revealed a mop stored head-side down in the drain compartment of a mop- bucket. The mop was not in use at the time of the observation. The Dietary Manager was asked if that is where the mop is usually stored he said, 'No, it should be hung up. He then proceeded to try and hang the handle of the mop on a wall mounted mop and broom holder. The holder would not hold the handle so he just took the mop head off, put it in a plastic bag and had one of his employees take it to the laundry. On 07/31/25 at 1:00 pm, a follow-up observation of the closet revealed a mop with the mop head up leaning against the wall of the closet. When asked if this was the proper way to store the mop, the Dietary Manager stated that it should probably be stored with mop head down which was also incorrect. Record review of an undated Policy/Procedure for Dietary Services revealed It is the policy of this facility that the facility shall have an organized food service, appropriately planning, equipped, and staffed to prepare and serve the number of meals created in the kitchen. Under the Procedures, #7 stated All cleaning equipment must be stored in designated area when not in use. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 6-501.16 Drying Mops. After use, mops shall be placed in a position that allows them to air-dry without soiling walls, equipment, or supplies.</p>		

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 07/31/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to 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 disease and infection for 1 of 6 residents (Resident #86) reviewed for infection control, in that: While providing colostomy care for Resident #86, LVN C failed to use proper infection control. These deficient practices could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #86's face sheet, dated 07/30/2025, revealed an admission date of 02/05/2025, and a readmission date of 05/01/2025, with diagnoses which included: Dementia (decline in cognitive abilities), Type 2 diabetes mellitus (high level of sugar in the blood), Dysphagia (Difficulty swallowing), Depression (mood disorder that causes a persistent feeling of sadness and loss of interest), Hypothyroidism (under active thyroid), Hypertension (high blood pressure), Ileostomy status (opening in the abdominal wall allowing for elimination of feces). Record review of Resident #86's Significant Change MDS, dated [DATE], revealed the resident had a BIMS score of 15 indicating no cognitive impairment. Resident #86 required total assistance with her ADLs, was always incontinent of bladder and, had a ostomy. Review of Resident #86's care plan, dated 02/06/2025, revealed a problem of Has an alteration in gastro-intestinal status r/t Diverticulitis with perforation and Ileostomy status. and an intervention of Provide ileostomy care and change bag as needed. Observation on 07/30/2025 at 12:05 p.m. revealed while providing Ileostomy (opening in the abdomen allowing waste to exit the body) care for Resident #86, LVN C, use sanitizer between change of gloves after removing the collection bag and after cleaning the stoma, however LVN C did not sanitize between her fingers. During an interview with LVN C, on 07/30/2025 at 12:25 p.m., she stated she did not realize she did not correctly sanitize her hands but confirmed she should sanitize between her fingers to prevent cross contamination and put the resident at risk for infection. She confirmed receiving infection control training within the year. During an interview with the DON on 07/30/2025 at 3:55 p.m., she stated staff had to sanitize between their fingers while sanitizing to prevent risk of infection for the residents. She confirmed training was provided for the staff at least annually and their skills were check at least annually Review of facility policy, titled Hand Hygiene, dated 10/2022, revealed Using alcohol-based hand rubs. Apply generous amount of product to palm of hands and rub hands together. Cover all surfaces of hands and fingers until hands are dry.</p>		