STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on interview and record review the facility failed to implement written policies and procedures that prohibit and prevent resident abuse for 1 of 5 residents (Resident #1) of five residents whose records were reviewed for abuse. Facility staff did not implement facility policy and immediately notify administration when FM #1 reported on 6/23/24 to LVN A that CNA B was rough with Resident #1 during a transfer. This failure could affect residents by placing them at risk of abuse if the reportable allegations are not reported timely after they are discovered. Findings included: Record review of a face sheet dated indicated Resident #1 is an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, unspecified (Primary, Admission), Pneumothorax, Cognitive communication deficit, Heart Disease, Chronic Obstructive Pulmonary Disease. Record review of a Resident #1's quarterly MDS assessment dated [DATE] indicated a BIMS of 4 which indicated severely impaired cognition. Record review of Resident #1's care plan dated 5/2/24 indicated Resident #1 had a history of pain with a start date of 4/29/24. Staff are instructed to handle gently and try to eliminate any environmental stimuli. During a phone interview on 6/25/24 at 9:55 a.m. FM #1 stated that when Resident #1 returned from the hospital on 6/23/24 after she had been hospitalized for fractured ribs. FM#1 stated she observed that CNA B was rough with Resident #1 when she jerked her up to change her. FM#1 stated she told CNA B that she (FM#1) would change Resident #1 herself. FM #1 stated she reported to LVN A that CNA B was rough with Resident #1. FM#1 stated she was concerned about Resident #1's safety and wellbeing. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 2:50 p.m. LVN A stated that when Resident #1 returned from the hospital and was in her room with FM #1. LVN A stated that FM #1 reported to him that CNA B was real rough with Resident #1. LVN A stated that FM #1 told him that [CNA B] was rough with her and made her get out of bed. LVN A stated that he was not in the room when CNA B assisted Resident #1 and did not think CNA B was the type of person to be abusive. LVN A stated that he had been trained on Abuse and Neglect and trained to report allegations of abuse immediately to the Administrator. LVN A stated that the facility had routine in-services on Abuse and Neglect and to report allegations to the ADM. LVN A stated he did not think CNA B had abused Resident #1 and had FM #1 stated that CNA B hit or punched Resident #1 he then would have reported it. During an interview on 6/25/24 at 3:15 p.m. with the ADM; he stated that when the FM told LVN A that CNA B was rough with the resident, it should had been reported to him. The ADM stated that if the family member had not used the word abused that LVN A may not have thought it was reportable. The ADM stated that had LVN A reported it to him, the facility would have investigated the reported incident. The ADM stated that I just gave in services on ANE and reporting two weeks ago. It is posted all over the building to report to me and my phone number is listed. The ADM confirmed that nothing had been reported to him by LVN A. During an interview on 6/25/24 at 3:24 p.m. with the DON, she stated that if a FM told LVN A that CNA B was rough with Resident #1, LVN A should have reported it to her or the ADM so it could be investigated. The DON stated that rough is not gentle and if someone reported that a staff was rough with a resident, she would have investigated it as the staff was being not gentle and either grabbing or pulling, rushing. The DON stated had it been reported to her, she would report it to the ADM and then report to the state. The DON stated that LVN A had been trained to report suspected abuse or neglect. The DON stated that the person making the complaint would not have to use the word abused and the word rough would be a reportable incident. The DON stated she had not been informed of this incident until now. During an interview on 6/25/24 at 3:53 p.m. with CNA C, stated that if a family member or staff member stated that a staff member was rough with a resident, she would immediately report to the charge nurse and to the Administrator. CNA C stated that she believed the term rough could mean tearing skin, pulling an arm out of socket and if a family member thinks a staff is being rough, they are rough, and it had to be reported. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/27/24 at 3:45 p.m. with CNA B; stated that when Resident #1 returned from the hospital her FM (#1) notified her that Resident #1 was sitting on the edge of the bed and the floor was wet. CNA B stated she entered Resident #1's room and found Resident #1 sitting on the edge of her bed with pants around her ankles. CNA B stated the floor was wet under Resident #1's feet and the pants were the roommates' pants as they were too small for Resident #1. CNA B stated that Resident #1 had been in the hospital and had fractured ribs. CNA B stated she stepped out of the room to get a pull-up for Resident #1. CNA B stated she removed the pants from Resident #1; s ankles, put a pull-up and pants on Resident #1 and then assisted Resident #1 to stand up to pull up the pull up and pants. CNA B stated she put her arms under Resident #1's arms to assist her to stand up and did not use any force nor was rough. CNA B stated after she dressed Resident #1, she assisted Resident #1 back onto her bed and realized that Resident #1's socks were wet. CNA B stated she attempted to remove the socks and the FM told her she would do it herself because she did not want Resident #1 to stand up again. CNA B stated that she had been trained on abuse/neglect and to report any allegations of abuse/neglect immediately to the abuse coordinator, the Administrator. CNA B stated that if someone told her that a staff member had been rough with a resident, she would immediately notify her charge nurse and then immediately would notify the Administrator that an allegation had been made. Record review of the facility's Abuse Prevention policy revised on 10/2023 revealed in part, the facility will provide protection for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect: - Include training for new and existing staff on activities that constitute abuse, neglect, reporting procedures. - Indicators of abuse include, but are not limited to: Resident, staff, or family report of abuse. -Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes. Immediately but not later than 2 hours of after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Record review of the facility's In-service on Abuse and Neglect for LVN A dated and signed 11/4/22 revealed in part: The facility during its orientation program and through ongoing training provides all employees with information regarding abuse and neglect, reporting requirements, prevention, intervention and detection. All personnel, residents, visitors, etc. are encouraged to report incidents of resident abuse or suspected incidents of abuse.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported immediately but not later than 24 hours after the allegation was made for 1 of 5 residents (Resident #1) reviewed for reporting. The facility failed to ensure staff immediately reported an allegation of when FM #1 reported on 6/23/24 to LVN A that CNA B was rough with Resident #1 during a transfer. This failure could affect residents by placing them at risk of abuse if the reportable allegations are not reported timely after they are discovered. Findings included: Record review of a face sheet dated indicated Resident #1 is an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, unspecified (Primary, Admission), Pneumothorax, Cognitive communication deficit, Heart Disease, Chronic Obstructive Pulmonary Disease. Record review of a Resident #1's quarterly MDS assessment dated [DATE] indicated a BIMS of 4 which indicated severely impaired cognition. Record review of Resident #1's care plan dated 5/2/24 indicated Resident #1 had a history of pain with a start date of 4/29/24. Staff are instructed to handle gently and try to eliminate any environmental stimuli. During a phone interview on 6/25/24 at 9:55 a.m. FM #1 stated that when Resident #1 returned from the hospital on 6/23/24 after she had been hospitalized for fractured ribs. FM#1 stated she observed that CNA B was rough with Resident #1 when she jerked her up to change her. FM#1 stated she told CNA B that she (FM#1) would change Resident #1 herself. FM #1 stated she reported to LVN A that CNA B was rough with Resident #1. FM#1 stated she was concerned about Resident #1's safety and wellbeing. During an interview on 6/25/24 at 2:50 p.m. LVN A stated that when Resident #1 returned from the hospital and was in her room with FM #1. LVN A stated that FM #1 reported to him that CNA B was real rough with Resident #1. LVN A stated that FM #1 told him that [CNA B] was rough with her and made her get out of bed. LVN A stated that he was not in the room when CNA B assisted Resident #1 and did not think CNA B was the type of person to be abusive. LVN A stated that he had been trained on Abuse and Neglect and trained to report allegations of abuse immediately to the Administrator. LVN A stated that the facility had routine in-services on Abuse and Neglect and to report allegations to the ADM. LVN A stated he did not think CNA B had abused Resident #1 and had FM #1 stated that CNA B hit or punched Resident #1 he then would have reported it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 3:15 p.m. the ADM stated that when the FM told LVN A that CNA B was rough with the resident, it should had been reported to him. The ADM stated that if the family member had not used the word abused that LVN A may not have thought it was reportable. The ADM stated that had LVN A reported it to him, the facility would have investigated the reported incident. The ADM stated that I just gave in services on ANE and reporting two weeks ago. It is posted all over the building to report to me and my phone number is listed. The ADM confirmed that nothing had been reported to him by LVN A. During an interview on 6/25/24 at 3:24 p.m. with the DON, she stated that if a FM told LVN A that CNA B was rough with Resident #1, LVN A should have reported it to her or the ADM so it could be investigated. The DON stated that rough is not gentle and if someone reported that a staff was rough with a resident, she would have investigated it as the staff was being not gentle and either grabbing or pulling, rushing. The DON stated had it been reported to her, she would report it to the ADM and then report to the state. The DON stated that LVN A had been trained to report suspected abuse or neglect. The DON stated that the person making the complaint would not have to use the word abused and the word rough would be a reportable incident. The DON stated she had not been informed of this incident until now. During an interview on 6/25/24 at 3:53 p.m. CNA C stated that if a family member or staff member stated that a staff member was rough with a resident, she would immediately report to the charge nurse and to the Administrator. CNA C stated that she believed the term rough could mean tearing skin, pulling an arm out of socket and if a family member thinks a staff is being rough, they are rough, and it had to be reported. During an interview on 6/26/24 at 9:35 a.m. with the ADM and DON; ADM stated that the facility completed a self-report of abuse to the state on 6/25/24 and has conducted interviews with LVN A and CNA B to determine who was involved in the allegation of abuse made by a family member. The ADM stated that during their investigation they were able to identify Resident #1 and FM #1 and have interviewed FM #1, LVN A and CNA B regarding the allegation of abuse that CNA B was rough with Resident #1. The ADM stated that CNA B is currently suspended and is not at the facility. The ADM stated that Resident #1 has not returned from the hospital at this time. During a phone interview on 6/27/24 at 3:45 p.m. CNA B stated that when Resident #1 returned from the hospital her FM (#1) notified her that Resident #1 was sitting on the edge of the bed and the floor was wet. CNA B stated she entered Resident #1's room and found Resident #1 sitting on the edge of her bed with pants around her ankles. CNA B stated the floor was wet under Resident #1's feet and the pants were the roommates' pants as they were too small for Resident #1. CNA B stated that Resident #1 had been in the hospital and had fractured ribs. CNA B stated she stepped out of the room to get a pull-up for Resident #1. CNA B stated she removed the pants from Resident #1; s ankles, put a pull-up and pants on Resident #1 and then assisted Resident #1 to stand up to pull up the pull up and pants. CNA B stated she put her arms under Resident #1's arms to assist her to stand up and did not use any force nor was rough. CNA B stated after she dressed Resident #1, she assisted Resident #1 back onto her bed and realized that Resident #1's socks were wet. CNA B stated she attempted to remove the socks and the FM told her she would do it herself because she did not want Resident #1 to stand up again. CNA B stated that she had been trained on abuse/neglect and to report any allegations of abuse/neglect immediately to the abuse coordinator, the Administrator. CNA B stated that if someone told her that a staff member had been rough with a resident, she would immediately notify her charge nurse and then immediately would notify the Administrator that an allegation had been made. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes dated from 6/19/24-6/25/24 revealed no progress notes entered by LVN A regarding FM#1 allegation that CNA B was rough with Resident #1. Record review of the facility provided Incident/Accident and Grievance records dated from 6/19/24-6/25/24 revealed no documentation that LVN A reported the allegation made by FM#1 that CNA B was rough with Resident #1. Record review of the facility's Abuse Prevention policy revised on 10/2023 revealed in part, the facility will provide protection for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect. - Include training for new and existing staff on activities that constitute abuse, neglect .reporting procedures. - Indicators of abuse include, but are not limited to: Resident, staff, or family report of abuse. - Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes. Immediately but not later than 2 hours of after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Record review of the facility's In-service on Abuse and Neglect for LVN A dated and signed 11/4/22 revealed in part: The facility during its orientation program and through ongoing training provides all employees with information regarding abuse and neglect, reporting requirements, prevention, intervention and detection. All personnel, residents, visitors, etc. are encouraged to report incidents of resident abuse or suspected incidents of abuse.

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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 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** 43849 Based on interview and record review, the facility failed to implement a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident # 2) of 8 Residents reviewed for comprehensive care plans. - The facility failed to identify and develop an intervention for Resident #2's behaviors of exposing his penis and urinating on the floor in the unit in Resident #2's comprehensive person-centered care plan. This failure could affect residents currently in the facility receiving care per comprehensive person-centered care plans resulting in resident no being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of a face sheet dated indicated Resident #2 is an [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease with early onset, Major depressive disorder, Dementia-mild with agitation, Generalized anxiety disorder, Impulse disorder, Cognitive communication deficit. Record review of a Resident #2's quarterly MDS assessment dated [DATE] indicated a BIMS of 2 which indicated severely impaired cognition and documented frequent urinary incontinence. Record review of Resident #2's care plan dated 4/11/24 indicated Resident #2 revealed documented problem, goal, or approach to address Resident #1's behavior and history of exposing his penis and urinating on floors in the unit. During a phone interview on 6/25/24 at 9:55 a.m.FM #1 stated that a male resident (Resident #2) exposes his penis and urinates in several areas in the unit Resident #1 resided in. FM#1 stated that she had witnessed on at least one occasion of the male resident's penis exposed and urinating on the floor, in Resident #1's room. During an interview on 6/25/24 at 2:50 p.m. LVN A stated that Resident #2 had a history of urinating on the floors in the unit. LVN A stated Resident #2 he does that, he will whip it out and pee wherever or by the residents on the floor, he just does that. LVN A stated that there is nothing in Resident #2's care plan to address the issue and staff just redirect him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 3:24 p.m. the DON stated that she was not aware that Resident #2 was pulling out his penis and peeing next to residents' bed. The DON stated that staff should have notified her so the behaviors could be monitored and placed in the care plan. The DON stated that she should have been notified so the doctor could be notified to order a urinalysis to check for a urinary tract infection. The DON stated that Resident #2's current care plan did not address Resident's behaviors of exposing himself and urinating on the floors in the unit. During an interview on 6/25/24 at 3:53 p.m. CNA C stated that Resident #2 had a history of pulling his pants down below his penis and peeing in various areas of the unit that included in closets, behind curtains, resident rooms, or hallways. CNA C stated that there is not a precursor to the behavior and staff often find urine on the floor. CNA C stated that she had worked at the facility for several years and was unaware if Resident #2's care plan addressed these behaviors. CNA stated that she had notified the nurses in the past and that it was not a new behavior. During an interview and observation on 6/26/24 at 11:25 a.m. with Resident #4, Resident was sitting at a table in the dining room participating in a coloring activity. Resident #4 stated that Resident #2 pees everywhere and will come into resident rooms and lay in their beds or pee on their floors. Resident #4 stated that there are not enough staff back here. During an interview on 6/26/24 at 11:39 a.m. with the Activity assistant; stated that Resident #2 will just go into a doorway and urinate. The Activity assistant stated that this occurred daily, and the female residents get upset. The Activity assistant stated that staff will find puddles of urine on the floor and staff do not always observe Resident #2 urinating on the floor. Record Review of the facility provided policy entitled, Comprehensive Care Plans, dated 1-26-24, revealed in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. Regarding unwanted or unacceptable behaviors: it is the responsibility of all staff to identify and report to the DON/designee new behaviors or changes from the resident's baseline and what, if any, interventions have been employed so these may be added to the care plan and communicated to the resident's direct care staff.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 2 of 8 residents (Resident #2, Resident #3) reviewed for staffing. The facility failed to have sufficient nursing staff in the memory care unit to provide supervision to assure resident safety. This failure could place residents at risk for not having their physical, mental, and psychosocial well-being met. Findings include: Record review of a face sheet dated 6/25/24 indicated Resident #2 is an [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease with early onset, Major depressive disorder, Dementia-mild with agitation, Generalized anxiety disorder, Impulse disorder, Cognitive communication deficit. Record review of a Resident #2's quarterly MDS assessment dated [DATE] indicated a BIMS of 2 which indicated severely impaired cognition and documented frequent urinary incontinence. Record review of Resident #2's care plan dated 4/11/24 indicated Resident #2 revealed documented problem, goal, or approach to address Resident #2's behavior and history of exposing his penis and urinating on floors in the unit. Record review of a face sheet dated 6/25/24 indicated Resident #3 is a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Dementia with anxiety and agitation, Mood disorder, Cognitive communication disorder, Depression, Alzheimer's disease, Generalized anxiety disorder. Record review of a Resident #3's quarterly MDS assessment dated [DATE] indicated a BIMS of 2 which indicated severely impaired cognition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's care plan dated 4/11/24 indicated Resident #3 revealed documented problem, goal, or approach to address Cognitive loss/Dementia: Anticipate needs and observe for non-verbal cues, approach in a calm manner. Psychosocial Well-being-Resident has behaviors such as wandering and can be combative at times, also wanders into other residents; Resident has physically abused behavioral symptoms gets aggressive at times with staff: Assess whether the behavior endangers the resident and/or others, intervene as necessary; avoid power struggles, avoid power struggles with resident; divert resident's behavior by redirecting. Keep distance between residents and others when resident becomes physically abusive, move resident to a quiet, calm environment. Record review of Resident #3's psychological assessment dated [DATE] revealed the following: On examination, patient exhibited loosening of associations and preservation. Thought content was significant for auditory hallucinations, visual hallucinations, paranoia, delusions. Patient's insight was poor. Judgment was poor. Patient risk of aggression is at risk for verbal aggression. Record Review of Resident #3's psychological assessment dated [DATE] revealed the following: Attention span and concentration was poor. Patient was oriented to person and no spheres. Patient was disoriented. Recent memory was severely impaired. Remote memory was severely impaired. Fund of knowledge was severely impaired on examination, patient exhibited loosening of associations, perseveration, and bizarre thoughts. Thought content was significant for auditory hallucinations, visual hallucinations, paranoia, delusions. Patient's insight was poor. Judgment was poor. Patient is at little to no risk of aggression. During a phone interview on 6/25/24 at 9:55 a.m. with FM #1; stated that a male resident (Resident #2) had exposed his penis and urinated in several areas in the secure unit. FM #1 stated that on several occasions there had only been one staff in the secure unit and residents had been left unsupervised in the common areas of the secure unit. During an interview on 6/25/24 at 2:50 p.m. with LVN A; stated that Resident #2 had a history of urinating on the floors in the unit. LVN A stated Resident #2 he does that, he will whip it out and pee wherever or by the residents on the floor, he just does that. LVN A stated that there should be always 2 staff in the secure unit and at times there are not 2 staff available if someone calls in or goes on break. During an interview and observation on 6/25/24 at 3:53 p.m. with CNA C; Stated that Resident #2 had a history of pulling his pants down below his penis and peeing in various areas of the unit that included in closets, behind curtains, resident rooms, or hallways. CNA C stated that there was not a precursor to the behavior and staff had often find urine on the floor. CNA C stated that she had worked at the facility for several years and was unaware if Resident #2's care plan addressed these behaviors. CNA C stated that she had notified the nurses in the past and that it was not a new behavior. CNA C stepped away and assisted a female resident behind closed doors for approximately five minutes. Residents were observed sitting in the dining room, a male resident was observed pacing the hallway and Resident #3 was observed pacing the hallway, entering resident rooms and the dining room while yelling and cursing. Resident #3 approached several residents as she cussed I'll beat your ass. CNA C exited the resident room and stated that she was the only staff in the secure unit because the other staff was on lunch. CNA C stated that Resident #3 would walk the hallways and cuss and yell throughout the day. CNA C stated that some residents have complained about Resident #3 and Resident #2 in the past. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and attempted interview on 6/25/24 at 4:07 p.m. with Resident #2, observed Resident #2 on his bed covered with blankets. Resident #2 had his eyes open and did not respond to verbal prompts. During an interview on 6/25/24 at 4:19 p.m. with the DON; stated that the secure unit should always have 2 staff, and she had not been aware that CNA C was the only one in the unit when the other staff member was on lunch. The DON stated that there had to be always two staff due to resident behaviors and resident needs. The DON stated that Resident #3 had a history of being aggressive towards other residents and staff had been made aware that there had to be two staff in the secure unit. The DON stated that either there would be 2 CNAs or 1 CNA and a nurse but there was no exception to the two staff rule. The DON stated that if staff had been assisting other residents behind closed doors than the other residents were not supervised. The DON stated that CNA C should have notified her that she was the only one in the unit and waited for another staff to monitor the other residents when she performed care behind a closed door. During an observation on 6/26/24 at 11:22 a.m. in the secured unit, Resident #3 was observed walking the secure hallway with two female staff within a few feet of Resident #3. Resident #3 paced back and forth while yelling out, I'll whoop your ass right now. Resident #3 entered an unknown resident room and stated, I'll beat your ass today. The female staff followed behind Resident #3 but did not enter the unknown resident room before Resident #3 exited back into the hallway. During an interview and observation on 6/26/24 at 11:25 a.m. with Resident #4, Resident was sitting at a table in the dining room participating in a coloring activity. Resident #4 pointed at Resident #3 who had walked in the dining room and was cussing I'll whoop your ass right now in the direction of other residents. Resident #4 stated, I hate that lady, she cusses too much. She takes stuff from the other residents. Resident #4 stated that sometimes there was not staff around to stop Resident #3 from getting into other residents' stuff or rooms. Resident #4 stated that Resident #2 pees everywhere and will come into resident rooms and lay in their beds or pee on their floors. Resident #4 stated that there are not enough staff back here. During an and interview and observation on 6/26/24 beginning at 11:27 a.m. in the secured unit, CNA D was observed in the hallway with another staff member following Resident #3. CNA D stated that there were always two staff in the secure unit unless a staff went to lunch. CNA D stated that they try to have two staff if possible. Resident #3 walked from the hallway into the dining room where several residents were participating in activities. Resident #3 walked up to several residents and touched the wheelchair of a resident. The Activity assistant was observed in the dining room assisting residents with activities. Resident #3 walked up to a table and grabbed several crayons and put them in her mouth and began to chew. Two female staff approached Resident #3 with a napkin and attempted to request Resident #3 to spit out the crayons. Resident #3 shoved CNA D and Resident #3 walked out of the dining room back into the hallway and entered another resident room as staff followed. Resident #3 walked out of the resident room back down the hallway where staff again attempted to have Resident #3 spit out the crayons. Resident #3-bit CNA D's finger and Resident #3 walked into the dining room and a male nurse entered to assist staff. The activity assistant brought a cookie to Resident #3 and staff persuaded Resident #3 to spit out the crayons and proceeded to eat the cookie. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	06/26/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 11:39 a.m. with the Activity assistant; stated that Resident #2 will just go into a doorway and urinate. The Activity assistant stated that this occurred daily, and the female residents get upset. The Activity assistant stated that staff will find puddles of urine on the floor and staff do not always observe Resident #2 urinating on the floor. The Activity assistant stated that Resident #3 goes into rooms and grabs stuff and residents get aggressive with her 'because she grabs stuff. The Activity assistant stated that she worked in the secure unit daily to perform activities and there had been several times that she found herself alone in the unit with no other staff. The Activity assistant stated that I'll turn around and no other staff are back here with me. The Activity assistant stated that due to residents' behaviors, dementia and roaming it was difficult to be the only staff in the secure unit. The Activity assistant stated her duties were to conduct resident activities and not to perform resident care. During an observation and attempted interview on 6/26/24 at 11:42 a.m., Resident #2 was observed exiting another resident's room. The Activity Assistant stated that Resident #2 had a history of sleeping in other resident rooms and should have been redirected to his own room. Record review of the facility provided policy and in-service dated 7/12/23 revealed: There should always be two staff members in the secured unit at all times. Record review of the facility provided policy, Staffing dated 9/28/23 revealed: Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care and considering the number, acuity and diagnoses of the facility's resident population.