

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Lubbock Hospitality Nursing and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344</p> <p>Based on Interviews and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and neglect for 1 of 6 residents reviewed for abuse.</p> <p>A. The ADM failed to follow the facility's abuse policy when Resident #1 reported allegations of abuse involving Resident #2 on an unknown date.</p> <p>B. The ADON failed to follow the facility's abuse policy when CNA A reported that Resident #1 alleged that CNA A was involved in abusing Resident #2 on 09/26/24.</p> <p>This failure could place residents at risk for abuse and neglect.</p> <p>Findings included:</p> <p>Record review of the facility policy, Abuse, Neglect, and Exploitation, revised May 2023 revealed:</p> <p>Policy</p> <p>The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property.</p> <p>Reporting/Response</p> <p>The facility will have written procedures that include:</p> <p>Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes:</p> <p>Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Record review of Resident #1's face sheet, dated 10/01/24, revealed an [AGE] year-old-female was admitted to the facility on [DATE] and a readmit on 09/30/24 with diagnosis to include dementia (cognitive loss), altered mental status (change in how well the brain functions) and UTI (urinary tract infection).</p> <p>Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed:</p> <p>*Section C Brief Interview for Mental Status score revealed a score of 10, which indicated the resident's cognition was moderately impaired.</p> <p>*Section B0800. Ability to understand others, Resident #1 had clear speech, could make herself understood and usually understood others.</p> <p>*Section E- Behavior. There were no potential indicators of psychosis (E0100). There was also no presence of physical, verbal or other behavioral symptoms (E0200). Overall, there was no presence of behavioral symptoms (E0300).</p> <p>Record review of Resident #1's care plan, dated 09/13/24, did not reveal any indication that Resident #1 had any known behaviors, but that she did have fluctuating cognition.</p> <p>Record review of Resident #1's progress notes for the time period 07/01/24-10/01/24 did not reveal any information regarding Resident #1 reporting the allegation of abuse.</p> <p>2. Record review of Resident #2's face sheet, undated, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnosis to include Alzheimer's (memory loss).</p> <p>Record review of Resident #2's Comprehensive Minimum Data Set, dated [DATE], revealed:</p> <p>*Section C Brief Interview for Mental Status score revealed a score of 7, which indicated the resident's cognition was severely impaired.</p> <p>*Section B0800. Ability to understand others. Resident #2 had clear speech, was usually understood and sometimes could understand others.</p> <p>*Section E- Behavior. There were no potential indicators of psychosis (E0100). There was also no presence of physical, verbal or other behavioral symptoms (E0200). Overall, there was no presence of behavioral symptoms (E0300).</p> <p>Record review of Resident #2's care plan, dated 09/05/24, did not reveal any indication that Resident #2 had any known behaviors, but did reveal that she had a memory problem related to Alzheimer's.</p> <p>Record review of Resident #2's progress notes for the time period 07/01/24-10/01/24 revealed no documentation regarding allegations of abuse.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/24 at 1:38 PM, Resident #1 stated staff were abusing Resident #2 in the facility. She stated when staff took Resident #2 into her room, that was when they abused her. She stated this because when the staff went into the room with Resident #2, she heard Resident #2 let out a blood-curdling scream. She stated she had not seen staff harm her at first because staff would tell her to mind her business. She said she believed when staff transferred Resident #2, they grabbed her by the wrist. She stated she was unsure of the date, but it may have been four days before her interview that she heard Resident #2 screaming in her room. She stated she went immediately to Resident #2's room, and two staff members, including CNA A, were in the room with Resident #2. She stated she went in and stood by the privacy curtain and saw the staff scratching and digging in Resident #2's stomach. She said the staff saw her and yelled for her to get out. She reported this to her friend (another resident in the facility) and the ADM. She said she was unsure of the date she told the ADM. She said she told the ADM the staff were abusing Resident #2. She said he told her his hands were tied and he would need an eyewitness to sit on the stand to testify. She said it upset her because Resident #2 was her friend, and she was a human being and did not need to be abused. She stated after she had reported the incident to the ADM, she was unsure if anything had been done because she still saw CNA A working. She stated she did not know who the other CNA was but believed it was the family member of CNA A.</p> <p>During an interview on 10/01/24 at 2:00 PM, Resident #2 was unable to answer any questions, and therefore, the interview did not contribute any information to the identified deficient practice.</p> <p>During an interview on 10/01/24 at 2:46 PM, the ADM stated he was unsure of the date when Resident #1 reported the incident, but it was over a week ago. He said when she did report the incident, he did not consider it an allegation of abuse. He said he could not remember the specific words that Resident #1 used but she expressed concern that Resident #2 may be hurt by staff because Resident #2 was screaming. The ADM said Resident #2 screamed during ADL care and he had heard her scream. He said Resident #1 did not say she saw anything specific. The ADM said he spoke with the DON, who stated Resident #2 screaming during ADL care was normal for her. He stated the DON also reported Resident #1 had been trying to get staff to move Resident #2 in her room. He stated the DON reported Resident #1 has tried to perform ADLS on other residents in the facility. The ADM stated he did not consider Resident #1's report as an allegation or a grievance but simply a concern or a misunderstanding on Resident #1's behalf. He stated he did not interview anyone outside of the DON and based on Resident #1's attempt to get Resident #2 as a roommate, they did not proceed further. He said he did not take additional actions to corroborate what the DON told him. He stated clearly, Resident #1 was fearful that Resident #2 might be getting hurt, but he felt that that was an honest reaction from a person who did not understand. He stated, in hindsight that the concern that Resident #1 reported may have been a grievance, and he should have documented the concern.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/24 at 4:34 PM, CNA A stated she was unsure of the date of the incident, but about a week ago, Resident #1 barged into the room while she and her partner were changing Resident #2. She stated Resident #1 always does this, even with other residents. She stated when Resident #1 barged in, she accused them (staff) of mishandling and abusing Resident #2. She stated Resident #1 was yelling that she saw the abuse with her own eyes. She stated she reported the incident to the ADON. She stated she told the ADON Resident #1 accused her and her partner of abusing Resident #2. She said the ADON responded that he was going to document the incident. She stated she had been trained to report abuse immediately to the charge nurse and the ADM even if the allegation included her. She stated she did report the incident to the charge nurse but did not report it to the ADM because it occurred on an overnight shift. She stated no one asked her any questions about the incident after she reported it to the ADON.</p> <p>During an interview on 10/01/24 at 4:29 PM, the ADON stated the CNAs told him that while changing, another resident, Resident #1, came in and asked her to leave so that the resident could have privacy. They also spoke with her about knocking before she entered the room. He stated that this happened twice in one night and was concerned that something was wrong with Resident #1. He said before they could address her, they noticed there were flashing lights from the ambulance, and Resident #1 left for the hospital. He stated no one (staff or resident) reported that there was an allegation of abuse. He stated the abuse coordinator was the ADM, and if they suspect witness abuse, it should be reported immediately to the ADM.</p> <p>During an interview on 10/01/24 at 5:07 PM, the ADM stated the purpose of following the abuse policies was to ensure that all residents were free from abuse and that they had taken all measures to ensure that residents were free from abuse. He stated the potential negative outcome of not following the abuse policies was that abuse could occur without being discovered or addressed. He stated he was familiar with the facility's abuse policy and had been trained on it. He stated he knew Resident #1 had concerns due to Resident #2 screaming. He stated Resident #1 did not specifically state that she had concerns with allegations of abuse. He stated Resident #1 stated she did not see anything. He said he immediately consulted with the DON, and they together decided this was not an allegation of abuse. He stated he did not speak with Resident #2 or follow up with any record review to corroborate or support his decision. He stated the system to monitor the facility's abuse policy was being followed, and staff were trained to notify the abuse coordinator immediately, which was him. He stated they should let him know if there was the smallest concern of abuse and not to investigate it themselves but to report. He stated he did not document or take any additional actions and had no reason why he did not follow the policy or document the concern. He said all staff in the facility were responsible for following the abuse policy.</p> <p>During an interview on 10/01/24 at 5:17 PM, the DON stated the potential negative outcome of not following the facility's abuse policy was that someone could be abused, harmed, or not be taken care of at the facility. She said she was familiar with the facility's abuse policy and had been trained on the policy. She stated she knew Resident #1 had a concern but did not consider it an allegation of abuse. She said she did not consider it an allegation of abuse because she knew both residents and was aware of their behaviors. She stated she was unsure if the behavior was documented but that she had observed both resident's behaviors. She stated the expectation was that if there was an allegation of abuse, they should immediately intervene and notify the ADM. She said then the allegation would be investigated. She said she did not talk to anyone about the incident except the ADON. She said everyone was responsible for following the abuse policy.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of HHSC reporting intake website did not reveal any reports/intakes of abuse involving Resident #1 or Resident #2 in September 2024 through 10/01/24.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344</p> <p>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or result in serious bodily injury to the administer of the facility and to other officials including the State Survey Agency in accordance with State law through established procedures for 2 of 6 residents (Residents #1 & 2) reviewed for abuse and neglect.</p> <p>A. The ADM failed to report an allegation of abuse involving Resident #2 that was reported to him on an unknown date by Resident #1.</p> <p>B. The ADON failed to report an allegation of abuse involving Resident #2 that was reported to him by CNA A on 09/26/24.</p> <p>These failures could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm.</p> <p>Findings included:</p> <p>Record review of the facility policy, Abuse, Neglect, and Exploitation, revised May 2023 revealed:</p> <p>Policy</p> <p>The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property.</p> <p>Reporting/Response</p> <p>The facility will have written procedures that include:</p> <p>Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes:</p> <p>Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>1.Record review of Resident #1's face sheet, dated 10/01/24, revealed an [AGE] year-old-female was admitted to the facility on [DATE] and a readmit on 09/30/24 with diagnosis to include dementia (cognitive loss), altered mental status (change in how well the brain functions) and UTI (urinary tract infection).</p> <p>Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed:</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Section C Brief Interview for Mental Status score revealed a score of 10, which indicated the resident's cognition was moderately impaired.</p> <p>*Section B0800. Ability to understand others, Resident #1 had clear speech, could make herself understood and usually understood others.</p> <p>*Section E- Behavior. There were no potential indicators of psychosis (E0100). There was also no presence of physical, verbal or other behavioral symptoms (E0200). Overall, there was no presence of behavioral symptoms (E0300).</p> <p>Record review of Resident #1's care plan, dated 09/13/24, did not reveal any indication that Resident #1 had any known behaviors, but that she did have fluctuating cognition.</p> <p>Record review of Resident #1's progress notes for the time period 07/01/24-10/01/24 did not reveal any information regarding Resident #1 reporting the allegation of abuse.</p> <p>2.Record review of Resident #2's face sheet, undated, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnosis to include Alzheimer's (memory loss).</p> <p>Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed:</p> <p>*Section C Brief Interview for Mental Status score revealed a score of 7, which indicated the resident's cognition was severely impaired.</p> <p>*Section B0800. Ability to understand others. Resident #2 had clear speech, was usually understood and sometimes could understand others.</p> <p>*Section E- Behavior. There were no potential indicators of psychosis (E0100). There was also no presence of physical, verbal or other behavioral symptoms (E0200). Overall, there was no presence of behavioral symptoms (E0300).</p> <p>Record review of Resident #2's care plan, dated 09/05/24, did not reveal any indication that Resident #2 had any known behaviors, but did reveal that she had a memory problem related to Alzheimer's.</p> <p>Record review of Resident #2's progress notes for the time period 07/01/24-10/01/24 revealed no documentation regarding allegations of abuse.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/24 at 1:38 PM, Resident #1 stated staff were abusing Resident #2 in the facility. She stated when staff took Resident #2 into her room, that was when they abused her. She stated this because when the staff went into the room with Resident #2, she heard Resident #2 let out a blood-curdling scream. She stated she had not seen staff harm her at first because staff would tell her to mind her business. She said she believed when staff transferred Resident #2, they grabbed her by the wrist. She stated she was unsure of the date, but it may have been four days before her interview that she heard Resident #2 screaming in her room. She stated she went immediately to Resident #2's room, and two staff members, including CNA A, were in the room with Resident #2. She stated she went in and stood by the privacy curtain and saw the staff scratching and digging in Resident #2's stomach. She said the staff saw her and yelled for her to get out. She reported this to her friend (another resident in the facility) and the ADM. She said she was unsure of the date she told the ADM. She said she told the ADM the staff were abusing Resident #2. She said he told her his hands were tied and he would need an eyewitness to sit on the stand to testify. She said it upset her because Resident #2 was her friend, and she was a human being and did not need to be abused. She stated after she had reported the incident to the ADM, she was unsure if anything had been done because she still saw CNA A working. She stated she did not know who the other CNA was but believed it was the family member of CNA A.</p> <p>During an interview on 10/01/24 at 2:00 PM, Resident #2 was unable to answer any questions, and therefore, the interview did not contribute any information to the identified deficient practice.</p> <p>During an interview on 10/01/24 at 2:46 PM, the ADM stated he was unsure of the date when Resident #1 reported the incident, but it was over a week ago. He said when she did report the incident, he did not consider it an allegation of abuse. He said he could not remember the specific words that Resident #1 used but she expressed concern that Resident #2 may be hurt by staff because Resident #2 was screaming. The ADM said Resident #2 screamed during ADL care and he had heard her scream. He said Resident #1 did not say she saw anything specific. The ADM said he spoke with the DON, who stated Resident #2 screaming during ADL care was normal for her. He stated the DON also reported Resident #1 had been trying to get staff to move Resident #2 in her room. He stated the DON reported Resident #1 has tried to perform ADLS on other residents in the facility. The ADM stated he did not consider Resident #1's report as an allegation or a grievance but simply a concern or a misunderstanding on Resident #1's behalf. He stated he did not interview anyone outside of the DON and based on Resident #1's attempt to get Resident #2 as a roommate, they did not proceed further. He said he did not take additional actions to corroborate what the DON told him. He stated clearly, Resident #1 was fearful that Resident #2 might be getting hurt, but he felt that that was an honest reaction from a person who did not understand. He stated, in hindsight that the concern that Resident #1 reported may have been a grievance, and he should have documented the concern.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/24 at 4:34 PM, CNA A stated she was unsure of the date of the incident, but about a week ago, Resident #1 barged into the room while she and her partner were changing Resident #2. She stated Resident #1 always does this, even with other residents. She stated when Resident #1 barged in, she accused them (staff) of mishandling and abusing Resident #2. She stated Resident #1 was yelling that she saw the abuse with her own eyes. She stated she reported the incident to the ADON. She stated she told the ADON Resident #1 accused her and her partner of abusing Resident #2. She said the ADON responded that he was going to document the incident. She stated she had been trained to report abuse immediately to the charge nurse and the ADM even if the allegation included her. She stated she did report the incident to the charge nurse but did not report it to the ADM because it occurred on an overnight shift. She stated no one asked her any questions about the incident after she reported it to the ADON.</p> <p>During an interview on 10/01/24 at 4:29 PM, the ADON stated the CNAs told him that while changing, another resident, Resident #1, came in and asked her to leave so that the resident could have privacy. They also spoke with her about knocking before she entered the room. He stated that this happened twice in one night and was concerned that something was wrong with Resident #1. He said before they could address her, they noticed there were flashing lights from the ambulance, and Resident #1 left for the hospital. He stated no one (staff or resident) reported that there was an allegation of abuse. He stated the abuse coordinator was the ADM, and if they suspect witness abuse, it should be reported immediately to the ADM.</p> <p>During an interview on 10/01/24 at 5:07 PM, the ADM stated the purpose of following the abuse policies was to ensure that all residents were free from abuse and that they had taken all measures to ensure that residents were free from abuse. He stated the potential negative outcome of not following the abuse policies was that abuse could occur without being discovered or addressed. He stated he was familiar with the facility's abuse policy and had been trained on it. He stated he knew Resident #1 had concerns due to Resident #2 screaming. He stated Resident #1 did not specifically state that she had concerns with allegations of abuse. He stated Resident #1 stated she did not see anything. He said he immediately consulted with the DON, and they together decided this was not an allegation of abuse. He stated he did not speak with Resident #2 or follow up with any record review to corroborate or support his decision. He stated the system to monitor the facility's abuse policy was being followed, and staff were trained to notify the abuse coordinator immediately, which was him. He stated they should let him know if there was the smallest concern of abuse and not to investigate it themselves but to report. He stated he did not document or take any additional actions and had no reason why he did not follow the policy or document the concern. He said all staff in the facility were responsible for following the abuse policy.</p> <p>During an interview on 10/01/24 at 5:17 PM, the DON stated the potential negative outcome of not following the facility's abuse policy was that someone could be abused, harmed, or not be taken care of at the facility. She said she was familiar with the facility's abuse policy and had been trained on the policy. She stated she knew Resident #1 had a concern but did not consider it an allegation of abuse. She said she did not consider it an allegation of abuse because she knew both residents and was aware of their behaviors. She stated she was unsure if the behavior was documented but that she had observed both resident's behaviors. She stated the expectation was that if there was an allegation of abuse, they should immediately intervene and notify the ADM. She said then the allegation would be investigated. She said she did not talk to anyone about the incident except the ADON. She said everyone was responsible for following the abuse policy.</p> <p>(continued on next page)</p>		

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