| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455940 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Hospitality Nursing and Rehabilitation Cen | 4710 Slide Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49154<br><br>Based on interview and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 10 residents (Resident #1) reviewed for comprehensive care plans.<br><br>The facility failed to ensure Resident #1's care plan (problem, goal, and approach) was updated to reflect his increasingly ongoing incident of physical and verbal aggressive behaviors.<br><br>This failure could place residents at risk of not receiving appropriate interventions to meet their current needs.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet, dated 11/22/24, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnosis to include unspecified dementia (impaired ability to remember), with other behavioral disturbance (behavior concerns), other frontotemporal neurocognitive disorder (damage to nerve cells in the frontal and temporal lobes of the brain), insomnia (difficulty sleeping), and chronic atrial fibrillation (irregular and rapid heartbeat).<br><br>Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed under Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. Also, Section B Hearing, Speech and Vision revealed that Resident #1 had clear speech, usually makes himself understood and usually understands others. His vision was adequate, and he did not wear corrective lenses. Additionally, Section E Behavior revealed that he had had physical behaviors such as hitting, kicking, pushing, scratching, grabbing, abusing others. These symptoms put the resident at significant risk for physical illness or injury. Resident #1 ' s symptoms also put others at risk for physical injury, significantly intrude on the privacy or activity of others, and significantly disrupt care or the living environment. The behaviors in this section were coded to have gotten worse.<br><br>(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 |
|---|---|---|---|
| | 455940 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Hospitality Nursing and Rehabilitation Cen | 4710 Slide Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1 ' s Care Plan, dated 11/05/24 did not reveal any information regarding him hitting a staff or getting into a resident-to-resident altercation. Further review revealed a problem area, initiated on 11/05/24, for the Baseline Care Plan will identify my care needs, risks, strengths, and goals for the first 48 hours. The goal was that behavioral needs will be evaluated for impact on quality of life, safety, and safety of others. Behavioral management plan will be addressed if needed with physician/NP, IDT, and resident/resident representative. The approach, initiated on 11/05/24, was that behavioral needs will be evaluated for impact on quality of life, safety, and safety of others. Also, the Behavioral management plan will be addressed if needed with physician/NP, IDT, and resident/resident representative. Additionally, a problem area, initiated on 11/05/24, was that Resident had a diagnosis of frontotemporal neurocognitive disorder and resides in the secured unit due to his/her wandering and poor safety awareness. The short-term goal date documented was 02/05/2025, was that I will not elope from the secured unit in the next 90 days. The approach, dated initiated 1/05/24, was to assure that I have proper fitting and appropriate foot attire. Complete wander alert and place in elopement binder in the event of elopement. Consent for placement in a secured unit will be obtained from the guardian and/or responsible party. I will have a Placement in a secured unit assessment on admission, quarterly and with significant change of condition. I will have an Elopement Assessment done on admission, quarterly and with significant change of condition. If I am wandering provide me with activities based on my prior lifestyle/interests. If I begin to wander, please provide me assistance to where I need to be going. Resident is only allowed to smoke in a designated location with supervision of at least one staff member. Staff will monitor me and report changes in exit seeking behaviors to the facility Administrator, Director of Nursing, Physician, and guardian/responsible party. Take a picture of me every quarter because I may have changed in my appearance and/or weight. When I begin to wander, provide comfort measures for my basic needs (example: pain, hunger, toileting, too hot/cold, etc.)<br><br>Record review of Resident #1's progress notes revealed the following:<br><br>11/10/24 nursing progress entered by LVN B at 11:47 PM: Resident #1 up in room urinating on ?oor, also putting self in ?oor and crawling around on ?oor and in hallway. When assisting up o? of ?oor hit CNA in the face, then started tearing up the machine for the air mattress (and trying to tear o? the hose to air mattress, been hitting on the wall, will continue to monitor).<br><br>11/11/24 nursing progress entered by LVN B at 04:49 AM: Resident #1 continues to go into other resident rooms hitting on walls or moving closet doors etc.<br><br>11/11/24 nursing progress entered by LVN B at 05:53 AM: CNA noted and had LVN look at Resident #1. Has 2 small abrasions (superficial injury to the skin) approximately, 2 cm. in size, one beside left eye, and the other above left eye; unknown how resident received abrasions; Resident #1 continues to go into other resident ' s rooms when being redirected; will lift up hand/arm as if going to hit.<br><br>11/14/24 nursing progress entered by the SW at 06:35 PM: SW received message that sta? member was punched in the face by Resident #1. SW called family member and Hospice to inform them of resident ' s behavior.<br><br>(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<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Hospitality Nursing and Rehabilitation Cen | 4710 Slide Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 11/14/24 nursing progress entered by LVN B at 08:30 PM: Resident #1 hit day CNA in the face, also reopened skin tear on both arms, this occurred back around 6PM, pacing floors, hospice notified of situation, will come to assess resident, hospice here to situation, new orders for Risperidone (medication that helped with mental health conditions) to be given of afternoon for sundowners (late day confusion), initial dose given.<br><br>11/14/24 nursing progress entered by LVN B at 08:40 PM: Resident #1 becoming agitated again hitting CNA in the chest and in the back with yellow wet floor signs , hospice notified again of situation, received orders for Seroquel 25mg one time dose (medication that treats schizophrenia and bipolar disorder), med was given, continues to pace floor yelling out at intervals.<br><br>11/16/24 nursing progress entered by RN A at 05:45 PM: Resident #1 initiated aggression toward another resident, and that resident in return hit the resident back. The resident (Resident #1) has a bruise appearing the left eye. Family member and staff with primary doctor ' s team was noti?ed as well. The family member stated that she would be up to see him this evening. The resident then was transported o? unit to be given a change of environment, resident attempted to go out back door and when sta? intervened resident became aggressive. Resident was transported with several sta? members back to Memory care and was given PRN IM Haldol 1ml injection (long-acting antipsychotic medication) to left hip.<br><br>11/17/24 nursing progress entered by the ADM at 11:25 AM: At approximately 5:45 PM on 11/16, NFA spoke with resident regarding aggression with another resident. Resident stated that he had loaned the other resident his clippers and that those clippers were his fathers and that he wanted them back. Resident confused as to where he was and about the clippers. NFA implemented 1 to 1 observation of resident and sat with resident for a few hours. Resident calmed and able to fall asleep. Sta? continues to monitor resident and hospice team noti?ed to ensure support for resident and ensuring resident behaviors are closely monitored for any continued signs of aggression.<br><br>11/17/24 nursing progress entered by the ADM at 11:27 AM: NFA observed resident this morning to assist with monitoring for aggressive behaviors. Resident remembers very little about incident from previous day and presents much more calmly today. Resident states that he is safe in facility and that he wants his family member to bring him some food. NFA advised staff to continue to monitor resident for aggressive behaviors and to intervene if any aggressive behaviors arise and notify hospice, doctor, and NFA if any concerns arise.<br><br>Record review of Resident #1's Physician Orders, undated, revealed an order dated 11/14/24 for Risperidone tablet (medication that helped with mental health conditions); 0.5 mg: tablet order once a day. Physician orders further revealed an order dated 11/15/24 for Risperdal (Risperidone) tablet; 1 mg: given oral twice a day. Lastly, there was an order dated from 11/18/24 to 11/28/24 for Haloperidol Lactate Solution (long-acting antipsychotic medication); 5mg/mL: 5mg injection every 24 hours, PRN.<br><br>(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<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Hospitality Nursing and Rehabilitation Cen | 4710 Slide Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/22/24 at 9:13 AM, the ADM stated there had been several recent changes of staff. He stated there currently was no DON as of yesterday. He stated the two ADON ' s he had also resigned, and he just hired a new ADON. The ADM stated Resident #1 was a new resident who moved in about two weeks ago. He stated Resident #1 appeared to be confused and could remember past events but could not remember current events. The ADM stated the hospice nurse came to see Resident #1. The ADM stated interventions were that there were significant medication changes to help with calming Resident #1 and they were monitoring him closely and waiting to see if it helped.<br><br>During an interview on 11/22/24 at 10:35 AM, CNA D stated Resident #1 punched her in the face several days ago when she tried to intervene because he was throwing chairs in the dining room. She stated she thought she would get a black eye, but she did not. She stated she was very shaken up about the incident. CNA D stated she reported it to the charge nurse and went home for the day. CNA D stated Resident #1 was a new resident and has been there a few weeks. She stated Resident #1 had not been aggressive with her since. She stated it happened on a Friday, but she could not remember the date it happened.<br><br>During an interview on 11/22/25 at 1:01 PM, CNA E stated around breakfast time she was in the dining room when she heard Resident #1 telling another resident (unidentified) to give his clippers back within 24 hours or there would be trouble. She stated she told Resident #1 to stop but then Resident #1 hit the other resident in the nose before she made it over to them. She stated she took Resident #1 to his room, and he fell asleep for two or three hours. She stated LVN C reported the incident to the ADM, and she was instructed to keep them separated. She stated this happened at breakfast time. She stated this was the first time this happened. She stated Resident #1 was new to the facility. She stated she was told that Resident #1 punched CNA D in the face prior to this incident when she tried to intervene when he was throwing chairs in the dining room.<br><br>During an interview on 11/22/25 at 2:25 PM, the SW stated according to progress notes on 11/14/24 at 6:35 pm Resident #1 punched CNA B in the face, and she had to call hospice to get a one-time dose of Seroquel (medication that treats schizophrenia and bipolar disorder) approved for staff to administer to him. She stated Resident #1 was put on one-to-one supervision that day. She stated hospice was contacted and changed his Risperidone (medication that helped with mental health conditions) from .5 mg to 1 mg twice a day, and they also prescribed Haldol (long-acting antipsychotic medication) as needed, and he has done great ever since then. She was not aware if CNA A sustained injures but she was very shaken up about it.<br><br>(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<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Hospitality Nursing and Rehabilitation Cen | 4710 Slide Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/22/24 at 4:11 PM, the ADM stated Resident #1 was calm initially however there had been a few reports of some agitation. The ADM stated the interventions after Resident #1 had behaviors were medication changes and in services with staff were completed. He stated he had also spoken with staff every day since and instructed them to monitor Resident #1 closely. The ADM stated there had been incidents with Resident #1 being aggressive with staff when providing care. He stated Resident #1 had been defensive with staff because he did not understand why they were providing care. The ADM stated Resident #1 was aggressive when things were happening around him because he did not understand what was going on and he was a new resident and was still adapting to the memory care unit. The ADM stated the resident-to-resident training had been verbal, there was no documentation to support training was provided to staff specifically on Resident #1, and staff also had general abuse training. The ADM stated training was given to staff after Resident #1 punched the CNA and were told to not get into his personal space when helping him eat or do anything else, especially if he was showing aggression. The ADM stated Resident #1 ' s behaviors were somewhat new and there had not yet been a tool created for staff to refer to know how to deal with his behaviors . The ADM stated he would have normally wanted to have that tool created within 1-2 days maximum and have appropriate supervision for Resident #1 and gotten social services involved to create interventions beyond medication changes. The ADM stated he was aware the Care Plan had not been updated after having behaviors. The ADM stated the entire team that would have updated the Care Plan had resigned.<br><br>During an interview on 11/25/24 at 9:27 AM, CNA F she was in the dining area feeding another resident, it was around 11:30 AM. She stated she heard Resident #1 arguing with another resident (unidentified). She stated she stated CNA E was talking to them trying to calm them down, when Resident #1 reached and punched the other resident (unidentified) in the mouth. She stated CNA E took Resident #1 to his room. She stated she was told to keep a closer eye on Resident #1 and report any additional issues. She stated afterwards, Resident #1 tried to get leave the facility and she tried to calm him down. She stated he pulled the Activity Assistant ' s hair.<br><br>During an interview on 11/25/25 at 9:46 AM , the Activities Assistant stated around 5:00 PM Resident #1 tried to get out of the facility and staff were trying to redirect him, so she went to assist them. She stated he opened a door, and he swung his arm and grabbed her hair. She stated staff were able get him to let go of her hair and redirected him back to the memory unit. She stated this happened on the same day that he punched another resident (unidentified). She stated staff had walked him around the facility to calm him down.<br><br>During an interview on 11/25/24 at 9:52 AM, LVN C stated he was the charge nurse on 11/16/24 when Resident #1 hit another resident. He stated he was standing outside of the dining room on the memory unit. He stated sometime in the mid-morning, Resident #1 came out if his room into the hallway and was looking for silver and black clippers and said another resident had them. He stated he went to Resident #1 ' s room to help look for them. He stated Resident #1 walked off and about 10-15 minutes later, he approached the resident and asked for his clippers and then swung and hit the other resident (unidentified) in the mouth. He stated CNA E was in between them. He stated he reported the incident to the ADM and was instructed to call hospice to get his medications checked, and he notified Resident #1 ' s daughter. He stated the ADM told him to watch them and keep them away from each other.<br><br>(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<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Hospitality Nursing and Rehabilitation Cen | 4710 Slide Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/25/24 at 3:56 PM, the ADM stated that he had been trained regarding care plan revisions but that he was not an expert. At the time of the incident (11/16/24) and the time of the interview, he did not have a Director of Nursing. He said he had been without a Director of Nursing since 11/15/24 at 10:30 AM, and this was the last time the DON was in the facility. He stated that if care plans were not revised timely, staff providing care may not understand or have the training they need to prevent training or other adverse outcomes. The ADM stated he was unaware that Resident #1's care plan had not been revised. He said that on the day (11/16/24), Resident #1 had his altercation with the other male resident. The DON was not in the facility, and that was who would have been responsible for updating and revising the care plan. He stated his ADONs would have also had the ability to revise or update the care plan, but they were not in the facility on 11/16/24 and no longer worked for the facility. He said he had not had an ADON in the facility since 11/15/24. He said he expected all care plans to be revised and accurate to meet the resident's needs. He said he expected the care plan to be revised within 3-5 business days of the behavior occurring. He said that he understood that he would be responsible for the care plans and revisions if he did not have a DON. He said Resident #1's care plan was not revised because it had been a challenging week. He said he had lost his clinical team and was focused on staffing, on-call, and any other deficits that the clinical team handled. He said it was an oversight on his behalf.<br><br>Record review of the facility's policy, Comprehensive Care Plans, revised: 1-26-2024 v.1 revealed the following in part:<br><br>Policy:<br><br>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.<br><br>Policy Explanation and Compliance Guidelines:<br><br>1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed.<br><br>2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment and by Day 21 of the patient's stay. All Care Assessment Areas ("CAAs") triggered by the MDS will be considered in developing the care plan. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the care plan. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.<br><br>3. The comprehensive care plan will describe, at a minimum, the following:<br><br>a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>d. The resident's goals for admission, desired outcomes, and preferences for future discharge.<br><br>(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<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Hospitality Nursing and Rehabilitation Cen | 4710 Slide Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate.<br><br>5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.<br><br>6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.<br><br>7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.<br><br>8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.<br><br>9. The services provided or arranged by the facility, as outlined in the comprehensive care plan, will meet professional standards of quality, and will be provided by qualified persons in accordance with each resident's written plan of care. |