

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse and neglect for two of five residents (Resident #1, Resident #2) reviewed for abuse and neglect. The facility failed to ensure a safe environment free from sexual abuse when Resident #2, who had a history of inappropriate sexual behaviors, placed her hand inside Resident #1's panties. The facility's DON failed to implement interventions upon Resident #2's admission on [DATE], when LVN F informed him Resident #2 was masturbating, and after Resident #2 inappropriately touched him on his pants. The Immediate Jeopardy (IJ) was identified on 09/04/25 at 6:18 PM. The IJ template was provided to the facility's Administrator and DON on 09/04/25 at 6:18 PM. While the immediacy was removed on 09/05/25 at 6:07 PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems, and because all their staff had not been trained on 09/05/25. These failures could affect residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm. Findings include:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet current as of 09/03/25, revealed a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #2 diagnoses included unspecified dementia severe with agitation (a behavioral and emotional state of dementia characterized by behaviors like restlessness, pacing, shouting, aggression, and repetitive actions), mood disorder due to known physiological condition (a mental disorder characterized by persistent changes in mood), and schizoaffective disorder bipolar type (mental health condition episodes that combines mania and depression).</p> <p>Review of Resident #2's Physician's Active Orders dated 08/22/25 included Psychiatric and Psychological services to evaluate and treat as needed.</p> <p>Record review of Resident #2's admission Comprehensive MDS, dated [DATE] revealed the following:</p> <p>*Section C Brief Interview for Mental Status (BIMS) revealed a score of 1 which indicated the resident's cognition was severely impaired.</p> <p>*Section E-Behavior:</p> <p>Physical behavioral symptoms directed towards other (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Senior PsychCare dated 08/26/25 indicated the facility had requested a referral for psych services. The Senior PsychCare dated 08/26/25 indicated the PNP obtained verbal consent from FM for psych services.</p> <p>Record review of Resident #2's admission documents from her previous facility included the following Progress Notes:</p> <p>*Effective date of 08/03/25 at 8:25 PM that was marked out indicated "Late Entry"; Resident #2 was found in male resident's room sitting on the side of his bed and was playing with male resident's pubic hair that was sticking outside of his brief. The resident was removed and redirected from the room.</p> <p>*Effective date of 08/03/25 at 8:32 PM indicated Resident #2 was placed on 1:1 with monitoring tech, who would be with her and documenting on her progress.</p> <p>*Effective date of 08/03/25 at 7:56 PM indicated Resident #2 went into a male resident's room, he was slightly exposed and she was leaning over and touching him on his peri area. Staff said his brief was on but had it slightly moved to the side and he was not stopping her. Resident #2 was removed immediately and her hand washed. Resident #2 was impulsive and confused.</p> <p>*Effective date 07/16/25, Resident #2 was kissing a male resident, and they were immediately separated.</p> <p>Record review of FNP T's Progress Note dated 09/02/25 indicated Resident #2 was a [AGE] year-old lady who was transferred from a facility to her current facility. The current facility's nursing staff had reported hypersexual behavior to included that Resident #2 was found in a resident's room with her hand down female resident's pants (Resident #1). FNP T noted she would consult with the psychiatric team and check labs.</p> <p>During an interview on 09/03/25 at 10:40 am, Resident #2 was asked a series of questions; however, her verbal responses were not understood. Instead, Resident #2 smiled each time she was asked a question, including if she had touched Resident #1 on her private area.</p> <p>Resident #1</p> <p>Record review of Resident #1's Face Sheet current as of 09/03/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnosis included dementia mild with mood disturbances (emotional or behavioral changes, such as anxiety, apathy, depression or irritability), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations).</p> <p>Record review of Resident #1's admission Comprehensive MDS, dated [DATE] revealed the following:</p> <p>*Section C, Brief Interview for Mental Status (BIMS) score revealed a score of 00, which indicated the resident's cognition was severely impaired.</p> <p>*Section E-Behavior, Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/25 at 3:04 PM, CNA A indicated she started her shift on 08/22/25 at 6 PM and worked until 6 am on 08/23/25. During this shift, CNA A said she was assigned as Resident #1's 1:1 observation, which meant she had to watch her closely and keep her out of residents' room. CNA A said before she left the facility on [DATE] at 6 am, she informed a CNA, whose name she could not recall, that she was leaving and transferring her observation to the next shift. CNA A said Resident #1 was asleep in her bed when she left.</p> <p>During an interview on 09/03/25 at 10:46 AM, CNA C indicated on 08/23/25 she was working with CNA P; however, CNA O, who was assigned as Resident #1's 1:1 observation had not started her shift at 6 am, instead she started at 7 am. CNA C said her and CNA P provided ADL care to the residents to get them ready for breakfast. CNA C said she saw Resident #1 in the dining/lobby area and saw Resident #2 going into Resident #1's room, where she sat and fell asleep on Resident #1's recliner. CNA C said she did not redirect Resident #2 to leave Resident #1's room because she has a history of becoming upset, and because Resident #1 was not in her room. CNA C said she did not see Resident #1 return to her room, while Resident #2 slept on her recliner. CNA C said she was unaware that Resident #2 had to be watched closer due to inappropriate sexual behavior, and she knew Resident #1 had behaviors of aggression and was supposed to be watched closer per FM's request.</p> <p>During an interview on 09/04/25 at 10:48 AM, CNA P indicated she worked on 08/23/25 and was directed by DON to keep an eye on Resident #1 due to inappropriate touching; however, she was not assigned as her 1:1 observation. CNA P said she worked with CNA C and they assisted residents with their ADLs to get them ready for breakfast. CNA P said CNA O was supposed to start her shift at 6 am and carry out Resident #1's 1:1 observation; however, she did not arrive until 7 AM. CNA P said she assisted Resident #1 with her ADLs and took her to the dining table because Resident #2 had entered Resident #1's room. CNA P said it was easier to take Resident #1 out of her room than Resident #2, which was why she allowed Resident #2 to stay in the room. CNA P said she informed LVN F, who was administering medications, that she was leaving Resident #2 in Resident #1's room. CNA P said at approximately 7 AM CNA O entered the memory unit and asked for the whereabouts of Resident #1 and replied that Resident #1 was supposed to be in the dining area. And that's when, LVN F yelled out for staff to get Resident #2 because she was foundling Resident #1 in her room and asked who was Resident #1's 1:1 observation. CNA P said she entered Resident #1's room and saw Resident #1 standing with her pants unbuckled and in front of Resident #2, who was sitting on the recliner and holding Resident #1 by her wrist. CNA P said earlier in the morning, she dressed Resident #1 and left her pants unbuckled because they did not fit her. CNA P said upon the start of her shift on 08/23/25 at 6 am, she knew Resident #1 was on 1:1 observation; however, she was not assigned to her and continued to care for the residents. CNA P said she was unaware that Resident #2 had a history of sexual behaviors. At 1:34 PM CNA P stated she had never implemented 1:1 observation for anyone. She stated she was working on 08/23/25 and does not recall anyone informing her that they were leaving, and that they had been the 1:1 observation for Resident # 1. She stated on 08/23/25 she was the person who assisted Resident #1 with dressing and then sat her at the dining room table.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/04/25 at 1:30 PM LVN L stated they are informed by the DON or the ADON that a resident is on 1:1 supervision. She stated that 1:1 supervision is a level of supervision that means that the staff is like the resident's "shadow" or like their "leash". She stated 1:1 supervision means that the staff must be close enough to verbally and physically intervene. She stated she was not responsible for assigning staff to 1:1 supervision. LVN L stated the DON or the ADON would make those assignments. She stated she is unaware of any documentation that staff must complete while they were on 1:1 supervision with residents. She stated the DON or ADON would be the person to let them (staff) know when the resident is no longer on 1:1 supervision. She stated the PNP was the only person that could take the resident off 1:1 supervision. She stated she had not had any special training but from her nursing experience she knew what 1:1 supervision looked like.</p> <p>During an interview on 09/05/25 at 10:35 AM, LVN F indicated on 08/23/25 she was in the hallway parallel to Resident #1's doorway as she prepared the next medication administration, when she witnessed Resident #1 standing in front of her recliner rocking back and forth, and Resident #2's hand inside her pantie. Resident #2, who was inside Resident #1's room, was sitting on Resident #1's recliner as she fondled Resident #1. LVN F said she said she yelled out to the CNAs "come get them" and questioned who was assigned as Resident #1's 1:1 observation. LVN F indicated she had not been given the responsibility of assigning 1:1 staff to residents in need of closer supervision, which had been the responsibility of DON and ADON. LVN F stated on 08/22/25 Resident #2 was a new admission to the facility. LVN F said she entered Resident #2's room and saw her masturbating. LVN F said she called the previous facility and spoke to LVN DD, who informed her Resident #2 had a history of being sexually inappropriate with the male residents, because she would go into their rooms and touch their private parts, and that's why she was transferred out of the facility. LVN F said she informed the DON that Resident #2 was masturbating; therefore, she could not conduct her heat-to-toe assessment, and that's when the DON entered her room and Resident #2 grabbed his pants. LVN F said Resident #2 was not assigned special supervision; however, Resident #1 had been on 1:1 observation since 08/21/25 due to an incident of aggression.</p> <p>During an interview on 09/04/21 at 1:41 PM, The DON said on 08/22/24 Resident #2 was admitted to the facility, and when he assessed her in the room by himself, she went for his belt buckle and he had to move her hand away. The DON said he asked LVN F to supervise Resident #2's assessment and nothing else happened during this assessment. The DON said he was unaware Resident #2 had a history of inappropriate sexual behaviors prior to her admission to the facility; however, he was informed that Resident #2 had to move from her previous facility due to being the victim of unwanted sexual advances by the male residents. The DON indicated if a resident has an incident of aggression the charge nurse will notify him, and then he will direct them to keep them separated and to place the aggression on 1:1 observation and would not be removed until the resident's assessed by psych services. The DON said the facility's central office reviewed Resident #2's file and directed the facility to accept her as a new admission. The DON confirmed on 08/23/25 Resident #1 was on 1:1 observation due to hitting a resident on 08/22/25. The DON said a CNA should have been within arm's reach of Resident #1, which would have prevented Resident #1 from being inappropriately touched by Resident #2. The DON said he and his staff were unaware that Resident #2 had a history of inappropriate sexual behaviors. The DON said on 08/23/25 he was informed by LVN F Resident #2 had her hand inside Resident #2's pants, and Resident #1 did not have a 1:1 observation at the time of this incident.</p> <p>During an interview on 09/04/25 at 10:48 AM, CNA E indicated she was unaware Resident #2 had a history of inappropriate sexual behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/25 at 11:41 PM, the admission Coordinator indicated Resident #2 was approved as a transfer to the facility by their Central Intake Team. This approval was sent to her via an email on 08/21/25, and Resident #2 was admitted to the facility on [DATE]. admission Coordinator said she did not review Resident #2's notes in the admission packet and confirmed Resident #2's admission transfer notes included 3 incidents of inappropriate sexual behavior (08/03/25 x 2 and 07/16/25).</p> <p>During an interview on 09/04/25 at 12:05 PM, the SW indicated she was unaware Resident #2 had a history of inappropriate sexual behavior; however, after Resident #2 touched Resident #1 inappropriately, she was placed on 1:1 observation.</p> <p>During an interview on 09/04/25 at 12:35 PM, the MDS Coordinator indicated she was unaware Resident #2 had a history of inappropriate sexual behavior; however, after Resident #2 touched Resident #1 inappropriately, she was placed on 1:1 observation. The MDS Coordinator said she does not assign residents 1:1 observation, nor does she include 1:1 or watch closely in a resident's care plan. The MDS Coordinator said she did not include Resident #1's inappropriate sexual behavior in her care plan, because she was not informed during her admission.</p> <p>During an interview on 09/04/25 at 1:19 PM, FNP U indicated on 08/21/25 she was informed Resident #1 had an incident of aggression, and that's when she was placed on 1:1 observation, until psych services could evaluate her. After this incident, FNP U said she was informed Resident #1 was inappropriately touched by Resident #2, who put her hand in her pants. FNP U said on 08/23/25 Resident #1 was supposed to be on 1:1 observation, and Resident #2 should not have had the opportunity to put her hand in her pants. The facility must ensure each resident receives adequate supervision and assistance to prevent this type of accident from happening.</p> <p>During an interview on 09/04/25 at 2:18 PM, the Administrator indicated he received an email that at the previous facility that the male residents were after Resident #2 sexually; therefore, she was approved by his central office to admit Resident #2. The administrator said he did not review Resident #2's file upon her admission to the facility. The Administrator indicated that the facility's investigation indicated LVN F witnessed Resident #2 with her hand inside Resident #1's panties. The Administrator said CNA A, who was assigned as Resident #1's 1:1 observation, should not have left her shift until she was replaced by a staff.</p> <p>During an interview on 09/04/25 at 3:47 PM, PNP indicated Resident #2 had a history of inappropriate sexual behavior, because on 08/22/25 LVN F found her masturbating, and she touched the DON on his pants during her assessment. PNP said he ordered Paxil that had to go through the facility's physician because she had not been approved for psych services. On 08/26/25 PNP said he received the approval for Resident #2's psych services. PNP said he was informed by the DON that Resident #2 had not displayed inappropriate sexual activity; therefore, PNP dc the need for 1:1 observation because the Paxil was showing good results. PNP said as of 09/04/25, he had not sent the facility his notes on his assessment with Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/05/25 at 10:35 AM, FNP T indicated Resident #2, who had a history of inappropriate sexual behaviors, should have been assigned a 1:1 observation or watched closely for 3 to 5 days , and should have had her inappropriate sexual behaviors care planned for her safety and the safety of others. FNP T said the observations should have been noted every 15 minutes for 72 hours, because they did not know if the resident will could be violent or hypersexual. FNP T said if Resident #1 was on 1:1 observation, then Resident #2 should never have had the opportunity to put her hand inside Resident #1's pants and panties.</p> <p>During an interview on 9/05/25 at 12:59 PM the DON stated that on 08/23/25 Resident #2 was placed on 1:1 supervision but they did not have documentation of that action. He stated because of the IJ they will now keep documentation of all residents who were placed on 1:1 supervision. He stated because of the IJ all residents in the secure unit were assessed by him and the SDON with no negative findings. He stated the ADON conducted safe surveys with no negative findings. He stated when the IJ was called on 09/04/25 the IDT team that included the department heads (the ADM, DON, BOM, Admissions Coordinator, HR, the DM, HK Supervisor, MDS Coordinator, and the ADM) trained all the staff on the ANE policy, 1:1 supervision (to include what it meant, the transfer process, how close they needed to be, when they could leave and documentation), and the Resident-to Resident Policy. He stated that residents who are placed on 1:1 supervision will need to ensure that they are close enough to intervene. He stated if the resident is sleeping the staff can be outside of the door and check every 15 minutes and use a flashlight so that the resident is not disturbed. He stated the 1:1 would be randomly checked to ensure that the documentation is up to date, staff are within the right distance and interventions are being followed. He stated during the week he and the ADON would do the random audits for 1:1 supervision but on the weekend, he had a RN supervisor. He stated he gave staff the opportunity to ask questions if they needed to. He stated Admissions was trained on reviewing the paperwork prior to accepting a resident in the facility. He stated before any resident is admitted to the facility their admission paperwork will be reviewed by the appropriate people in the IDT. He stated they did participate in a QAPI meeting that addressed all the components of the IJ.</p> <p>(continued on next page)</p>		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Abuse, Neglect and Exploitation revised on 08/05/25 indicated "it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercation. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitate or enabled through the use of technology." "Criminal sexual abuse is serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conducted described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse of Title 18, United States Cod, or any similar offense under State law. In other works , serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lac the ability to understand the nature of the sexual act." "Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that ae necessary to avoid physical harm, pain , mental anguish, or emotional distress. "Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury of harm.</p> <p>The Administrator and DON were notified on 09/04/25 at 6:18 PM that an IJ situation was identified due to the above failures and the IJ template was provided.</p> <p>The following Plan of Removal was accepted on 09/05/2025 at 10:46AM:</p> <p>"Plan of Removal</p> <p>09/05/2025</p> <p>Per the information provided in the IJ template given to the facility Administrator and DON on 09/04/25 at 6:18 PM</p> <p>The facility failed to ensure a safe environment free from sexual abuse when Resident #2, who had a history of inappropriate sexual behaviors, placed her hand inside Resident #1's panties.</p> <p>The facility's DON failed to implement interventions upon Resident #2's admission on [DATE], when LVN F informed him Resident #2 was masturbating, and after Resident #2 inappropriately touched him on his pants.</p> <p>Residents residing in the memory unit received a skin assessment and/or a safe survey on 8/23/2025 with no additional negative findings. Person(s) Responsible: Charge Nurse, social services, and/or designee</p> <p>Date: 8/26/2025</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Education provided to Administrator and Director of Nursing on the Abuse & Neglect Policy, 1:1 (employees should remain on 1:1, when placed on 1:1, without fail, until 1:1 is discontinued), Resident-to-Resident Policy, reviewing admission paperwork and care planning/educating staff, when needed, on sexual behaviors and interventions. Person(s) Responsible: Regional [NAME] President of Operations and/or Regional Nurse Consultant</p> <p>Date: 8/23/2025</p> <p>All staff educated on the Abuse & Neglect Policy, 1:1 (employees should remain on 1:1, when placed on 1:1, without fail, until 1:1 is discontinued), and Resident-to-Resident Policy. Schedules will be reviewed and the Administrator, Director of Nursing, and/or a Designated staff member will be responsible to ensure all staff will be educated prior to working their next shift. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee.</p> <p>Date: 9/4/2025</p> <p>Referrals/admissions will be reviewed prior to admission to ensure high risk history, such as sexual or physical aggression, and care plans/interventions will be put into place and staff will be communicated with prior to/at admission. Care plans can be found in Matrix in the plan of care. Person(s) Responsible: admission Coordinator, Administrator, Director of Nursing, Assistant Director of Nursing, and/or Designee</p> <p>Date: 9/4/2025</p> <p>When residents are placed on 1:1, Administrator, Director of Nursing, Assistant Director of Nursing, and/or Designee will spot check, daily, Monday-Friday and a designee such as a charge nurse and/or weekend supervisor will spot check, daily, Saturday and Sunday, to ensure staff are following policy and education provided. Person(s) Responsible: Administrator, Director of Nursing, Assistant Director of Nursing, and/or Designee Date: 9/4/2025</p> <p>QAPI&mdash;</p> <p>Action: Ad hoc QAPI performed with Medical Director, notified of the Immediate Jeopardy template and the facility's plan to remove it. No additional recommendations at this time. Person(s) Responsible: Administrator Date: 9/4/2025</p> <p>On 09/05/25 the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by:</p> <p>During an interview on 09/05/25 at 11:09 AM, the DON said the in-services indicated observation levels will be implemented by CNAs, nurses, ADONs, DON, SW, and other staff (activity director, housekeepers, and office staff as needed).</p> <p>During an interview on 09/05/25 the admission Coordinator was in-serviced to ensure referrals for new admissions are reviewed prior to admission. If a resident is identified with a history of sexual or physical aggression, this will be care planned to include interventions for staff to follow.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/05/25 at 12:59 PM the DON stated that on 08/23/25 Resident #2 was placed on 1:1 supervision but they did not have documentation of that action. He stated because of the IJ they will now keep documentation of all residents who were placed on 1:1 supervision. He stated because of the IJ all resident</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for two of five residents (Resident #1, Resident #2) reviewed for abuse, neglect, and exploitation. The facility failed to implement their policies and procedures for identifying and addressing at admission Resident #2's history of inappropriate sexual behavior to prevent Resident #2, from placing her hand inside Resident #1's pantie. The Immediate Jeopardy (IJ) was identified on 09/04/25 at 6:18 PM. The IJ template was provided to the facility's Administrator and DON on 09/04/25 at 6:18 PM. While the immediacy was removed on 09/05/25 at 6:07 PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems, and because all their staff had not been trained on 09/05/25. These failures could affect all residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm. Findings include: Resident #2 Record review of Resident #2's face sheet current as of 09/03/25, revealed a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #2 diagnoses included unspecified dementia severe with agitation (a behavioral and emotional state of dementia characterized by behaviors like restlessness, pacing, shouting, aggression, and repetitive actions), mood disorder due to known physiological condition (a mental disorder characterized by persistent changes in mood), and schizoaffective disorder bipolar type (mental health condition episodes that combines mania and depression). Review of Resident #2's Physician's Active Orders dated 08/22/25 included Psychiatric and Psychological services to evaluate and treat as needed. Record review of Resident #2's admission Comprehensive MDS, dated [DATE] revealed the following: *Section C Brief Interview for Mental Status (BIMS) revealed a score of 1 which indicated the resident's cognition was severely impaired. *Section E-Behavior: Physical behavioral symptoms directed towards other (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, packing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 to 3 days. Wandering-Presence & Frequency: Has the resident wandered? This was coded with a 0 to indicate this behavior was not exhibited. *Mobility Devices: none of the devices (cane, walker, wheelchair, limb prosthesis) were used. *Functional Abilities-Mobility: Walk 10 feet, once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. This was coded an 88, which meant she had not attempted due to medical condition or safety concerns. Record review of Resident #2's Care Plan dated 08/24/25 revealed her inappropriate sexual behavior was included in her plan after she was found with her hand in Resident #1's panties on 08/23/25. This plan included: *Problem: will not exhibit socially inappropriate/disruptive behavior pattern, specifically impulsive sexual behavior. This would be addressed by approaching Resident #2 and removing her from resident's room and unsafe situations. Maintain a calm environment and calm approach to the resident. Assess whether the behavior endangers the resident and/or others and intervene if necessary. *Problem: has a history of touching other residents inappropriately: This would be addressed through staff and by redirection. *Record review of Resident #2's Event Report dated 08/23/25 indicated Resident #2 was involved in an incident alleging she had her hand down the pants of Resident #1. This incident was witnessed by LVN F, the residents were separated by CNA C and CNA DD, and Resident #2 was placed on one-to-one observation with the nursing staff (1:1, defined as a staff member constantly with the resident and documents at 15-minute intervals). Resident #2, who was in Resident #1's room when this incident occurred was removed from Resident #1's room. This report indicated Resident #2 was assessed and there were no signs of trauma. On 09/02/25 at 9:40 am FNP T gave LVN F orders for Resident #2 to have labs, Senior Psych referral and Aricept 5 mg. q hs. On 09/02/25 at 10:37 am PNP gave LVN F order for Resident #2's Remeron to be change to HS, and to change Paxil to am, and have nursing to monitor for over sedation. PNP added the diagnosis of Alzheimer's late onset to Resident #2's diagnosis. *The Facility Event Summary Report dated 08/23/25 indicated on 08/23/24 Resident #2 was found with her hand in Resident #1's pantie. After this incident, Resident #1 and Resident #2 were placed on 1:1 observation provided by the nursing staff. The residents were assessed and there were no signs of trauma, and the FNP and PNP were notified of this incident on 08/23/25. Review of</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to review and revise resident's comprehensive care plans by the interdisciplinary team after each assessment for 1 (Resident #8) of 12 residents reviewed for comprehensive care plans. The facility failed to update or add interventions to Resident #8's care plan regarding aggressive and physical behaviors toward other residents that occurred on 08/05/25 and 08/29/25. These failures could result in residents not receiving the care that they need. Findings Included: Record review of Resident #8's face sheet, dated 09/03/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), psychotic disturbance (mental health condition characterized by loss of touch with reality), mood disturbance (significant change in a person's emotional state), anxiety (increased worry), cognitive communication deficit (Difficulty communicating), depressive episodes (periods of significant low mood or loss of interest that can interfere with daily life), and schizoaffective disorder (mental health condition that combines symptoms of schizophrenia and mood disorder). Record review of Resident #8's Comprehensive Minimum Data Set, dated [DATE], revealed the following: *Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. *Section E did not reveal any coded behaviors. Record review of Resident #8's physician orders, undated, revealed the following: *Hydroxyzine tablet; 25 mg 1tablet PO Every 8 hours PRN; diagnosis: pain: 01/03/25 and end date: open ended. *Ativan- Benadryl Topical gel; 1 mg/25mg/ ML; 4 clicks (1ML); topically every 8 hours as needed; diagnoses: anxiety: 7/23/25 and end date 08/06/25. *Rexulti; .5 mg; once a morning; diagnosis: dementia: 09/02/25 and end date: open ended. Resident #8's care plan, dated 6/19/25 revealed the following: *Resident #8 had a focus with the category behavioral symptoms for resident use of physical aggression. (7/28/25) The goal was for Resident #8 to maintain appropriate space and not to engage in physical aggression. Interventions included managing Resident #8's space with other residents and redirect Resident #8 to maintain distance and not to be physically aggressive. *Resident #8 had a focus with the category of physical aggression. Resident #8 at physically aggressive behaviors at times (6/19/25). The goal was for Resident #8, not to harm residents with physical abusive behavior. Resident #8 would be monitored frequently to avoid further altercations. Interventions included assisting the resident with placement in an alternative therapeutic unit. Assess whether the resident's behavior was dangerous to other residents and intervene as necessary. Avoid overstimulation. Convey attitude of acceptance towards the resident. And maintain a calm environment and approach to the resident. Obtain a psychiatric consult if needed and provide activities and daily schedule that resembles the resident prior lifestyle. Record review of Resident #8's progress notes, dated 06/01/25-09/03/25, revealed the following: *08/6/25 at 9:16 AM the DON documented Resident #8 was assessed and found to have no issues or signs of trauma. Resident #8 was witnessed to be the aggressor in an incident involving another resident and was separated in place on one-to-one supervision. After residence were separated the representatives and families of the residence were notified of the incident and the need for an alternative placement. FNP U was notified with no new orders given and PNP was notified for a follow up with no new current orders at this time. The DON and administrator were also notified. *08/22/25 at 10:11 AM the SW documented a phone call was placed to a behavioral rehabilitation center. Was notified by the behavior rehabilitation center. That Resident #8 was clinically denied admission. *08/29/25 at 6:00 PM the DON documented Resident #8 was involved in an altercation with another resident. Resident #8 was witnessed, striking another resident in the face after the other resident was seen speaking to Resident #8. What was said was not able to be determined or it or if it had relevance to the instigation of the incident. Both residents were immediately separated, and Resident #8 was placed on one-to-one observations. Both residents were evaluated for signs of trauma or neurological changes or signs of abrasion, redness, or bruising. There were no signs able to be seen or presented upon resident assessment. Resident #8 representative was notified and approved for the need for alternative placement. *09/01/25 at 1:20 PM the DON documented Resident #8 was still actively being considered for alternate placement due to behaviors. *09/02/25 at 10:50 AM the SW documented Resident #8 1:1 supervision was discontinued after the IDT met. During an interview on 09/03/25 at 3:50 PM, Resident #8 was unable to participate in an interview as he did not answer any questions related to the incident that occurred on 08/29/25. He was able to tell the investigator that he felt safe and wanted to walk. During an interview on 09/04/25 at 1:45 PM Resident #8 did not answer the investigator's questions</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents and/or hazards as possible for 2 of 5 residents (Resident #1, Resident #2) reviewed for supervision. The facility failed to ensure Resident #1, and Resident #2 received supervision to prevent Resident #2, who had a history of sexual behaviors, from sexually abusing Resident #1, when she put her hand in her panties. Resident #1 was on one to one (1:1) supervision due to a previous incident of aggression with a different resident; however, she was allowed to alone in her room with Resident #2. The Immediate Jeopardy (IJ) was identified on 09/04/25 at 6:18 PM. The IJ template was provided to the facility's Administrator and DON on 09/04/25 at 6:18 PM. While the immediacy was removed on 09/05/25 at 6:07 PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems, and because all their staff had not been trained on 09/05/25. These failures could affect all residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm, due to lack of supervision. Findings include:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet current as of 09/03/25, revealed a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #2 diagnoses included unspecified dementia severe with agitation (a behavioral and emotional state of dementia characterized by behaviors like restlessness, pacing, shouting, aggression, and repetitive actions), mood disorder due to known physiological condition (a mental disorder characterized by persistent changes in mood), and schizoaffective disorder bipolar type (mental health condition episodes that combines mania and depression).</p> <p>*Record review of Resident #2's admission Comprehensive MDS, dated [DATE] revealed the following:</p> <p>Section C Brief Interview for Mental Status (BIMS) score revealed a score of 1 which indicated the resident's cognition was severely impaired.</p> <p>Section E-Behavior:</p> <p>Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days.</p> <p>Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, packing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 to 3 days.</p> <p>Functional Abilities-Mobility: Walking 10 feet, once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. This was coded an 88, which meant she had not attempted due to medical condition or safety concerns.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Record review of Resident #2's Care Plan, dated 08/24/25 revealed her inappropriate sexual activity was included in her plan after she was found with her hand in Resident #1's panties on 08/23/25.</p> <p>Problem: will not exhibit socially inappropriate/disruptive behavior pattern, specifically impulsive sexual behavior. This would be addressed by approaching Resident #2 and removing her from resident's room and unsafe situations. Maintain a calm environment and calm approach to the resident. Assess whether the behavior endangers the resident and/or others and intervene if necessary.</p> <p>Problem: has a history of touching other residents inappropriately: This would be addressed through staff and by redirection.</p> <p>*Record review of Resident #2's Event Report dated 08/23/25 indicated Resident #2 was involved in an incident alleging she had her hand down the pants of Resident #1. This incident was witnessed by LVN F, the residents were separated by CNA C and CNA DD, and Resident #2 was placed on one-to-one observation with the nursing staff (1:1, defined as a staff member constantly with the resident and documents at 15-minute intervals). Resident #2, who was in Resident #1's room when this incident occurred was removed from Resident #1's room. This report indicated Resident #2 was assessed and there were no signs of trauma.</p> <p>On 09/02/25 at 9:40 am FNP T gave LVN F orders for Resident #2 to have labs, Senior Psych referral and Aricept 5 mg. q hs.</p> <p>On 09/02/25 at 10:37 am PNP gave LVN F order for Resident #2's Remeron to be change to HS, and to change Paxil to am, and have nursing to monitor for over sedation. PNP added the diagnosis of Alzheimer's late onset to Resident #2's diagnosis.</p> <p>Resident #1:</p> <p>Record review of Resident #1's Face Sheet current as of 09/03/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnosis included dementia mild with mood disturbances (emotional or behavioral changes, such as anxiety, apathy, depression or irritability), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), insomnia (trouble sleeping).</p> <p>*Record review of Resident #1's admission Comprehensive Minimum Data Set, dated [DATE] revealed:</p> <p>Section C, Brief Interview for Mental Status (BIMS) score revealed a score of 00, which indicated the resident's cognition was severely impaired.</p> <p>Section E-Behavior, Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days.</p> <p>Wandering-Presence & Frequency: Has the resident wandered? This was coded with a 0 to indicate this behavior was not exhibited.</p> <p>Functional Abilities-Mobility, walking 10 feet, once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. This was coded a 6, which meant she could complete this activity by herself with no assistance from a helper.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Record review of Resident #1's Care Plan dated 08/12/25 included:</p> <p>Problem: updated on 08/23/25 to include due to impaired cognition, Resident #1 is at risk for unwanted sexual advances from other residents. This would be addressed by ensuring client safety.</p> <p>Problem, on 08/12/25 the plan included that she had been physically aggressive towards others. The plan included cueing resident to maintain space between self and others and assisting resident in moving self away while interacting with others.</p> <p>*Record review of Resident #1's Observation Detail List Report noted by LVN N on 08/23/25 at 11:18 am indicated Resident #2 was witnessed with her hand down Resident #1's pants, in Resident #1's room. The nursing staff immediately entered the room and separated Resident #1 and #2. Resident #2 was placed on 1:1 observation due to this allegation. Resident #1 was assessed and she had no signs of trauma.</p> <p>*Record review of Resident #1's Progress Notes indicated the following:</p> <p>On 08/26/25 Resident #1's Interdisciplinary Team met and discontinued her 1:1 observation. 08/23/35 Resident #1 (who was on 1:1 observation) was involved in an incident in which resident (Resident #2) was witnessed with her hand down resident #1's pants in Resident #1's room. Nursing staff entered the room, separated Resident #1 and #2, and removed Resident #2 from Resident #1's room. Resident #1 was assessed and there were no signs of trauma.</p> <p>During an interview on 09/03/25 at 10:40 am, Resident #2 was asked a series of questions; however, her verbal responses were not understood. Instead, Resident #2 smiled each time she was asked a question, including if she had touched Resident #1 on her private area.</p> <p>During an interview on 09/03/25 at 10:46 am, CNA C indicated on 08/23/25 she was working with CNA P; however, CNA O, who was assigned as Resident #1's 1:1 observation had not started her shift at 6 am, instead she started at 7 am. CNA C said her and CNA P provided ADL care to the residents to get them ready for breakfast. CNA C said she saw Resident #1 in the living/dining area and saw Resident #2 go into Resident #1's room, where she sat and fell asleep on Resident #1's recliner. CNA C said she did not redirect Resident #2 to leave Resident #1's room because she has a history of becoming upset, and because Resident #1 was not in her room. CNA C said she did not see Resident #1 return to her room, while Resident #2 slept on her recliner. CNA C said she was unaware that Resident #2 had to be watched closer due to inappropriate sexual behavior, and she knew Resident #1 had behaviors of aggression and was supposed to be watched closer per FM's request.</p> <p>During an interview on 9/04/25 at 1:34 PM CNA P stated that prior to 08/23/25, she had never done 1:1 observation. She stated she was working on 08/23/25. She stated she did not recall anyone specifically telling her that they were leaving, and they were the 1:1 staff for Resident # 1. She stated on 08/23/25 she was the person to get Resident #1 dressed and she sat her at the dining room table.</p> <p>During an interview on 09/03/25 at 11:15 AM, Resident #1 indicated nobody had hurt her and she could not recall being touched on her body by Resident #2.</p> <p>During an interview on 09/04/25 at 10:48 AM, CNA E indicated she was unaware Resident #1 had a history of inappropriate sexual behavior.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/25 at 10:48 AM, CNA P indicated she worked on 08/23/25 and was directed by DON to keep an eye on Resident #1 due to inappropriate touching; however, she was not assigned as her 1:1 observation. CNA P said she worked with CNA C and they assisted residents with their ADLs to get them ready for breakfast. CNA P said CNA O was supposed to start her shift at 6 am and carry out Resident #1's 1:1 observation; however, she did not arrive until 7 AM. CNA P said she assisted Resident #1 with her ADLs and took her to the dining table because Resident #2 had entered Resident #1's room. CNA P said it was easier to take Resident #1 out of her room than Resident #2, which was why she allowed Resident #2 to stay in the room. CNA P said she informed LVN F, who was administering medications, that she was leaving Resident #2 in Resident #1's room. CNA P said at approximately 7 AM CNA O entered the memory unit and asked for the whereabouts of Resident #1 and CNP replied that Resident #1 was supposed to be in the dining area. And that's when, LVN F yelled out for staff to get Resident #2 because she was foundling Resident #1 in her room and asked who was Resident #1's 1:1 observation. CNA P said she entered Resident #1's room and saw Resident #1 standing with her pants unbuckled and in front of Resident #2, who was sitting on the recliner and holding Resident #1 by her wrist. CNA P said earlier in the morning, she dressed Resident #1 and left her pants unbuckled because they did not fit her. CNA P said upon the start of her shift on 08/23/25 at 6 am, she knew Resident #1 was on 1:1 observation; however, she was not assigned to her and continued to care for the residents. CNA P said she was unaware that Resident #2 had a history of sexual behaviors. At 1:34 PM CNA P stated she had never implemented 1:1 observation for anyone. She stated she was working on 08/23/25 and does not recall a night CNA informing her that she was leaving, and that they had been the 1:1 observation for Resident # 1. She stated on 08/23/25 she was the person who assisted Resident #1 with dressing and then sat her at the dining room table.</p> <p>During an interview on 09/04/25 at 11:41 PM, the admission Coordinator indicated Resident #2 was approved as a transfer to the facility by their Central Intake Team. This approval was sent to her via email on 08/21/25, and Resident #2 was admitted to the facility on [DATE]. The admission Coordinator said she did not review Resident #2's notes in the admission packet; and then confirmed Resident #2's admission transfer notes did include 3 incidents of inappropriate sexual behavior 08/03/25 - two incidents, and one incident on 07/16/25.</p> <p>During an interview on 09/04/25 at 12:05 PM, the SW indicated she was unaware Resident #2 had a history of inappropriate sexual behavior; however, after Resident #2 touched Resident #1 inappropriately, she was placed on 1:1 observation.</p> <p>During an interview on 09/04/25 at 12:35 PM, the MDS Coordinator indicated she was unaware Resident #2 had a history of inappropriate sexual behavior; however, after Resident #2 touched Resident #1 inappropriately, she was placed on 1:1 observation. The MDS Coordinator said she does not assign residents 1:1 observation, nor does she include 1:1 or watch closely in a resident's care plan. The MDS Coordinator said she did not include Resident #1's inappropriate sexual behavior in her care plan, because she was not informed during her admission.</p> <p>During an interview on 09/04/25 at 1:19 PM, the FNP U indicated on 08/21/25 she was informed Resident #1 had an incident of aggression, and that's when she was placed on 1:1 observation, until psych services could evaluate her. After this incident, FNP U said she was informed Resident #1 was inappropriately touched by Resident #2, who put her hand in her pants. FNP U said on 08/23/25 Resident #1 was supposed to be on 1:1 observation, and Resident #2 should not have had the opportunity to put her hand in her pants. The facility must ensure each resident receives adequate supervision and assistance to prevent this type of accident from happening.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/21 at 1:41 PM, the DON indicated if a resident has an incident of aggression the charge nurse will notify him, and then he will direct them to keep them separated and to place the aggressor on 1:1 observation and would not be removed unit the resident's assessed by psych services. The DON said the facility's central office reviewed Resident #2's file and directed the facility to accept her as a new admission. The DON said on 08/22/24 Resident #2 was admitted to the facility, and when he assessed her in the room by himself, she went for his belt buckle, and he had to move her hand away. The DON said he asked LVN F to supervise his assessment of Resident #2's and nothing else happened. The DON said he was unaware Resident #2 had a history of inappropriate sexual behaviors prior to her admission to the facility; however, he was informed that Resident #2 had to move from her previous facility due to being the victim of unwanted sexual advances by the male residents. The DON indicated on 08/23/25 Resident #1 was on 1:1 observation due to hitting a resident on 08/22/25. The DON said a CNA should have been within arm's reach of Resident #1, which would have prevented Resident #1 from being inappropriately touched by Resident #2. The DON said he and his staff were unaware that Resident #2 had a history of inappropriate sexual behaviors. The DON said on 08/23/25 he was informed by LVN F Resident #2 had her hand inside Resident #1's pants, and that Resident #1 did not have a 1:1 observation at the time of this incident.</p> <p>During an interview on 9/04/25 at 1:40 PM CNA E stated that she has never been any resident's 1:1 staff. She stated they are typically informed by the DON or the previous shift staff may tell them if a resident is on 1:1 supervision. She stated the DON would tell them if a resident was off 1:1 supervision. She stated she had been trained by the facility staff that they stay until relief comes. She stated she did not know when, but the training had occurred since she had been at the facility.</p> <p>During an interview on 09/04/25 at 2:18 PM, the Administrator indicated that the facility's investigation included that LVN F witnessed said she witnessed Resident #2 with her hand inside Resident #1's panties. The Administrator said CNA A, who was assigned as Resident #1's 1:1 observation, should not have left her shift until she was replaced by a staff.</p> <p>During an interview on 09/04/25 at 3:04 PM, CNA A indicated she started her shift on 08/22/25 at 6 PM and worked until 6 AM on 08/23/25. During this shift, CNA A said she was assigned as Resident #1's 1:1 observation, which meant she had to watch her closely and keep her out of residents' room. CNA A said before she left the facility on [DATE] at 6 am, she informed a CNA, whose name she could not recall, that she was leaving and transferring her observation to the next shift. CNA A said Resident #1 was asleep in her bed when she left.</p> <p>During an interview on 09/04/25 at 3:47 PM, PNP indicated Resident #2 had a history of inappropriate sexual behavior, because on 08/22//25 LVN F found her masturbating, and she touched the DON on his pants during her assessment. PNP said he ordered Paxil that had to go through the facility's physician because she had not been approved for psych services. On 08/26/25 PNP said he received the approval for Resident #2's psych services. PNP said he was informed by the DON that Resident #2 had not displayed inappropriate sexual activity; therefore, PNP dc the need for 1:1 observation because the Paxil was showing good results. PNP said as of 09/04/25, he had not sent the facility his notes on his assessment with Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/05/25 at 10:35 PM, FNP T indicated Resident #2, who had a history of inappropriate sexual behaviors, should have been assigned a 1:1 observation or watched closely for 3 to 5 days, and should have had her inappropriate sexual behaviors care planned for her safety and the safety of others. FNP T said the observations should have been noted every 15 minutes for 72 hours, because you don't know if the resident will could be violent or hypersexual. FNP T said if Resident #1 was on 1:1 observation, then Resident #2 should never have had the opportunity to put her hand inside Resident #1's pants and panties.</p> <p>During an interview on 09/05/25 at 10:35 AM, LVN F indicated on 08/23/25, Resident #2 was not assigned special observation; however, Resident #1 was on 1:1 observation due to an incident of aggression on 08/21/25. On 08/23/25 LVN F said she was in the hallway parallel to Resident #1's doorway as she prepared the next medication administration, when she witnessed Resident #1 standing in front of her recliner rocking back and forth and Resident #2's hand inside her pantie. Resident #2, who was inside Resident #1's room, was sitting on Resident #1's recliner as she fondled Resident #1. LVN F said she said she yelled out to the CNAs &ldquo;come get them&rdquo; and questioned who was assigned as Resident #1's 1:1 observation. LVN F indicated she was not informed CNA O was not starting her shift at 6 AM, had not been given the responsibility of assigning 1:1 staff to residents in need of closer supervision, which had been the responsibility of DON and ADON.</p> <p>The facility's policy and procedure, Observation Levels, dated 04/2024 indicated &ldquo;It is the policy of the facility that staff monitoring is instituted to maintain the safety of each resident and provided by a system of progressive intensity of resident observation and oversight. The use of the level that provide each resident with optimal level of safety in the least restrictive manner will be utilized. Resident will be routinely observed in compliance with physician orders and/or clinical protocols.&rdquo;</p> <p>The level of supervision included:</p> <p>Standard observation (assess and document at no less than every two hours). Minimum level of observation for all residents.</p> <p>Line of sight (assess and document at 15-minute intervals). A level of observation wherein the resident remains in staff view. A specific staff member may be assigned, and the line-of-sight observation is maintained by staff in person and not through video monitoring.</p> <p>One to one (staff member constantly with the resident and documents at 15-minute intervals). Consist of One-to-one with a resident never farther away than 10 or less feet. The residents must remain within this parameter. A licensed nurse my place a resident ton line-of-sight or one-on-one and increase the level of observation at any time as clinically necessary. In all cases the least restrictive clinically appropriate intervention will be implemented. The license nurse my not decrease the level of observation until conferring with the director of nursing/designee and/or physician.</p> <p>The procedure includes three levels of resident observation are used. The levels are designated to provide increasing intensity of observation, precaution, and oversight commensurate with physician and staff. The appropriate observation level is implemented:</p> <p>After evaluation and assessment, a level of observation may be instituted by the attending physician or registered nurse.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>If a registered nurse institutes an observation level, the attending physician is notified as soon as possible.</p> <p>The physician's order shall include the Observation Level and the reason for the monitoring.</p> <p>The charge nurse will assign staff to perform the standard observation level on a designated set of residents. Resident online of sight or one on one will be assigned specific staff.</p> <p>The charge nurse will assign staff to perform the standard observation level on a specific designated set of residents. Resident online of sight or one on one will be assigned specific staff. The nurse will arrange for staff to be relieved for breaks and meals.</p> <p>Assigned staff will complete the resident observations as rounds are made and document on the rounds from. Staff will observe the resident's location and note the residents' behavior. Rounds are not to be documented in advance.</p> <p>In addition to recording the whereabouts of resident at ordered intervals, the purpose of observation is to provide a system of progressive intensity of resident observation, precaution and oversight based on resident acuity, severity and type of symptoms, and overall needs.</p> <p>The order of observation level is communicated to all staff.</p> <p>Staff must hand-off responsibility for maintaining observation of assigned resident of any break or potential interruption in completing assigned rounds.</p> <p>The Administrator and DON were notified on 09/04/25 at 6:18 PM that an IJ situation was identified due to the above failures and the IJ template was provided.</p> <p>The following Plan of Removal was accepted on 09/05/2025 at 10:46AM:</p> <p>&ldquo;Plan of Removal</p> <p>09/05/2025</p> <p>The facility failed to provide the &ldquo;planned&rdquo; or &ldquo;scheduled&rdquo; 1:1 supervision for resident #1 that resulted in exposing her to a hazard of being inappropriately / sexually touched by resident #2.</p> <p>1. On 08/23/25 Resident #2, who was the aggressor that put her hand inside Resident #1's panties, was placed on 1:1 observation. Resident #1, who was supposed to be on 1:1 observation when Resident #2 put her hand in her panties, was returned to 1:1 observation. On 08/26/25, Resident #2 was taken off of 1:1 observation after IDT's review. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: 8/26/2025</p> <p>2. Residents residing in the memory unit received a skin assessment and/or a safe survey on 8/23/2025 with no additional negative findings. Person(s) Responsible: Charge Nurse, social services, and/or designee Date: 8/23/2025</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Education was provided to the Administrator and the Director of Nursing on the Abuse & Neglect Policy, 1:1 (employees should remain on 1:1, when placed on 1:1, without fail, until 1:1 is discontinued), and the Resident-to-Resident Policy. Person(s) Responsible: Regional [NAME] President of Operations and/or Regional Nurse Consultant Date: 9/4/2025</p> <p>4. All staff educated on the Abuse & Neglect Policy, 1:1 (employees should remain on 1:1, when placed on 1:1, without fail, until 1:1 is discontinued), and Resident-to-Resident Policy. Schedules will be reviewed and the Administrator, Director of Nursing, and/or a Designated staff member will be responsible to ensure all staff will be educated prior to working their next shift. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: 9/4/2025</p> <p>5. When residents are placed on 1:1, Administrator, Director of Nursing, Assistant Director of Nursing, and/or Designee will spot check, daily, Monday-Friday and a designee such as a charge nurse and/or weekend supervisor will spot check, daily, Saturday and Sunday, to ensure staff are following policy and education provided. Person(s) Responsible: Administrator, Director of Nursing, Assistant Director of Nursing, and/or Designee Date: 9/4/2025</p> <p>6. QAPI—</p> <p>Action: Ad hoc QAPI performed with Medical Director, notified of the Immediate Jeopardy template and the facility's plan to remove it. No additional recommendations at this time. Person(s) Responsible: Administrator Date: 9/4/2025</p> <p>7. During an interview on 9/05/25 at 12:59 PM the DON stated that on 08/23/25 Resident #2 was placed on 1:1 supervision but they did not have documentation of that action. He stated because of the IJ they will now keep documentation of all residents who were placed on 1:1 supervision. He stated because of the IJ all residents in the secure unit were assessed by him and the SDON with no negative findings. He stated the ADON conducted safe surveys with no negative findings. He stated when the IJ was called on 09/04/25 the IDT team that included the department heads (the ADM, DON, BOM, Admissions Coordinator, HR, the DM, HK Supervisor, MDS Coordinator, and the ADM) trained all the staff on the ANE policy, 1:1 supervision (to include what it meant, the transfer process, how close they needed to be, when they could leave and documentation), and the Resident-to Resident Policy. He stated that residents who are placed on 1:1 supervision will need to ensure that they are close enough to intervene. He stated if the resident is sleeping the staff can be outside of the door and check every 15 minutes and use a flashlight so that the resident is not disturbed. He stated the 1:1 would be randomly checked to ensure that the documentation is up to date, staff are within the right distance and interventions are being followed. He stated during the week he and the ADON would do the random audits for 1:1 supervision but on the weekend, he had a RN supervisor. He stated he gave staff the opportunity to ask questions if they needed to. He stated Admissions was trained on reviewing the paperwork prior to accepting a resident in the facility. He stated before any resident is admitted to the facility their admission paperwork will be reviewed by the appropriate people in the IDT. He stated they did participate in a QAPI meeting that addressed all the components of the IJ.</p> <p>On 09/05/25 the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on 09/05/25 at 7:55 AM revealed CNAs B, C and DON were working on the memory unit. The DON, who was monitoring, said he was filling in because CNA M was not able to work her shift, and ADON, would also fill in as needed. The DON said there was not a resident in this unit, who was on 1:1 observation or a special level of observation. The staff were expected to monitor and prevent Resident #2 from entering a resident's room. The memory unit had a 3-foot-tall wall that is approximately 12 feet wide and separates the living/dining area from the hallway, which allowed staff to see the residents in the living/dining area and the hallway. Resident #2 did not enter a resident's room.</p> <p>Observation on 09/05/25 at 8:05 AM, revealed Resident #2 was observed walking around the living/dining area and the CNAs were in the hallway and living/dining area observing approximately 9 Residents, including Residents #1 and #2. Resident #2 did not enter a resident's room.</p> <p>Observation on 09/05/25 at 10:06 AM, CNAs, B, C, and DON, who was monitoring, were on duty, and Resident #2 was walking from the hallway to the living/dining area. Resident #2 did not enter a resident's room.</p> <p>Observation on 09/05/25 at 11:21 AM, CNAs, B, C, and DON, who was monitoring, were on duty, and Resident #2 was walking from the hallway to the living/dining area. Resident #2 did not enter a resident's room.</p> <p>Observation on 09/05/25 at 11:23 AM, CNAs, B, C, and DON, who was monitoring, were on duty, and Resident #2 was standing near the CNAs. Resident #2 did not enter a resident's room.</p> <p>Observation on 09/05/25 at 2:10 PM, CNAs, B, C, and LVN F, who was monitoring, were on duty, and Resident #2 was walking in the living/dining area. Resident #2 did not enter a resident's room.</p> <p>Observation on 09/05/25 at 4:55 PM, CNAs B and C, and MA G, who was monitoring, were in the memory care unit, and Resident #2 was walking in the hallway. Resident #2 did not enter a resident's room.</p> <p>Interview on 09/05/25 at 12:57 PM, the DON indicated Resident #2 was the only one identified with sexual behaviors; however, since 08/23/25 she had not made any attempts to touch a resident or staff inappropriately.</p> <p>*Record Review of Resident #2's Event Report dated 09/03/25 indicated:</p> <p>On 08/24/25 at 10:54 AM. Resident #2 was being monitored on the memory unit on, and she was wandering among the common areas with 1:1 assigned staff member. She exhibits no signs of agitation or pain. She has minimal verbal exchanges and has been minimal in complete thoughts and sentences.</p> <p>On 08/24 at 4:22 PM Resident #2 only makes visual contact nonverbal, in good spirit, affect appropriate, and can't assist with questions to complete any SW admission assessments.</p> <p>On 08/26/25 at 10:56 AM revealed Resident #2's Interdisciplinary Team met and discontinued her 1:1 observation.</p> <p>On 09/02/05 LVN F received orders from FNP T, who was in the facility, to complete Resident #2 a CBC, CMP, TSH, A1C, senior psych referral, and Aricept 5mg q hs. This report included that on</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/02/25 at 10:37 AM LVN F received orders from PNP to change Remeron to HS, change Paxil to AM, monitor for over sedation, and add history of Alzheimer's late onset.</p> <p>*Review Resident #2's FNP T's Progress Note dated 09/02/25 indicated Resident #2 was taking Aricept 5 mg at bedtime orally once a day. This assessment indicated Resident #2 required memory care unit, Aricept, and psych consult.</p> <p>During interview conducted with staff on duty on 09/05/25 from 10:06 PM until 5:01 PM that worked on the 6 AM to 6 PM shift (FNP T at 10:06 PM, LVN F at 10:35 AM , DON at 11:09 PM, ADON at 11:32 PM, CNA H at 1:06 pm, LVN I at 1:36 PM, CNA HH at 1:56 PM, LVN F at 1:49 PM, SW at 2:12 PM, CNA P at 2:32 PM, Activity Director at 2:50 PM, MA J at 2:58 PM, CNA II, at 3:23 PM, Admissions Coordinator at 3:29 PM, HK Supervisor at 4:45 PM, MA G at 5:42 PM), and 6 pm to 6 am shifts (RN Z at 5:51 PM, and CNA and CNA D at 1:28 PM). These staff were in-serviced on preventing Abuse, Neglect, and Exploitation, Levels of Observation, and Resident to Resident Altercat</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 12 residents (Resident #3) reviewed for pharmacy services. The facility failed to monitor, review and reconcile Resident #3 medication administration record from on 8/21/25 which resulted in an official unknown count of (Hydrocodone) to be unaccounted for. This failure could place at an increased risk of drug diversion and misuse of resident medications or possibly make resident medication unavailable to meet their clinical needs. Findings included: Resident #3 Record review of Resident #3's face sheet, 9/03/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include muscle weakness, pneumonia (infection in the lung), intellectual disability (disability that affects cognitive ability), nonspecific skin eruption (skin rash). Record review of Resident #3's Comprehensive Minimum Data Set, dated [DATE], revealed the following: *Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. *Section N Medications revealed Resident #3 took the following high-risk medications: none checked to include opioids. Record review of Resident #3's care plan, dated 7/14/25, did not have a care plan for pain. Record review of Resident #3's physician order, undated, revealed the following: Hydrocodone -acetaminophen 5-325 mg; 1 tab Q 6 hr prn for pain; diagnosis: pneumonia; order start date: 5/09/25 and end date: open ended. Resident #3's MAR for May 2025 and June 2025 revealed that Resident #3 was not administered any hydrocodone-acetaminophen 5-325 mg prn. Resident #3's MAR for July 2025 revealed that Resident #3 was administered any hydrocodone-acetaminophen 5-325 mg prn 1 time by LVN L on 07/25/25 at 10:45 AM. Resident #3's MAR for August 2025 revealed that Resident #3 was administered any hydrocodone-acetaminophen 5-325 mg prn 5 times: *(8/18/25) by LVN K at 7:19 PM, *(8/19/25) by LVN F at 11:57 AM, *(8/25/25) by LVN L at 9:20 AM, *(8/27/25) by LVN F at 3:18 PM and, *(8/28/25) by LVN F at 1:12 PM. Resident #3's MAR for September 2025 revealed that Resident #3 was not administered any hydrocodone-acetaminophen 5-325 mg prn as of 09/04/25. Record review of Resident #3's progress notes, dated 06/01/25-09/03/25, revealed: *08/28/25 at 2:32 PM LVN F documented: Resident #3 was heard making noises and she found Resident #3 on the floor. Resident #3 was assessed and assisted to the geriatric chair. There were no visible injuries and ROM was intact. Pain medication was administered with efficacy. Further review of progress notes revealed there were no additional progress notes regarding Resident #3's pain, pain administration, or missing pain medications. Record review of Resident #3's Controlled Drug Receipt /Record/ Disposition Form, dated 5/06/25 revealed that out of an 8-quantity card of Hydrocodone 5-325 mg facility staff administered 8 tabs between the date of 05/09/25 and 07/27/25. Record review of Resident #3's Controlled Drug Receipt /Record/ Disposition Form, dated 8/14/25 revealed that out of a 60-quantity card of Hydrocodone 5-325 mg facility staff administered 12 tabs between the date of 08/15/25 and 08/20/25. Record review of Resident #3's Controlled Drug Receipt /Record/ Disposition Form, dated 8/15/25 revealed that out of a 30-quantity card of Hydrocodone 5-325 mg facility staff administered 5 tabs between the date of 08/15/25 and 09/04/25. Record review of Resident #3's Controlled Drug Receipt /Record/ Disposition Form, dated 8/15/25 revealed that out of a 26-quantity card of Hydrocodone 5-325 mg facility staff administered 26 tabs between the date of 08/22/25 and 09/02/25. Record review of Resident #3's Controlled Drug Receipt /Record/ Disposition Form, dated 8/15/25 revealed that out of a 30-quantity card of Hydrocodone 5-325 mg facility staff administered 0 tabs had been administered from the 30-count card. Record review of Resident #3's Controlled Drug Receipt /Record/ Disposition Form, dated 8/15/25 revealed that out of a 30-quantity card of Hydrocodone 5-325 mg facility staff administered 0 tabs had been administered from the 30-count card. Record review of Resident #3's pain assessments, dated 05/01/25-09/05/25, revealed the following: Resident #3 had a pain level of 4 out of 10 on 05/09/25 documented by LVN K. Resident #3 had a pain level of 4 out of 10 on 06/07/25 documented by LVN N. Resident #3 had a pain level of 4 out of 10 on 06/09/25 documented by LVN K. Resident #3 had a pain level of 2 out of 10 on 06/11/25 documented by LVN N. Resident #3 had a pain level of 4 out of 10 on 06/16/25 documented by MA J. Resident #3 had a pain level of 4 out of 10 on 06/22/25 documented by LVN N. Resident #3 had a pain level of 2 out of 10 on 07/03/25 documented by (space was left blank). Resident #3 had a pain level of 2 out of 10 on 07/05/25 documented by LVN N. Resident #3 had a pain level of 4 out of 10 on 07/23/25 documented by LVN X. Resident #3 had a pain level of 7 out of 10 on 07/26/25 documented by</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen be free from unnecessary drugs without adequate indications for its use for 2 of 12 (Resident #4 and Resident #6) reviewed for unnecessary medications. The facility failed to ensure that Resident #4 PRN orders for psychotropic drugs (Lorazepam (2MG/ML) were limited to 14 days and or provide a physician's rationale indicating that it was appropriate for the PRN order to exceed the 14 day stop date. The facility failed to ensure that Resident #6 PRN orders for psychotropic drugs (Lorazepam (2MG/ML) were limited to 14 days and or provide a physician's rationale indicating that it was appropriate for the PRN order to exceed the 14 day stop date. This failure could lead to residents being prescribed medications without indication and place residents at risk of unnecessary side effects and a decline in overall health. Findings included: Resident #4 Record review of Resident #4's face sheet, dated 09/03/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnosis of generalized anxiety disorder (increased worry), psychosis (mental health condition characterized with by false contact with reality. Record review of Resident #4's Comprehensive MDS, dated [DATE], revealed the following: *Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. *Section N Medications revealed Resident #4 took the following high-risk medications: Anti-anxiety Resident #4's care plan, dated 6/19/25 revealed the following: Resident #4 had a focus for psychotropic drug use specifically that Resident #4 had potential for complications related to antidepressant medications, specifically Lorazepam. (initiated 7/9/25) The goal was for Resident #4 to be free from side effects to the medication and to not exhibit side effects from taking antianxiety medications. Staff should monitor resident's functional status each shift. Staff should monitor resident's mood and response to medication. Staff should monitor side effects such as sedation, drowsiness, dizziness, nausea and vomiting. The staff should have a pharmacy review monthly. Record review of Resident #4's physician orders, undated, revealed the following: *Lorazepam .5 mg/ML; .25 ML every 6 hours prn diagnosis: generalized anxiety; order start date: 12/18/24 and end date: open ended. Record review of #4's medication consent, dated 08/28/24, revealed Resident #4's MAR for July 2025 revealed that Resident #4 was not administered Lorazepam .5 mg/ML: .25 ML prn. Resident #4's MAR for August 2025 revealed that Resident #4 was administered Lorazepam .5 mg/ML: .25 ML prn on the following dates: *08/01/25 at 11:27 AM by LVN W *08/01/25 at 6:29 PM by RN Y (doses effective), *08/05/25 at 2:46 PM by LVN F (dose effective), and *08/25/25 at 4:06 PM by LVN L (dose effective). Resident #4's MAR for September 2025 revealed that Resident #4 was not administered Lorazepam .5 mg/ML. Record review of Resident #4's Consultant Pharmacist Recommendation, dated 08/28/24, signed by the Pharmacy Consultant revealed: In accordance with state and federal guidelines, psychotropic drugs, PRN, orders for psychotropic drugs are limited to 14 days, except when the attending position or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Then here she should document the rationale in the resident medical record and indicate the duration for the PRN order. Response: Continue PRN use for 90 days, as the benefit outweighs the risk. Record review of Resident #4's progress notes, dated 06/01/25-09/03/25, revealed the following: *08/01/25 at 4:33 PM, LVN W documented Resident #4 was witnessed rolling himself from the edge of the bed onto his fall mat and appeared to be confused. The resident was given .25 ml of lorazepam to help with anxiety and agitation. Further review reviewed there were no additional progress notes regarding lorazepam, medication administration or anxiety. During an interview on 09/05/25 at 10:31 AM, Resident #4 did not contribute any information related to the specific failure. Resident #6 Record review of Resident #6's face sheet, dated 09/19/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), generalized anxiety (increased worry) and cognitive communication deficit (difficulty communicating). Record review of Resident #6's Quarterly MDS, dated [DATE], revealed: *Section C Brief Interview for Mental Status score revealed a score of 02, which indicated the resident's cognition was severely impaired. Section N Medications revealed Resident #6 did not take high-risk medications, to include anti-anxiety. Record review of Resident #6's physician orders, undated, revealed the following: *Lorazepam 2 mg/ ML; .25 ML Every 4 hours PRN; diagnosis: pain: 08/03/25 and end date: open ended. Record review of Resident #6's updated prescription order, dated 09/09/25, revealed: *Lorazepam 2 mg/ ML; .25 ML Every 4 hours PRN; diagnosis: Generalized anxiety: 09/09/25 and end date: 09/23/25 Record review of Resident #6's MAR for August and</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 3 of 5 medication carts (1 nurses medication cart for memory care on Station 2, 1 nurses medication cart for Station 2 and 1 medication aide cart for Station 1), reviewed for medication storage. The facility failed to maintain proper medication storage after the following was found: The nurse medication cart located on Station 2 contained medication Lorazepam (2MG/ML; dated 8/11/25) that required refrigeration for Resident #4. The nurse's medication cart for Memory care located on Station 2 contained medication (2MG/ML; dated 8/03/25) that required refrigeration for Resident #6. The medication aide cart for Station 1 contained medication Lorazepam (unable to see the dose) that required refrigeration for Resident #5. This failure could place residents at risk of not receiving prescribed medications that are not effective or that could expire faster than the printed date. Findings included: An observation of Station II memory medication cart was conducted on 09/04/25 at 6:21 AM revealed Resident #6's Lorazepam 2MG/ML; dated 8/03/25 with a refrigeration sticker across the front, located on the cart. Observations of the Station II nurses medication cart on 09/4/25 revealed the following: *At 6:14 AM revealed Resident #4's Lorazepam 2MG/ML; dated 8/11/25 with a refrigeration sticker across the front, located on the cart. LVN L stated she was going to place the medication in the refrigerator, LVN L left to place the medication in the refrigerator. *At 6:21 AM revealed Resident #6's Lorazepam 2MG/ML; dated 8/03/25 with a refrigeration sticker across the front, located on the cart. *6:36 AM revealed Resident #5's Lorazepam (unable to see the dose) located on the medication cart. The label was not legible to read. The resident's last name only was handwritten at the top along with the name of the medication (Ativan). The label on the box appeared to be damaged by an unknown liquid. The investigator could not identify the directions, resident's name, dose amount, and who the medication was prescribed to. The date filled on the box was 02/05/25 and the label on the bottle inside was also not legible. During an interview on 9/05/25 at 9:56 AM the FNP T stated liquid Lorazepam had to be stored at a certain temperature or it would lose the effectiveness. She stated she was unaware that there was liquid Lorazepam that was being stored in the cart. She stated she had not been in the facility for the past 30 days as she was on medical leave. FNP T stated proper storage of liquid Lorazepam was common nursing knowledge. During an interview on 9/05/25 at 12:59 PM the DON stated he was familiar with the facility's medication storage policy. He stated each resident medication labels should include frequency, time and day the resident should receive the medication, when the medication was opened, quantity of the medication, name of the medication, name of the resident, route and any special instructions. He stated he could not observe the expected and required information on Resident #5's Lorazepam, but it had been discarded and reordered. He stated the purpose of proper storage and labeling was to ensure resident safety. He stated the potential negative outcome for not practicing proper storage and labeling, specifically refrigerating the Lorazepam and ensuring that medications had the proper labeling was the Lorazepam could have an adverse effect for the resident receiving the medication. He stated the medication could also be improperly administered to the residents. He stated he had been trained that if there was a medication that had been out for an unknown time, he had been trained to immediately remove the medication as he does not know how long it was out. He stated that he was in the process of discarding and reordering Resident #4 and Resident #6 PRN Lorazepam. He stated the facility's system to monitor proper storage, and labeling was conducting cart audits. He stated they were conducting random cart audits, but he stated they did not observe or check the residents Lorazepam. He stated he had been trained to adhere to pharmacy/medication labels. The DON stated he could not say that his nurses had formally been trained at the facility on proper storage and labeling, but it was a standard nursing practice taught in nursing school. He stated he did not have a reason and was unsure why Resident #5's Lorazepam was not labeled correctly and why none of the liquid Lorazepam was not refrigerated as instructed on the medication label. He stated that he expected all pharmacy labels to be adhered to and all special instructions such as refrigeration to be followed. He stated the nurses and medication aides were responsible for ensuring that that there was always proper labeling and storage for all medications in the facility. He stated the filled date listed on the medication was the date the medication came to the facility. During an interview on 9/05/25 at 2:07 PM the ADM stated he was familiar with the facility's policy, Medication Storage and Labeling, and although the policy was not specific a medication label should include resident name, medication name, dose, directions of administration, expiration and at least the physician's name. He stated he was unable to see the required identified</p>		