STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455942	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Health Care Center	4120 22nd Pl Lubbock, TX 79410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 11 of 16 toilets reviewed for safe environment, in that: - On June 25, 2024, the toilets in rooms #3, #8, #13, #16, #32, #50, #51, #52, #56, and Resident #2's and #3's rooms were unsecured to the floor and unstable. These failures could place the residents and public at risk for injury and falls. The Findings include: Record review of Resident #2's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had a history of hypoxia (oxygen is insufficient at the tissue level), hypertension (high blood pressure), anxiety, and seizures. Record Review of Resident #2's BIMS assessment dated [DATE], revealed Resident #2 had a BIMS score of 15 which indicates Resident #2 was cognitively intact. Record review of Resident #2's care plan dated 6/10/2024 revealed Resident #2 required 1 staff assistance for toilet use. Record review of Resident #3's undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #3 had a history of morbid obesity, unspecified lack of coordination, hypertension (high blood pressure), and seizures. Record review of Resident #3's BIMS assessment dated [DATE] revealed resident had a BIMS score of 15, which indicated Resident #3 was cognitively intact. Record review of Resident #3's care plan dated 5/17/2024 revealed resident required 1 staff assistance for toileting. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with ADM on 6/25/24 at 10:32 AM, she stated on new admission they will be checking the toilets. She stated the last maintenance staff had since quit and a new staff will begin Monday July 1st. She stated all the toilets had been checked by ADM and an Admission staff and a list had been given to maintenance to have the loose toilets assessed. She stated they only found one loose toilet and it was reinforced. During an interview with Maintenance Staff on 6/25/24 at 10:53 AM he stated I wasn't here that day (6/15/24) since I was off for the weekend. They called me that day and they let me know the toilet had fallen on a resident. They stated she had been sitting down and she fell and tried to grab the toilet and the toilet tilted on her. They told me they would call the plumbers that day and by the time I got back on 6/18 I went to check on it, but it still had a bit of a wobble. The toilet couldn't be tightened anymore because it would break the base. The ADM made a list of toilets to assess, and I checked them all. I tightened two of them, and noted the bolts were old and rusted, so I replaced them. If there were any toilets that had issues the facility usually would let me know but it was not a part of my monthly check up. I think the facility could do the checks monthly, but it was never something that had been brought. I had been here 10 months and my last day was 6/24/24. During an interview with Resident #2 on 6/25/24 at approximately 11:47 AM, she stated she had been told her toilet was loose but did not think anyone had come to fix it. Resident #2 stated she had used the toilet for the first time the previous night and had noted it was still loose. During an interview with Resident #3 at approximately 11:48 AM, he stated his toilet was too short for him but had not noticed if it was loose. During an observation of rooms #50, #51, #52, #56, and Resident #2's room on 6/25/24 at approximately 11:50AM, the toilets were loose, not secured to the floor and were unstable. During an interview with CNA A on 6/25/24 at 1:05pm she stated, I have not noticed any other issues with any other toilets in the facility. The facility did an in-service on the toilet and toilet seats. They told us to notify maintenance as soon as possible if the toilet was having issues and not let residents use them. I think maintenance should check the toilets regularly. This type of incident had not happened before. During an interview with Admission staff on 6/25/2024 at 3:05 pm, she stated she checked the toilets for being loose by grabbing the center of the toilet with both her gloved hands and attempted to move the toilet. She stated the ones that were loose were circled on a sheet and the ones not circled were fine. She stated when she was done checking the toilets, she gave the list to the ADM. She stated she does not typically do these types of checks. During an observation of the facility toilets on 6/25/2024 at approximately 3:11 PM, toilets in rooms #3, #8, #13, #16, #32, #50, #51, #52, #56, and Residents #2's and #3's rooms were found to be unsecured to the floor and unstable. Observations of the toilets were conducted with Admission Staff and the ADM. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Housekeeping Supervisor on 6/25/24 at 4:31pm, she stated I give a checklist to the housekeepers, and they mark what is missing and if something was loose. They must check everything on the list and as soon as they give me the paper, I put it in maintenance box if there is something that needs to be repaired. Two staff members told me there were two loose toilets in Resident #2's room and I can't remember the other room. There was supposed to be a sign on Resident #2's room saying it was out of order. I was not aware of any of the other rooms having loose toilets. The bathrooms are cleaned daily. The housekeepers are supposed to check the toilets and to make sure they are cleaning around but not removing the caulking. My expectations are for the housekeepers to clean the bottom and around the toilet and removed any urine buildup or stains. I in serviced my staff to start checking the toilets after the incident with Resident #1. Prior to this recent in-service we had not had any other training or in servicing regarding toilet maintenance. During an interview with ADM on 6/25/24 at 4:44pm, she stated the negative consequences of the toilets not being secured appropriately could be injury to a resident. The facility will be monitoring and doing safety and environmental rounds. I will most likely go through and check the toilets myself. Record review of page titled Resident Room Roster dated 6/15, revealed room [ROOM NUMBER], #5, #13, #30, #31, #35, #39, #54, and #53 had been circled for further assessment of the toilets. The page was signed by Admission Staff and ADM. Record Review of facility policy titled Preventative Maintenance/Work- Order Request, revealed: 1. The facility will repair or replace damaged/broken equipment or building amenities as needed. 2. the facility will educate all staff members on the procedure for requesting repair of damages to the building or equipment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview and record review, the facility failed to ensure that the resident environment remained free of accident hazards for 1 of 1 resident (resident #1) reviewed for accidents in that: - On June 15, 2024, Resident #1 ambulated to the bathroom and sat on the toilet, the toilet was unstable and loose causing Resident #1 to fall. These failures could place residents at risk for injury. The findings include: Record review of Resident #1's undated face sheet, revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 was discharged [DATE], per resident and family request. Resident #1 had a history of emphysema (a type of lung disease that causes breathlessness), CHF (congestive heart failure), and hypertension (high blood pressure). Record Review of Resident #1's BIMS assessment dated [DATE], revealed Resident #1 had a BIMS score of 14 which indicates Resident #1 was cognitively intact. Record review of Resident #1's care plan dated 6/16/2024 did not reveal Resident #1 required assistance to the bathroom or incontinence care. Record review of the facility Provider investigation report dated 6/21/2024 revealed on 6/15/2024 at 3:35pm Resident #1, took herself to the bathroom. Resident #1 was found on the floor, Resident #1 stated that when she was going to the bathroom the toilet wobbled and she fell . The toilet was leaning on her. Aide and 2 nurses attended to the resident. Resident #1 had a laceration on wrist. The ADM called plumbers. Resident #1 refused to move rooms. ADM brought a bedside commode. Bruise is on the neck later after skin assessment, nurse went back in to assess. Resident #1 complained of aches and pains, x-ray was ordered. No issues found on X-ray. Sunday- resident arm is showing a bruise. Complaining of aches and feels sore. Provider investigation report signed by ADM on 6/16/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with ADM on 6/25/24 at 10:32 AM, she stated she saw the toilet herself and the toilet was leaning slightly. She stated the bolts were both still in the toilet but one of the bolts had stripped from the floor. She stated Resident #1 had gone to the bathroom and her assumption is Resident #1 was wiping and when she leaned over the resident may have fallen at that point. She stated CNA A found her. She stated Resident #1 had a bruise to her arm, and a laceration to the wrist, and later a bruise to her neck. ADM stated Resident #1 denied hitting the sink but was found under the sink. She stated Resident #1 had denied pain at the time of the incident but a few hours later, she began to complain of left arm pain and her back. She stated the facility performed x-rays on her left arm and back and the reports were negative for acute fractures. She stated Resident #1 had been admitted on [DATE] on the same day of the incident. She stated Resident #1 did not want to change rooms, so a bedside commode was brought in. She stated Resident #1 had discharged two days later unrelated to the incident, as the resident was unwilling to do therapy. ADM stated Resident #1 had come in for skilled nursing due to COPD. During an observation of Resident #1's toilet, on 6/25/24 at approximately 11:45AM, the toilet was secured to the floor and unmovable. During an interview with CNA A on 6/25/24 at 1:05pm she stated I heard Resident #1 screaming and I went into her room, and Resident #1 was on the floor and the toilet was leaning over but not on top of her. I screamed because I didn't want to leave her alone and the nurse came in. Resident #1 had a scrape on her left arm. The toilet was easily moveable at that point. The side the toilet was leaning on was still connected to the floor, and the other side was lifted. During an interview with ADM on 6/25/24 at 4:44pm, she stated the negative consequences of the toilets not being secured appropriately could be injury to a resident. She stated the facility would be monitoring and doing safety and environmental rounds. She stated she would most likely assess the toilets herself. During an interview with Resident #1's family member on 6/25/24 at 4:30pm, they stated they had checked on Resident #1 later that afternoon the day of the fall. She stated Resident #1 was having pain in her back and left forearm. She stated she obtain a couple of significant bruises on her arm and left side of the neck. She stated Resident #1 had end stage COPD (chronic obstructive pulmonary disease, a condition of the airway and difficulty or discomfort in breathing) and often confused. She stated Resident #1 was able to walk short distances. She stated Resident #1 had gone to the bathroom and sat on the toilet and the toilet bolted and she fell off with the toilet leaning on Resident #1. She stated the facility put a bedside toilet by her bed until they could get the toilet fixed. She stated Resident #1 did not want to be there and was discharged to the assisted living she was at prior. She stated the staff was very attentive but not very knowledgeable and either not aware of or not concerned with the issue at hand. During an interview with Resident #1 on 6/26/24 at 11:43 AM she stated, I feel that this incident was 100 % preventable. I walked into the bathroom, sat on the toilet and the whole thing turned over and I fell over, the toilet fell on top of me. I didn't even get a chance to take off my pants. I had a cut on my left wrist that has a butterfly band aid, and they x-rayed me to make sure I didn't break anything. I did not break anything, but my left wrist is still bruised and sore. The bruise on my neck looks fine, it is still sore but no problem there. The facility seemed concerned, but I think it was because they didn't want to get sued, I don't feel like it was genuine. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility undated policy title Event Reporting; Completion of, revealed: 1. The facility will complete an Event report on variances that occur within the facility. Variances include falls, skin tears, bruises, abrasions, lacerations, fractures, choking, burns, elopement, or behavior that affects others. 7. Investigation: The investigation should be completed by the DON/Administrator or designee. The investigation report documents a thorough investigation of the events of the reported Event including persons, equipment, and materials that were involved. The investigation report must include what actions were taken to prevent subsequent Events and signatures of the individuals as indicated on the form.