| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455942 | A. Building<br>B. Wing | 06/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lubbock Health Care Center | 4120 22nd Pl<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for narcotic medication being accounted for.<br><br>The facility failed to prevent Resident #1's Lorazepam Medication from being accounted for.<br><br>This failure could place residents at risk for not receiving prescribed medication.<br><br>Findings include:<br><br>Record review of Resident #1's, undated, face sheet revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses which included: depression (loss of interest), anxiety (feeling of uneasiness), acute systolic (congestive) heart failure (heart weakness), acute respiratory failure with hypoxia (lack of oxygen in body), acute respiratory failure with hypercapnia (too much carbon dioxide in the blood).<br><br>Record review of a Resident #1's quarterly MDS, dated [DATE], revealed a BIMS of 09, which indicated moderate cognitive impairment.<br><br>Record review of Resident #1's physician orders, dated 06/09/2025, revealed an active order for Lorazepam Intensol Oral Concentrate 2 MG/ML(Lorazepam) Give 0.5 ml by mouth four times a day related to generalized anxiety disorder. Ordered on 05/06/2025.<br><br>(continued on next page) |

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

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

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's Individual Control Drug Record Narcotic Count sheet for the Lorazepam Intensol 2 MG/ML revealed the facility received the medication from the pharmacy on 05/21/2025 and quantity received 101 syringes, 0.25 ml each. The record revealed on 05/21/2025, 7 were given, on 05/22-27/25 8 were given per physician orders. On 05/27/2025 there is a line drawn through the amount remaining at 12:30PM to change the amount remaining from 48 to 44 and signed by the DON and ADON. The count on the narcotic count sheet for 05/27/2025 at 12:30 PM indicated two were given with 48 remaining. The count after shift changed at 7:00PM on 05/27/2025 the narcotic count sheet indicated 2 syringes were given with 42 doses remaining. There were four syringes missing at that time. The narcotic count sheet was corrected to indicate on 05/27/2025 at 12:30PM the count needed to indicate the four missing syringes and the count was changed from 48 to 44. Then the last dose for 05/27/25 was given after the count was corrected and 42 syringes remained. There were 101 syringes received on 05/22/2025, 55 syringes were given between 05/22/2025 and 05/27/2025 at 12:30 PM. That left 46 syringes, the count was showing 48 on the narcotic count sheet, there were four syringes missing so the count was corrected on 05/27/25 to indicate 44, then 2 syringes were given at 7:00 PM and the count indicated 42 remained.<br><br>Record review of Resident's #1 MAR dated 06/09/2025 revealed Lorazepam Intensol 2 MG/ML give 0.5ml by mouth four times a day for generalized anxiety disorder was given as ordered on 05/27/2025.<br><br>During an interview on 06/09/2025 at 11:10 AM, RN A stated on 05/27/2025 LVN B had control of the medication cart and at the beginning of the shift 6:00AM - 6:00PM, the narcotic count was correct. At the end of the shift LVN C took over the medication cart for 6:00PM - 6:00AM and the narcotic count was not correct. She stated per the facility protocol if the narcotic count is off, staff must stay at the facility, the DON must go to the facility to count the narcotics and attempt to locate the narcotics. The staff involved in any missing narcotics would be required to take a drug test. She stated LVN B agreed to the drug test however the temperature of the urine was below normal and LVN B was asked to repeat the drug test, she refused and walked out.<br><br>During an interview on 06/09/2025 at 11:30 AM, the ADON stated she received a call on 05/27/2025 that the narcotic count was off by four syringes of Lorazepam for Resident #1. She stated she counted the medication cart with LVN C and looked at the narcotic record sheet for any mistakes. She searched all the medication carts for the missing medication and interviewed LVN B and LVN C. She stated LVN C reported she accepted the medication cart, however they [LVN B and LVN C] did not go to the refrigerator and count the Lorazepam in the refrigerator at shift change. She stated LVN C told her they counted the Lorazepam on the paper but forgot to go to the refrigerator and count the medication. She stated she interviewed LVN B and she told her they counted the Lorazepam on paper and forgot to go to the refrigerator and count the medication. She stated HR was at the facility and per facility policy both staff involved would need to be drug tested. She stated LVN B provided her urine sample, and the temperature was too low for the test to be accurate and LVN B was asked to provide a second test. She stated LVN B refused the second test and walked out of the facility. She stated medication carts are to be counted at shift change 6:00AM and 6:00PM. She stated she expected staff to count the medication carts correctly, notify the DON and herself immediately, staff to remain at the facility until administrative staff arrived. She stated to count the medication cart correctly all medications should be counted including all medications in the refrigerator.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/09/2025 at 11:51 AM, the DON stated she received a call from LVN C and the narcotic count was off by four syringes of Lorazepam for Resident #1. She stated all medication carts were checked and interviewed LVN B and LVN C. She stated LVN C admitted at shift change they [LVN B and LVN C] did not count the Lorazepam in the refrigerator for Resident #1. She stated LVN B told her she grabbed all four syringes of Lorazepam for Resident #1 and placed them in her pocket at the beginning of her shift. LVN B stated Resident #1 takes two syringes at a time and that is given twice per her shift 6:00AM - 6:00PM. LVN B assured her she gave all four syringes to Resident #1 and was not sure where the four missing syringes were. She stated per facility policy staff involved in missing medication concerns would be drug tested. She sated LVN B gave her urine sample to HR and it was not the correct temperature and LVN B was told she would need to provide another sample. She stated LVN B refused to provide a second sample and walked out of the facility. She stated medications carts are to be counted at the time of shift change. She stated staff are to count all pills in the medication carts one staff to check the paper record and the other staff to check the medication to ensure they match and to count all medication in the refrigerator. She stated nurses are aware medications are kept in the refrigerator. The facility replaced the missing medication and Resident #1 did not miss any medication. The facility in-serviced all nurses and medication aides on counting all narcotic medication in the medication carts and the refrigerators.<br><br>During an interview on 06/09/2025 at 12:06 PM, LVN C stated she worked on 05/27/2025 from 6:00PM - 6:00AM. She stated when she arrived for her shift, she counted the narcotics in the medication cart with LVN B, but not the Lorazepam in the refrigerator. She stated that a little after shift changed, she went to get the Lorazepam for Resident #1 out of the refrigerator and noticed there were four syringes less than what the narcotic count sheet showed. She stated she sent a text to the ADON and called LVN B. She stated LVN B returned to the facility, and they could not locate the four syringes of Lorazepam. She stated that LVN B told her she grabbed all four syringes at one time and kept two in her pocket for the next dose during her shift. She stated after the DON and ADON arrived they counted all the medication carts and could not find the four syringes of the Lorazepam for Resident #1. She stated she had to take a drug test and received coaching for not counting the medication in the refrigerator. She stated the reason they did not count the medication in the refrigerator is they trusted each other, and it didn't seem like a concern at the time, and she knew better. She stated, there are a lot of pre-filled syringes in the refrigerator, and it is time consuming to count them all. She stated the DON had her call and get the four syringes replaced for Resident #1 and he did not miss any Lorazepam. She stated since the incident she was trained and in-serviced on counting narcotics.<br><br>During an attempted interview on 06/09/2025 at 12:27 PM, LVN B did not answer the phone call, or reply to the text message that was sent to her regarding the investigation.<br><br>During an interview on 06/09/2025 at 12:30 PM, the ADM stated he contacted the local police department case number 250080395and filed a report, however he was not sure they would do anything, since the cost of the medication was $1.00.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/09/2025 at 1:45PM, HR Manager stated she received a call from LVN C and was told medication was missing. She stated the facility protocol is they must drug test everyone that had access to the medications and that night it was LVN B and LVN C. She stated she went to the facility and informed both LVN B and LVN C they needed to provide a drug test. She stated LVN B provided a urine sample, and the temperature was too low, and the test would not provide accurate results. She stated she informed LVN C that she would need to provide another urine sample as part of the protocol. She stated LVN B refused the second test. She stated she informed LVN B that as part of her employment anytime there was an incident involving medications staff would be drug tested and if she refused, she would self-terminate her employment. She stated LVN B refused and walked out of the facility. She stated LVN B signed the Employee Agreement and Consent to Drug and/or Alcohol testing on 02/27/2025 and received the Employee Handbook on that same date.<br><br>During an interview on 06/09/2025 at 4:34PM, Resident #1 stated all he knew about his medications is that at times he had refused the Lorazepam because he didn't have anxiety.<br><br>Record review of in-service dated 05/27/2025, instructor DON, subject: Narcotic Count each nurse/medication aide must count narcotics with the oncoming nurse/medication aide no matter what. You do not skip any narcotic counts. All narcotics that are kept in the refrigerator must be counted as well. If the count is off, please notify DON/ADON immediately.<br><br>Record review of Employee Agreement and Consent to Drug and/or Alcohol Testing for LVN B signed by LVN B on 02/27/2025. The document revealed: the employee agreed to submit to a drug or alcohol and to furnish a sample of my urine, breath, and/or blood analysis. I understand and agree that if I at anytime refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination.<br><br>Record review of the facility policy Controlled Medications - Administration dated 03/2025.<br><br>Policy<br><br>Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations.<br><br>Procedure<br><br>8. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech, or equivalent as allowed by your State regulatory agency and is documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit. |