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	12/09/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen (Kitchen A) reviewed for dietary services. [NAME] D failed to ensure food was stored, prepared, and served under sanitary conditions. Food items-including butter and rolls were left uncovered for extended periods while in the kitchen. Resident drink cups were stored on 12/7/25 by DA A and DA E: Trays were stacked directly on top of uncovered cups, exposing the rims of the cups to the unsanitary underside of serving trays. DM failed to discard spoiled sweet potatoes that were visibly rotten and stored with fresh food items. DA A and DA E failed to label and date beverages stored in the walk-in refrigerator. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 12/7/25 in Kitchen A:Butter:The butter remained uncovered while not actively being served during the following times: 9:45 AM to 10:20 AM 11:22 AM to 11:45 AM 2:00 PM to 2:05 PM Uncovered or Improperly Stored Items:At 9:45 AM, a large container of tea was observed in the kitchen sink with a large tea bag steeping inside. At 10:02 AM, DA E removed the tea from the sink and placed it on a table near the kitchen entrance. The large tea container remained uncovered while DA E filled smaller pitchers one at a time to fill resident cups. The larger container remained uncovered throughout this process. At 9:50 AM, three trays of glasses were observed stacked on top of one another, exposing the rims of the glasses to the underside of the serving trays. A total of 48 glasses had exposed rims. At 10:05 AM, DA A unstacked the cups, allowing DA E to fill them with tea. DA A then covered the filled cups with saran wrap and placed them in the walk-in refrigerator. Unlabeled Food/Drink Items:At 9:52 AM, 39 cups of unknown liquids with lids were observed in the walk-in refrigerator. The liquids were not labeled or dated. Spoiled/Rotten Food:At 9:56 AM, 17 spoiled sweet potatoes with visible white fuzzy substance were observed stored in a plastic bag dated 11/26/25 with fresh russet potatoes. The spoiled sweet potatoes remained present until the investigator exited at 10:20 AM. The spoiled sweet potatoes remained present during subsequent observations at 11:36 AM to 11:45 AM and again at 2:00 PM to 2:05 PM. Rolls:Cook D removed trays of rolls from the oven at 9:59 AM and 10:02 AM. Both trays remained uncovered and not actively being served or buttered until 10:20 AM. During this time, DA A was observed sweeping near the uncovered rolls.The following observations were made on 12/8/25 in Kitchen A:Butter:The butter remained uncovered while not actively being served during the following times: 7:03 AM to 7:11 AM 11:30 AM to 12:35 PM At 6:30 PM, saran wrap was observed covering the butter; however, the utensil remained in the container. Spoiled/Rotten Food:The spoiled sweet potatoes dated 11/26/25 remained stored with russet potatoes during observations at: 7:04 AM to 7:11 AM 11:35 AM to 12:35 PM At 6:44 PM, the investigator brought the spoiled sweet potatoes to DA C's attention. Unlabeled Food/Drink Items:At 7:10 AM and again at 6:45 PM, the same 39 unlabeled cups of liquid remained in the walk-in refrigerator until addressed by the investigator. During an interview on 12/08/25 at 6:44 PM, DA C stated that he was unaware of the rotten sweet potatoes. He counted the sweet potatoes and confirmed there were 17 in total. DA C stated that he was unaware that the juices were in the refrigerator unlabeled and not dated. He stated that he believed they were (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	orange juice and cranberry juice. He stated that he was unaware of when they were made. DA C stated that he did not see the rotten sweet potatoes in the walk-in dry pantry. He stated that when he counted them, he could smell that they were rotten and was unsure how they were missed. He stated that regarding the butter, it was his job to cover the butter at the end of the night and place it in the refrigerator. He stated that when he came in, the butter was generally always uncovered and was left for him in the evening as one of his tasks. DA C stated that the potential negative outcome of having spoiled or rotten food stored with residents' fresh or ready-to-eat food was that they could not use even the fresh food. He stated that having spoiled or rotten food could affect the overall health of the residents. He stated that the potential negative outcome of not labeling food was the same as having spoiled food stored with fresh food. He stated that they would not be able to use food that was not labeled or dated because it could be old and affect the overall health of the residents. He stated that if food such as butter was not covered, then items could fall into the butter, staff could spray something and it could get into the food, or staff could be cleaning around the food and debris could get into the butter. He stated that this could make residents sick if they consumed it. He stated that he was familiar with the food storage policy but had only been at the facility a short time. DA C stated that the system to ensure foods were being labeled timely was to label food and drink items as they were prepared. He stated that spoiled food should be discarded immediately and not stored with fresh food items. He stated that all food not being used should be covered. He stated that he did not have a reason for the juices not being dated and labeled, the spoiled sweet potatoes being stored with other food items, nor did he have a reason why the butter was not covered and left for him to cover in the evenings. He stated that he had been trained to cover food items not actively being served but had never been trained to cover the butter. He stated that he knew to discard spoiled food items, but generally the DM discarded the food items. He stated that the aides typically dated and labeled the juices. DA C stated that all staff were responsible for ensuring that food was properly covered, discarded when appropriate, and dated and labeled. During an interview on 12/09/25 at 8:12 AM, the DM stated that he was familiar with his facility's policies and expectations regarding food storage and labeling. He stated that the potential negative outcome for not covering food was related to infection control. He stated that items could get into the food without staff knowing and could then be served to residents. He stated that the potential negative outcome for not discarding spoiled or rotten food and storing it with fresher food was that the fresher food could be contaminated and potentially harm residents if served. The DM stated that the potential negative outcome for not labeling and dating food was that the food could be spoiled. He stated that a person may not know how long the food or drink item had been stored or even what the item was. He stated that it could be something that a resident was allergic to and could harm that resident. The DM stated that he was unaware at the time of the potential violations. He stated that he did not observe the stacked glasses. He stated that he assumed the rolls were cooling and that was why they were uncovered. He stated that it was normal practice for staff to allow items to cool uncovered. He stated that he was unaware that staff were leaving the large tea container uncovered in the kitchen sink while the tea steeped. The DM stated that he was unaware that the spoiled or rotten potatoes were in the dry pantry, as he would have normally discarded them. He stated that he was unaware of the unlabeled juices in the walk-in refrigerator. He stated that his system to monitor and ensure food items were not spoiled was that they generally ordered fresh food items weekly to meet menu needs. He stated that following policies and procedures such as the first in, first out method helped ensure that food items that arrived first were used before newer items. He stated that staff assisted one another in the kitchen to ensure food was covered, labeled, and that no spoiled or rotten food was present. He stated that he expected food not actively being served or prepared to be properly stored and labeled according to company procedures. He stated that the butter should have been covered. He stated that glasses should never be stacked in a manner that exposed the rims to the underside of the serving tray. He stated that the facility had lids for cups and that those lids should have been used. He stated that juices should have (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	been labeled and dated. He stated that the facility had stickers indicating the date, item name, expiration date, and staff initials. The DM stated that all spoiled or rotten foods should have been discarded immediately. The DM stated that it was everyone's responsibility to cover food not actively being served, date and label food items, and discard spoiled or rotten foods. He stated that cooks specifically handled fresh or raw food items. The DM stated that he did not have a reason for the uncovered food items, unlabeled drink items, or spoiled food being stored with fresh food and stated these were items that were simply missed. During an interview on 12/09/25 at 8:37 AM, [NAME] D stated that she was familiar with the facility's policies and expectations regarding proper food storage and labeling. She stated that the potential negative outcome of stacking resident cups and exposing the rims of the glasses to the underside of the serving tray was that bacteria could get on the rim and cause residents to become ill. She stated that the potential negative outcome of food and drink items not being covered while actively being served was that something could get on or into the item. She stated that chemicals or trash could get into the item and potentially make residents sick. She stated that similar to stacked resident cups, staff would not be able to tell what may have contaminated the cups. [NAME] D stated that if food and drink items were not labeled, staff would not know how long the items had been present and they could potentially make residents sick. She stated that the potential negative outcome of not discarding spoiled or rotten food and storing it with fresh food was contamination, which could ultimately make residents sick. [NAME] D stated that she was aware of the uncovered butter and stated that this was how it had been done and that the butter was always readily available for use. [NAME] D stated that she was aware of the tea being uncovered in the sink but was unaware of the unlabeled juices in the walk-in refrigerator. She stated that she observed aides place juice in the walk-in refrigerator. She stated that she was unaware of the stacked resident glasses and the rotten sweet potatoes. [NAME] D stated that she did not think to cover the rolls because she was allowing them time to cool. She stated that she was unaware that the rolls needed to be covered while cooling. [NAME] D stated that the system to monitor food storage and labeling was education and monitoring provided by the DM. She stated that the DM would review policies with staff and correct them if issues were observed. She stated that she and her coworkers had been trained regarding food storage and labeling. She stated that she expected all food to be covered, dated, labeled, and that spoiled food be discarded. [NAME] D stated that all staff were responsible for food storage and labeling. She stated that the reason the rolls were uncovered was because she was allowing them to cool. She stated that she did not have a reason why the butter remained uncovered, as it had always been done that way. She stated that she believed she buttered the rolls while the HHSC investigator was in the kitchen. During an interview on 12/09/25 at 10:02 AM, DA E stated that she was familiar with the facility's expectations and policies regarding food storage and labeling. She stated that the potential negative outcome for not covering food properly when it was not actively being used was that germs could get into the food or drink item and negatively affect residents. She stated that the potential negative outcome for storing rotten or spoiled food with fresh food items was contamination and potential illness to residents. She stated that the potential negative outcome for stacking resident cups and exposing the rims to the underside of the serving tray was contamination, and residents could place their mouths on contaminated surfaces and become sick. DA E stated that the potential negative outcome for not labeling and dating food or drink items was that staff may forget when the items were prepared, and items such as juice could spoil quickly. DA E stated that she was aware of the tea being uncovered and was taught by another staff member, who was no longer employed at the facility, to do it that way. She stated that she believed it was acceptable. She stated that on 12/08/25, she placed a lid on the container. DA E stated that she was aware that cups were stacked without lids but stated that she did not always correct others because she did not want to be perceived as mean. DA E stated that she was unaware of the spoiled or rotten potatoes. She stated that she typically checked bananas and potatoes because they spoiled quickly. She stated that staff had been focused on cleaning the walls recently. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She stated that she did not observe the rolls or butter uncovered. She stated that she was aware of some juice not being labeled. She stated that she labeled trays as orange juice but that one tray that was not individually labeled contained apple juice and cranberry juice in addition to orange juice. DA E stated that the system to monitor proper food storage and labeling was reviewing errors when they occurred and receiving correction and coaching from the DM. She stated that staff sometimes corrected one another. She stated that she expected all food to be covered and labeled, especially when not actively being used. She stated that cups should not be stacked and that juice could be prepared one tray at a time. She stated that cups should be covered with lids or saran wrap and that tea should be covered. She stated that all staff were responsible for ensuring food was properly labeled and stored, spoiled food was discarded, food was covered when not actively being used, and resident cups were not stacked and exposed to the underside of serving trays without a lid or barrier. DA E stated that she did not have a reason why the observations occurred. She stated that she focused on drinks, while the cook typically focused on food. During an interview on 12/09/25 at 10:24 AM, DA A stated that she was familiar with the expectations and policies regarding food labeling and storage. She stated that the potential negative outcome for stacking cups and exposing the rims to the underside of the serving tray was that the bottom of the tray could be dirty and residents could become sick if exposed. She stated that it did not cross her mind to consider the risk when stacking trays. She stated that the potential negative outcome for storing spoiled or rotten food with fresh food was contamination, and that one bad apple ruins the bunch, which could make residents sick. She stated that the potential negative outcome for not covering food that was not actively being served or prepared was that food could develop freezer burn in the refrigerator, collect bacteria, or make residents sick. She stated that the butter had been left uncovered since she started working at the facility and that she had been there approximately six or seven months. She stated that uncovered food could allow gnats or flies into the food, especially when the back door was opened. She stated that while sweeping, dust could have entered uncovered food and made residents sick. She stated that the potential negative outcome for not labeling and dating food was that staff would not know when the food was placed in the refrigerator and that it could be expired. She stated that staff may not know what the food item was, which could result in giving residents food to which they were allergic. She stated that she was aware of the tea being left uncovered in the sink. She stated that she and another aide alternated monthly duties, with one responsible for drinks and the other responsible for ice. She stated that she was aware of stacked cups, uncovered butter, and uncovered rolls but was unaware of the spoiled sweet potatoes in the dry pantry. She stated that she was aware of apple and cranberry juice not being labeled. She stated that the system to monitor and prevent violations was to label items immediately after preparation and discard spoiled food immediately. She stated that there was no system in place for covering butter, as it had always been left uncovered throughout the day. She stated that the pantry was checked and cleaned at least twice a week. She stated that she had been trained on labeling but was unaware that the sweet potatoes were spoiled, although she knew to discard spoiled food. She stated that she had been trained not to stack cups and expected all items to be labeled. She stated that she attempted to check for spoiled food. She stated that all staff were responsible for kitchen tasks, and that if a staff member prepared a food or drink item, they were responsible for ensuring it was done properly. She stated that staff worked as a team and anyone could complete tasks. She stated that everyone was responsible for discarding spoiled food and ensuring items were properly labeled. She stated that she did not have a reason why the observations occurred. During an interview on 12/09/25 at 12:00 PM, the ADM stated that she was familiar with the expectations and policies regarding food storage and labeling. She stated that all food should be stored according to policy. She stated that all food and drink items should be labeled upon receipt. She stated that the potential negative outcome for not labeling and dating food was that the food could spoil without staff realizing and could be served to residents, causing food poisoning or illness. She stated that the potential negative outcome for not discarding spoiled or (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	rotten food was cross-contamination and food poisoning. She stated that the potential negative outcome for not covering food that was not actively being served or prepared was cross-contamination, debris entering the food, and illness or food poisoning. She stated that the potential negative outcome for stacking cups and exposing rims to the underside of serving trays was cross-contamination, infection control concerns, and residents consuming debris. She stated that she was unaware of the observations in the kitchen until she was informed by the HHSC investigator on 12/08/25. She stated that she had been trained regarding food storage and labeling during her AIT process. She stated that kitchen staff had been trained on facility expectations and policies regarding food storage. She stated that all staff should be aware of the guidelines. She stated that she expected kitchen staff not to place residents at risk for cross-contamination. She stated that she expected routine tasks such as labeling food, covering food not actively being served or prepared, and discarding spoiled or rotten items to be completed immediately. She stated that responsibility initially rested with individual kitchen staff and was overseen by the DM, with tasks to be completed properly and routine inspections conducted. She stated that she did not have an excuse for the observations that occurred and stated that the fact it was a weekend may have had an impact. Record review of the facility's policy titled and dated, Food Storage and supplies (2012), reflected: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin and insects. Open packages of food are stored in closed containers with covers or in sealed bags, and data is to when open. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to market by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a Best Buy for use by date. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as when 2 when it is received, the chef stable items will be stored in a first in first out manner to be used within one year. On perishable foods, microorganisms such as mold, yeast, and bacteria can multiply and cause food to spoil. Filled foods will develop in labor or texture due to natural spoilage bacteria. If a food has developed such spoilage characteristics, it should not be eaten. The bacteria that can be found on food: pathogenic bacteria, which is caused foodborne illness, and spoilage bacteria, which causes flu to deteriorate and develop unpleasant characteristics such as an undesirable taste or odor making the food non wholesome, but do not cause illness. Record review of 2022 Food Code U.S. Food and Drug Administration revealed:Preventing Contamination from the premises (Food Storage):3-302.11(A)Food shall be protected from contamination by storing food: Where it is not exposed to splash, dust, or other contamination. This includes:Covering food using lids, wrappers, foil, sneeze guards, or other protective barriersPreventing exposure to dust, debris, insects, drips, splash, equipment surfaces, and employees3-303.12(A) Food on display shall be protected from contamination by packaging, sneeze guards, or other effective means.Sections 2-301.14 and 2-301.15

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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. Based on observations, interviews, and record review the facility failed to ensure a resident has a right to a safe, clean, comfortable and homelike environment for 1 of 20 residents reviewed for physical environment. A handrail in the shower room on South Hall was loose. This deficient practice has the potential to place residents at risk for injuries related to falls that could result in bruising, skin tears, wounds, fractures, and decreased quality of life. Findings include: During a confidential interview held on 12/08/2025 at 2:00 PM, 3 of 7 confidential residents mentioned a loose handrail in the shower room on South Hall. 3 of 7 confidential residents stated the handrail had been loose for an unknown period of time. The confidential residents stated staff who assist them with bathing were aware of the loose handrail in the shower room. During an observation on 12/08/2025 at 03:15 PM the left side (under the shower head) handrail in the first shower was noted to be loose and this surveyor was able to move the handrail back and forth approximately 1-2 inches on the near side of the handrail. The handrail was secured on each end, and the far end of the handrail was secure, with no movement. During an interview on 12/08/2025 at approximately 3:30 PM, CNA H stated he was aware there was a handrail loose in the shower room on South Hall. CNA H stated the loose handrail had been reported to the maintenance supervisor, but he did not know the status of the repair. CNA H stated his job duties included assisting residents with bathing. CNA H stated he was unsure how long the handrail had been loose. CNA H stated he did not use the shower room on South Hall often, to assist residents in bathing, since he primarily used the shower room on East Hall. During an interview on 12/09/2025 at 10:10 AM, CNA G stated her job duties included assisting residents with bathing in the shower room located on the South Hall (across from the nurse's station). CNA G stated she had worked at the facility for approximately 3 years. CNA G stated she was aware the left handrail in the first shower stall was loose. CNA G stated the handrail had been loose for as long as she had worked at the facility. CNA G stated she reported this concern to the maintenance supervisor, and the handrail had been fixed in the past. CNA G stated the handrail became loose after it was fixed, and it was reported again to maintenance. CNA G stated she was advised the tile would have to be removed for the handrail to be fixed properly, but she did not know when that would be done. CNA G stated she ensured residents did not use that handrail by informing residents of the loose handrail and asking them not to use it. CNA G stated she could not prevent residents from grabbing the loose handrail if they reached out for it out of instinct. CNA G stated she did not feel residents were at risk of falling because she wouldn't let them fall. CNA G stated there was a risk the handrail could break completely if a resident put their weight on it, but she did not feel this was a risk to the residents since she advised them not to use it. CNA G stated no residents had fallen due to the loose handrail. CNA G stated there were no residents who showered independently. During an interview on 12/09/2025 at 10:30 AM the MS stated he had worked at the facility for approximately one year. The MS stated he was aware the handrail (on the left side) in the first shower stall of the shower room on South Hall was loose. The MS stated the handrail had become loose several times, and he has continuously tightened it. The MS stated the tile in the shower would have to be removed to fix the handrail properly to ensure it did not become loose again. The MS stated he had submitted a proposal for a bid to have the shower on East Hall renovated, and the loose handrail in the shower on South Hall was included in the bid. The MS stated he did not think the bid was approved by the facility's corporate office due to pricing, and a new bid was being proposed to break down the renovation into individual sections. The MS stated he did not know the status of the new bid. The MS stated he would begin checking the handrail in the shower room more frequently until the repair could be completed. The MS stated the facility had a process of reporting necessary repairs by staff placing the needed repair in the Maintenance Care system. The MS stated if the repairs were more urgent, staff could have reported the repair to him directly. The MS stated the loose handrail had been reported to him on (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple occasions by the Maintenance Care system as well as by staff directly. The MS did not know when the last report was received regarding the loose handrail or when he last tightened it. The MS stated he checked the Maintenance Care system daily to prepare his daily scheduled maintenance. The MS stated he did not check the shower rooms daily, and he relied on staff to report maintenance needs. The MS stated he did not feel the loose handrail in the shower room was at risk of breaking completely. The MS stated the handrail was secured with a toggle bolt, so the tile would have to break off for the handrail to come off of the wall completely, and he did not feel this was possible. The MS stated the loose handrail impacted residents since they could not use it to help them stand or support their weight. The MS stated he did not know if the loose handrail was a risk to a resident falling or incurring an injury. The MS stated he was the person responsible for fixing the loose handrail, as long as it was reported to him by staff. During an interview on 12/09/2025 at 11:00 AM the DON stated she was not aware of the loose handrail in the shower room on South Hall. The DON stated all maintenance requests were reported to the MS directly or through the Maintenance Care system. The DON stated the MS was responsible for ensuring all repairs were completed timely. The DON stated she was not aware of any falls or accidents due to the loose handrail in the shower room on South Hall. The DON stated it was her expectation that repairs would be completed as soon as possible, and for nursing staff to report needed repairs as they became aware of the need for repair. The DON stated a loose handrail in a shower staff could pose a safety hazard to a resident and could potentially result in a fall and/or injury. During an interview on 12/09/2025 at 11:20 AM the ADM stated she was not aware of a loose handrail in a shower stall in the South Hall shower room. The ADM stated it was her expectation that all needed repairs be reported directly to the MS or in the Maintenance Care system. The ADM stated the MS is responsible for checking Maintenance Care daily and prioritizing tasks based on resident need and safety. The ADM stated she was not aware the handrail had been loose, ongoing, for potentially 3 years. The ADM stated it had not been reported to her previously. The ADM stated renovations of the shower room on East Hall were pending, but she was not certain if this included the handrail in the South Hall shower room. The ADM stated she would follow up to ensure the handrail was fixed as soon as possible. The ADM stated there was a risk to residents if a handrail were loose since it could potentially break and result in a resident falling or incurring an injury. Record Review of the facility's document titled, Scheduled Tasks, created on 09/12/2025, included the following: Resident Bathing: Inspect shower room and shower equipment Runs 2nd MONDAY of month in: ALL MONTHS At 09:00 Record Review of the facility's policy pertaining to handrails revealed the following: The Facility was unable to provide a policy related to handrails.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed, and documented, that it was appropriate for the PRN order to be extended beyond 14 days for 1 of 20 resident (Resident #11) reviewed for PRN psychotropic medications, in that: Resident #11 had an active PRN order for alprazolam (Xanax) without a documented 14-day stop date, despite facility policy and regulatory requirements. This failure could place residents at risk for receiving unnecessary medications. Findings included: A record review of Resident #11's face sheet dated [DATE] revealed that Resident #11 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that include anxiety. A record review of Resident #11's Comprehensive Minimum Data Set, dated [DATE] revealed the following: Section C (Brief Interview for Mental Status) score of 05, indicating severely impaired cognition. Section N (Medications) revealed Resident #11 received an antidepressant; however, the MDS did not reflect that Resident #11 received an antianxiety medication. A review of Resident #11's Psychotropic Medication Consent dated [DATE] revealed that Resident #11 provided consent and was informed of potential side effects and risks associated with alprazolam (Xanax), including agitation, appetite changes, blurred vision, confusion, dizziness, drowsiness, dry mouth, fatigue, hypotension, nightmares, sedation, slurred speech, and urinary retention. A review of Resident #11's physician order dated [DATE] revealed the following order:Xanax oral tablet 0.26 mg, give one tablet by mouth every eight (8) hours as needed for anxiety.(Order date: [DATE]; Start date: [DATE]) A review of Resident #11's Medication Administration Record (MAR) revealed: [DATE]: Resident #11 received one dose of PRN Xanax on [DATE]. [DATE]: Resident #11 did not receive any doses of PRN Xanax. A review of Resident #11's care plan dated [DATE] revealed that Resident #11 had behavioral concerns related to anxiety and depression, with a goal of no evidence of behavioral problems through the review date. Interventions included administering medications as ordered and monitoring and documenting side effects for effectiveness. During an interview on [DATE] at 7:23 AM Resident #11 did not express any concerns and did not provide information related to the facility's deficient practice regarding the absence of a 14-day stop date for PRN psychotropic medication. During an interview on [DATE] at 11:02 AM, the DON stated that she was familiar with the expectations and policy regarding psychotropic medications, specifically that PRN psychotropic medications required a 14-day stop date. She stated that after the 14 days expired on PRN psychotropic medications, the medication was either discontinued, or a new order was created. She stated that the purpose of this rule was to ensure that residents did not receive medications they did not need. She stated that the potential negative outcome for not having a 14-day stop date on a PRN psychotropic medication was that residents might receive unnecessary medications. She stated that this was a standard medication practice for hospice and that facility nursing staff were responsible for ensuring that when an order was entered, the 14-day stop date was included, even if the order came from hospice. She stated that she did have a concern that the medication might be needed and not be available in the facility. She stated that she understood these were the rules and that they needed to follow the rules. She stated that the purpose of the rules was to keep people safe. She stated that she was unaware that Resident #11 had a PRN psychotropic medication that did not have a 14-day stop date. She stated that she monitored resident medications weekly and that this issue was missed. She stated that the system to monitor resident medication orders was to review them upon admission and weekly thereafter. She stated that the nurse who entered the order would have been responsible. During an interview on [DATE] at 12:00 PM, the ADM stated that she was slightly familiar with the expectations and policy regarding psychotropic medications, specifically that PRN psychotropic medications were required to have a (continued on next page)

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	455942	A. Building B. Wing	12/09/2025

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Lubbock Health Care Center	4120 22nd Pl Lubbock, TX 79410

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14-day stop date. She stated that the potential negative outcome for a PRN psychotropic medication not having a 14-day stop date was that the medication could be administered unnecessarily, which could potentially cause harm. She stated that she was unaware that Resident #11 had a PRN psychotropic medication without a 14-day stop date. She stated that the system to monitor resident medications was that clinical staff, such as nursing, reviewed medication orders. She stated that nursing staff reviewed medication orders for requirements such as stop dates on PRN psychotropic medications. She stated that she had not been trained specifically on this requirement but assumed that nursing staff had been trained through onboarding and required training. The ADM stated that she expected the nursing staff and nursing department to adhere to all state and federal regulations and to act in the best interest of residents. She stated that psychotropic medications should not be administered past the 14-day stop date unless a new order was written. She stated that the charge nurse and the DON were responsible, and that even under her supervision, the DON was responsible. She stated that she did not have a reason why Resident #11's PRN Xanax did not have a 14-day stop date. Attempts were made to contact the Medical Director to discuss psychotropic and unnecessary medications on [DATE] at 1:45 PM and again on [DATE] at 8:50 AM; however, the Medical Director was unavailable, and messages were left. Attempts were made to contact the Nurse Practitioner to discuss psychotropic and unnecessary medications on [DATE] at 8:50 AM; however, the Nurse Practitioner was unavailable, and a message was left. Record review of the facility's policy titled and dated, Medication Administration and General guidelines (2025), reflected: Medicines are administered as prescribed, in accordance with the state regulations using good nursing principles and practices and only by persons legally authorized to do so. ProcedureModern medications are administered; the following documentation is provided:getting some administration, does route of administration and if applicable the injection site. Record review of the facility's policy titled and dated, Psychotropic Medication ([DATE]), reflected: 30 would ensure that the resident is free from chemical or strength imposed for purpose of discipline or convenience in that are not required to treat the resident medical symptoms. Residents should only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Also, interventions have been attempted in or deemed clinically contraindicated.It's like a trooper drug is any drug that affects brain activities associated with mental processes and behaviors. These drugs include, but are not limited to, drugs in the following categories: anti-anxiety PRN orders for antidepressants, hypnotic, and anti-anxiety drugs are limited to 14 days. Except if the extended beyond 14 days, he or she should document the rationale in the residence medical record and indicate the duration for the PRN order. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending position or prescribing practitioner evaluates the resident for the appropriateness of that medication.

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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** Based on observation, record review, and interview, the facility failed to ensure adequate supervision and assistance devices to prevent accidents for 1 (Resident #4) of 20 reviewed for accidents and supervision. The facility failed to consistently supervise Resident #4 while smoking and failed to ensure the use of a smoking apron, despite assessments and negotiated risk agreements identifying the need for direct supervision due to the risk of injury. These failures had the potential to result in resident harm, including burns or other smoking-related injuries. Findings included: A record review of Resident #4's face sheet dated 12/08/25 revealed that Resident #4 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that include a cognitive communication deficit. A record review of Resident #4's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C (Brief Interview for Mental Status) score of 09, indicating moderately impaired cognition. Section J (Health Conditions) revealed Resident #4 used tobacco. A record review of Resident #4's care plan dated 12/01/25 revealed that Resident #4 smoked and was frequently noncompliant with scheduled smoking times. The stated goal was for Resident #4 to be able to smoke without causing injury. Interventions included redirecting Resident #4 to scheduled smoking times and requiring the use of a smoking apron while smoking. The care plan did not include supervision while smoking. A review of progress notes dated 10/07/25 through 12/08/25 revealed the following: On 10/16/25 at 10:30 AM, the ADM documented she was notified that Resident #4 was outside smoking outside of supervised smoking hours. The smoking policy and schedule were explained, and Resident #4 stated she did not care and felt the rules were unfair. On 10/19/25 at 5:08 PM, LVN J documented Resident #4 was resistant to education regarding smoking safety. The Resident Representative was notified. On 11/06/25 at 4:17 PM, the SW documented a negotiated risk agreement was completed due to Resident #4 being observed falling asleep while smoking. The agreement stated Resident #4 would be supervised while smoking. On 11/07/25 at 12:50 PM, the DON documented that Resident #4 was required to wear a smoking apron due to falling asleep while smoking. A review of Resident #4's negotiated risk agreements dated 11/06/25 and 12/08/25 revealed that Resident #4 agreed to wear a smoking apron and to be supervised while smoking. Attendees included the POA, ADM, Resident #4, and the Medical Director. A review of the smoking assessment dated [DATE] revealed Resident #4 required direct supervision while smoking and a fire-resistant smoking apron. Record review of weekly skin assessments dated 12/04/25 and 12/11/25 revealed no smoking-related injuries. Record review of an incident report dated 12/15/25 revealed no smoking-related incidents between 09/15/25 and 12/15/25. On 12/07/25 at 12:30 PM, Resident #4 was observed returning from smoking. An unknown staff member was present outside with Resident #4 and multiple residents. On 12/09/25 at 10:23 AM, Resident #4 was observed outside smoking without a smoking apron. She was alert while smoking her cigarette. MA B was observed coming in from the patio. On 12/09/25 at 11:15 AM, Resident #4 was observed in the kitchen with no burn holes on her clothing or blanket. On 12/09/25 11:20 AM, Resident #4 was observed outside smoking unsupervised and without a smoking apron. She was She was alert while smoking her cigarette. During an interview on 12/09/25 at 11:15 AM Resident #4 stated she could smoke independently and did not need supervision or a smoking apron. She stated staff sometimes watched her smoke, but she did not need assistance. When asked who let her out to smoke on 12/09/25 she did not answer. When asked who gave her the cigarette and a lighter, she became upset and asked why the HHSC investigator was asking all of the questions and stopped answering questions. During an interview on 12/09/25 at 12:00 PM, the ADM stated that she was familiar with the expectations and policy regarding incidents and accidents. She stated that the potential negative outcome for not preventing incidents and accidents was resident harm. She stated that Resident #4 could potentially fall if not supervised. She stated that it was documented that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 did not adhere to the smoking policy. She stated that she and staff informed Resident #4 about the risks of her actions. The ADM stated that she was unaware, at the time she was on her way to dietary, that Resident #4 was outside smoking. She stated that she went to give one of the dietary aides a message. She stated that Resident #4 should not have had the door code but would sometimes press on the door to go outside. She stated that staff constantly made adjustments to redirect Resident #4. She stated that Resident #4 should have been supervised while smoking. She stated that Resident #4 was noncompliant with wearing her smoking apron. She stated that the system to monitor Resident #4 was constant redirection and attempts to bring her inside. She stated that staff should stay with Resident #4 and remind her of designated smoking times. The ADM stated that she had been trained on incident and accident prevention. She stated that she completed training on incidents and accidents a few months prior. The ADM stated that she expected the safety of Resident #4 and all residents to be maintained. She stated that she did not agree with allowing one resident to smoke at any given time while requiring other residents to wait. She stated that all staff were responsible for ensuring resident safety and preventing incidents and accidents. During an interview on 12/09/25 at 12:33 PM, the DON stated that she was familiar with the expectations and policy regarding incidents and accidents. She stated that the potential negative outcome was injury to the resident. The DON stated that she was unaware that Resident #4 was outside smoking unsupervised on 12/09/25 at 10:23 AM and at 11:20 AM. She stated that she was unaware of the smoking times without referencing the policy but knew that there were designated smoking times and that those times were supervised. She stated that she and her staff had been trained that smoking times were supervised and that staff were to follow the smoking assessment for each resident. She stated that she expected all staff to follow the rules. She stated that Resident #4 had a history of going outside on her own. She stated that Resident #4 refused to wear her smoking apron. She stated that staff should stay with Resident #4 if they observed her outside. She stated that all staff were responsible for preventing incidents and accidents and following assessments. She stated that the reason Resident #4 was observed outside was potentially because she let herself out. She stated that the door would alarm, but depending on staff proximity, it could be difficult to hear. She stated that staff redirected Resident #4 frequently but that Resident #4 would give staff a hard time. She stated that staff had explained the concerns to Resident #4's responsible party. She stated that there was no reason staff should not have stayed with Resident #4 if they observed her outside. During an interview on 12/09/25 at 12:50 PM, MA B stated that she went outside to give Resident #4 her medications. She stated that she was not the staff member who let Resident #4 outside. She stated that she was not normally the staff who supervised smokers. She stated that she was not thinking and went outside to administer the medication that Resident #4 was outside smoking unsupervised. She stated she went to give her the medication and went to finish her medication pass. She stated that Resident #4 would tell staff when she wanted to smoke and that she believed Resident #4 could smoke by herself. She stated that she was unaware that Resident #4 was required to wear a smoking apron. She stated that she knew Resident #4 could open the door and would become upset when staff attempted to redirect her. During an interview on 12/15/25 at 4:46 PM, Resident Representative I (Resident #4's Representative) stated that Resident #4 was determined to smoke. He stated that facility staff tried to encourage her to smoke at appropriate times, but she did not listen. He stated that he did not have concerns with facility staff, as they were always trying to encourage Resident #4 to follow the rules. He stated that Resident #4 would go outside on her own without staff because she was impatient. He referred to Resident #4 as stubborn and an old [NAME] woman and stated that this made it difficult for facility staff to get her to follow the rules. He stated that Resident #4 would think she was being singled out, but that was not the case, as facility staff were trying their best. He stated that in a perfect world, every resident would have their own personal staff, but that was impossible. He stated that he and facility staff had discussed the possible use of nicotine patches to help with Resident #4's urge to smoke. He stated that he believed facility staff were trying to help (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4, but that she made it difficult. During an interview on 12/16/25 at 11:02 AM, the ADM stated that staff had previously been in-serviced on the smoking policy. She stated that there was no specific training conducted solely for Resident #4. She stated that residents were not singled out and that all residents were expected to adhere to the smoking policy. She stated that staff had been working with Resident #4 and her family regarding smoking concerns. She stated that the POA was not happy with the policy and stated an intention to move Resident #4. She stated that nicotine patches had been suggested in the past but were not a request that could be accommodated. She stated that it was not recommended that Resident #4 use a nicotine patch while continuing to smoke. She stated that the facility implemented weekly changes to the door code and emphasized staff not to share the code. She stated that staff consistently spoke with Resident #4, and Resident #4's response was that it was not fair. She stated that staff consistently informed Resident #4 that the policy was for her safety. She stated that although noncompliance with the smoking apron was not specifically care planned, Resident #4's overall noncompliance with rules and care was care planned. She stated that Resident #4 would become verbally combative with staff when redirected. The ADM stated that staff were attempting to be proactive through staff training, resident redirection and education, and family communication and support. She stated that at one time Resident #4 was allowed to have her own smoking supplies, but due to changes, she was no longer permitted to do so. She stated that Resident #4 would ask other residents for cigarettes and look in ashtrays. She stated that Resident #4 had not sustained any burns or injuries related to smoking within the past 90 days. Record review of the facility's smoking schedule, undated, reflected: 7:00 AM smoke breaks supervised by housekeeping9:00 AM smoke breaks supervised by activity11:00 AM smoke breaks supervised by housekeeping and laundry1:00 smoke break supervised by dietary3:00 PM smoke break supervised by maintenance and housekeeping on the weekendthere is no smoke break during 5:00 PM during meal time.7:00 PM smoke breaks supervised by nursing8:00 PM smoke break supervised by nursing9:00 PM smoke break supervised by nursing11:00 smoke break supervised by nursingAll cigarettes and lighters must be remained at the nurses station. Residents need to be escorted by staff during smoke breaks. Record review of the facility's policy titled Smoking Policy (undated), reflected:Smoking policies must be formulated and adopted by the facility. The policies must comply with applicable codes, regulations and standards, including local ordinances. The facility is responsible for informing residents, staff, visitors, and other affected parties of smoking policies through distribution in or posting. The facilities responsible for enforcement of smoking policies which must include at least the following provisions:Matches, lighters or other ignition sources for smoking are not permitted to be kept or stored in a residence room. A safe smoking assessment will be done regularly for each resident who smokes. Smoking by residents classified as unsafe will be prohibited except when the resident will be directly supervised by facility personnel or visitors who are aware of the residents' limitations with smoking. The resident must be within direct view of smoking supervisor, and reasonably close proximity the supervisor, and the supervisor must be able to quickly respond in the event of an emergency. Additionally, the supervisor, whether staff or visitor must be aware of these responsibilities.Smoking designated location smoking patio area offset of dining area.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and maintained in accordance with currently accepted professional standards for 1 of 2 medication carts (Medication Cart 2) reviewed.The facility failed to ensure 2 loose pills in Medication Cart 2 were properly labeled or stored. This failure could place residents at risk for medication errors and drug diversion.The findings include: During an observation on [DATE] at 10:03AM with MA B on Medication cart 2, 1 green pill and 1 white pill were found in the second drawer, unlabeled. During an interview with MA B on [DATE] at 10:08AM, she stated she had been trained on checking the medication carts monthly through in-services. She stated she had been trained to check the carts weekly and as needed throughout the week. She stated the carts are checked for expired medication, loose pills, cleanliness and making sure the narcotic count is correct. She stated the DON was responsible for checking the carts, but staff were also responsible for ensuring the carts were in working order. She stated the potential negative outcome could be mistaking the medication for a different resident's medication and administering it to the incorrect resident. She stated she had checked Medication Cart 2 on [DATE] and had been surprised to find those two loose pills in the medication cart. During an interview with the DON on [DATE] at 10:25 AM, she stated the two pills found were identified as amitriptyline (treatment of major depressive disorder) for the green pill and furosemide (used primarily to treat fluid retention and high blood pressure) for the white pill. During an interview with the DON on [DATE] at 10:23 AM, she stated nursing staff were trained to check the medications carts at least weekly. She stated training was done upon hire and as needed. The DON stated staff were trained to check for expired medication, loose pills, and overall cleanliness. She stated a potential negative outcome of having loose pills in the cart could be residents running out of their medication or potentially a staff member grabbing the medication by accident and administering it to a resident. She stated they monitor compliance by doing weekly sweeps with staff members and ensuring the carts were kept up to date. She stated it was all staff members' responsibility to ensure the carts were clean and free of loose pills any time they assume responsibility over the carts. During an interview with the ADM on [DATE] at 10:33AM, she stated staff were trained to check the carts monthly and administration does a sweep as well to ensure the carts are kept clean and updated. She stated if there were any issues that came up during those sweeps, they were addressed at that time. She stated staff should be looking for expired mediation, loose pills or any items that may not belong in the carts and ensuring the narcotic count was accurate. She stated a potential negative outcome could be residents missing medications, drug diversion, or potential medication error if the wrong medication was given to the wrong resident accidentally. She stated it is the DON's responsibility to conduct training and to make sure the cart checks were being done. Record review of facility policy titled Medication Storage in the Facility dated 2025 revealed: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations orthose of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staffmembers lawfully authorized to administer medications.13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exits. 14. Medication storage areas are kept clean, well lit, and free of clutter.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure resident essential equipment was maintained in safe and proper operating condition for 1 (Resident #7) of 20 residents. Resident #7's oxygen concentrator was observed with a red alert light illuminated, indicating a potential malfunction, and staff were unaware or failed to report and address the issue in a timely manner. This failure had the potential to result in inadequate oxygen delivery and respiratory distress, placing the resident at risk for harm. Findings included: A record review of Resident #7's face sheet dated 12/08/25 revealed that Resident #7 is a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that include cognitive communication deficit and mild persistent asthma. A record review of Resident #7's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C (Brief Interview for Mental Status) score of 13, indicating intact cognition. Section N (Medications) revealed that Resident #7 participated in oxygen therapy. A record review of Resident #7's physician order dated 12/08/25 revealed the following:Oxygen: 2-5 liters per minute via nasal cannula every shift related to mild persistent asthma (order date 08/12/25; start date 08/12/25). A record review of Resident #7's care plan dated 11/10/25 revealed that Resident #7 was on oxygen therapy with a goal of having no signs or symptoms of poor oxygen absorption. Interventions included ensuring oxygen was administered at 2-3 liters per minute via nasal cannula. A review of Resident #7's Medication Administration Record (MAR) for December 2025 revealed that Resident #7 received oxygen daily at 2-5 liters per minute and oxygen saturation levels were monitored and maintained between 94% and 100%. A review of Resident #7's oxygen report (undated) revealed oxygen saturation levels ranged from 93% to 99% from 09/10/25 through 12/05/25. A review of Resident #7's progress notes dated 10/07/25 through 12/08/25 did not reveal documentation related to oxygen therapy concerns. On 12/08/25 at 10:50 AM, Resident #7's oxygen concentrator was observed with the red alert light illuminated. The oxygen flow was measured at 3.5 liters per minute. The key located under the red light indicated the red light meant oxygen flow rate less than 0.5 liters per minute or oxygen concentration less than 73%. During an interview on 12/08/25 at 10:51 AM, Resident #7 stated her oxygen concentrator had a red light on for approximately three months. She stated the airflow did not seem as strong but that she felt she could breathe. She stated staff were aware that the red light was on. During an interview on 12/09/25 at 11:02 AM, the DON stated that she was familiar with the expectations and the policy regarding essential equipment. She stated that if something was wrong, then the essential equipment was replaced or maintenance was completed immediately. She stated the potential negative outcome for essential equipment not properly working, specifically the oxygen concentrator, was that the resident may not be getting enough oxygen or the oxygen that was prescribed by the provider. She stated that this could affect the resident cognitively, especially oxygen delivery to the brain. She stated that she was not aware that the red light was lit on the oxygen concentrator and that no one had ever reported this issue to her. She stated the system to monitor essential equipment, such as oxygen, was that nursing staff were required to go in daily to check residents' oxygen. While checking the resident's oxygen level, they would also assess the machine. She stated that nursing staff should be checking every Sunday during the overnight shift, the water and tubing, as this was changed weekly. She stated that the resident never told her about the oxygen concentrator not working properly. She stated that when the concentrator was not working properly and could not be maintained, they would contact the vendor for a new machine. The DON stated that she had been trained that essential equipment should be in operating condition. The DON stated she expected all essential equipment to be in operating condition and, if not, the equipment needed to be replaced or fixed immediately. The DON stated the Maintenance Supervisor was responsible for maintaining the equipment. She stated nursing staff could change the filters. She stated the red light or alert should have been addressed even if the machine did not make a sound or (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alarm. She stated she did not have a reason why Resident #7's oxygen concentrator was not addressed and that she was unaware of how long the red light had been on. During an interview on 12/09/25 at 11:35 AM, the Maintenance Supervisor stated that he was responsible for changing filters and providing maintenance when he was informed of the need. He stated that staff would tell him in passing if things needed to be fixed. He stated no one had reported to him that any resident oxygen concentrators needed maintenance. He stated that in the system he used to track maintenance tasks, a task would naturally generate to check oxygen concentrators, but it was not for one specific resident. He stated he had no way of knowing which residents had oxygen concentrators. He stated he would go room to room and check to see if anything was wrong. He stated he was unaware that Resident #7 had an oxygen concentrator. He stated he was not made aware until 12/08/25, when the issue was discussed in a group chat. He stated the potential negative outcome of a resident's oxygen concentrator not working properly was that the resident may not be able to breathe properly. He stated he had not been trained, outside of maintenance requests or system-generated tasks, to routinely service medical equipment. During an interview on 12/09/25 at 11:41 AM, Medical Supply stated that he was unaware that Resident #7's oxygen concentrator had a red alert light on. He stated he knew the concentrator was replaced on 12/08/25. He stated he did not deal with oxygen concentrators directly but believed that responsibility fell to the Maintenance Supervisor. He stated the potential negative outcome of a concentrator not working properly was that the resident may not be able to breathe properly. During an interview on 12/09/25 at 12:00 PM, the ADM stated that she was familiar with the expectations and policy regarding resident essential equipment being operational. She stated that essential equipment should be routinely cleaned. She stated that items such as filters should also be changed as needed. She stated that any preventative or other maintenance should also be adhered to. She stated that the potential negative outcome for resident essential equipment, such as oxygen concentrators, not working properly could mean that the resident would go without oxygen as prescribed by the physician, which could result in respiratory distress. She stated that she was unaware until surveyor intervention that the resident had a concentrator that was not working properly. She stated she spoke with a charge nurse, and the charge nurse had not been informed about the oxygen concentrator. She stated that she instructed nursing staff to report such issues in the future. She stated that the system to monitor residents' essential equipment, such as oxygen concentrators, was that she relied on staff to report issues as they arose. She stated she expected the Maintenance Supervisor to check oxygen concentrators on a regular basis. She stated she was unaware whether he knew which residents had oxygen concentrators. She stated she expected him to go room to room to ensure equipment was functioning properly. She stated she had been trained, and that all staff had been trained, regarding checking residents' essential equipment and reporting issues to the appropriate party, including herself, so that the appropriate vendor could repair or replace equipment as needed. She stated she did not have written documentation showing staff training but stated that training was verbally provided during orientation. She stated she expected all equipment-related issues, especially those affecting health and safety, to be reported immediately and addressed. She stated all staff were ultimately responsible for ensuring that essential equipment, specifically oxygen concentrators, was working properly for residents who required them. She stated she did not have a reason why Resident #7's oxygen concentrator had not been addressed and stated that no one reported the issue to her. Record review of the facility's policy titled and dated, Oxygen Administration (undated), reflected: Oxygen therapy includes the administration of oxygen in liters per minute. By cannula or face masks to treat hypoglycemic conditions caused by pulmonary or cardiac diseases. Oxygen therapy is also prescribed to ensure oxygenation of all body organisms and systems. The amount of oxygen by percent of concentration or by liter per minute in the method of administration is ordered by the physician. The administration, monitoring of responses in safety precautions is associated with it are performed by the nurse. GoalsMaintain oxygenation with safe and effective delivery of prescribed oxygen.The (continued on next page)

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	12/09/2025

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

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident will maintain an effective breathing pattern with administration of oxygen.Resident will be free from infection.ProcedureCheck the tubing including any nasal prongs or mask that is in use on the patient when it malfunctions or becomes visibly contaminated. Oxygen concentrators should be cleaned according to manufacturer's recommendations. Change your clean oxygen concentrator filters according to manufacturers recommendations. Record review of the facility's policy titled and dated, Respiratory Policies and Procedures (June 2006), reflected: Every 90 days:Perform a purity and project on each unit every 90 days. Analyze the oxygen on each concentrator in service. Calibrate the oxygen analyzer according to the procedure. Attach the oxygen analyzer to the concentrator. Completed a new maintenance sticker in place on the unit. Replace the unit if necessary. Document the maintenance on the oxygen concentrator field maintenance report.