

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Heritage Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 University Ave Lubbock, TX 79413	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927</p> <p>Based on observations, interviews, and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity for 1 of 32 residents (Resident #98) reviewed for dignity issues:</p> <p>The facility did not place a urinary catheter drainage bag in a privacy bag to screen/cover it from view for Resident #98 on 03/06/2025 and 03/07/2025.</p> <p>This failure placed residents in the facility, with urinary catheters, at risk of feeling uncomfortable or embarrassed and decreased privacy.</p> <p>Findings included:</p> <p>Record review of Resident #98's Admission Record dated 03/7/2025, a [AGE] year-old male with an admitted [DATE], with diagnoses that included the following: Osteomyelitis (a bone infection that happens when bacterial or fungal infections spread from other parts of your body into bone marrow); Pathological fracture (when force or impact didn't cause the break to happen, instead, an underlying disease leaves bones weak) , left femur (thigh bone); Bed confinement status (unable to tolerate any activity out of bed); Neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems); and hydronephrosis (when urine backs up into one or both of the kidneys).</p> <p>Record review of Resident #98's Physician Orders, undated, revealed: Foley Catheter: Provide catheter care every shift Every Shift; Foley Catheter: Output every shift Every Shift; Foley catheter: Size 16 French Diagnosis: Neurogenic Bladder.</p> <p>During an observation on 03/6/20/25 at 1:30 PM Resident #98 was lying in bed with the room door open. Resident #98 had an indwelling urinary catheter drainage bag on the left side of the bed, facing the door. The urinary catheter drainage bag was visible through the open door and not in a privacy bag. The urinary catheter drainage bag was observed to contain urine.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up observation and interview 03/7/20/25 at 9:30 AM Resident #98 was lying in bed, with the room door open. Resident #98's urinary catheter bag was on the left side of the bed, facing the door. The urinary catheter drainage bag was again visible through the open door and not in a privacy bag. Resident #98 stated he could not recall the urinary catheter drainage bag ever being in a privacy bag. Resident #98 stated he was not aware it was possible to place it in a privacy bag, and he stated he would prefer the privacy bag.</p> <p>During an interview on 03/07/2025 at 3:57 PM the DON stated it was the facility's policy to always provide a privacy bag for a resident's urinary catheter drainage bag, unless the resident specifically requested to not have one. The DON stated she was not aware of any residents at the facility who had requested to not have the privacy bag. The DON stated it was the charge nurse on each shift's responsibility to ensure each resident had a privacy bag on their urinary catheter drainage bag. The DON stated the charge nurse on each shift should have been monitoring this during their daily rounds and when they provided catheter care for the resident. The DON stated this was trained to nursing staff upon hire as well as during regular in-service trainings. The DON stated a resident not being provided a privacy bag for their urinary catheter drainage bag could make a resident feel their dignity and privacy were violated if they did not want anyone to know they had a catheter.</p> <p>During an interview on 03/07/2025 at 4:09 PM the ADM stated it was the facility's policy to provide a privacy bag for a resident's urinary catheter drainage bag, and they should have always been covered. The ADM stated if a residents urinary catheter drainage bag was left uncovered, it was because someone overlooked it, because there was no reason the privacy bag should not be used. The ADM stated any nursing staff could have placed the privacy bag, as needed. The ADM stated all nursing staff were responsible for ensuring the privacy bags were provided and they should have seen this when they were providing care and treatment to the resident. The ADM stated the nursing management team and the ADM were responsible for ensuring privacy bags were always used. The ADM stated nursing staff received regular training by the nurse management team regarding catheter care and dignity. The ADM stated if the privacy bag was not used for a resident's urinary catheter drainage bag, this could affect the resident's dignity.</p> <p>During an interview on 03/07/2025 at 5:00 PM the ADON stated she worked on the floor as a charge nurse regularly. The ADON stated all urinary catheter drainage bags should be placed in a privacy bag. The ADON stated all nursing staff were responsible for ensuring a resident's urinary catheter drainage bag was placed in a privacy bag, and this should be monitored on each shift by the charge nurse. The ADON stated if a resident's urinary catheter drainage bag was not placed in a privacy bag, it could have caused a dignity issue for the resident.</p> <p>Record review facility policy titled Dignity, revised February 2021, revealed the following:</p> <p>Policy Statement:</p> <p>Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Residents are treated with dignity and respect at all times.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p> <p>12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example:</p> <p>a. helping the resident to keep urinary catheter bags covered;</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>46425</p> <p>Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 19 of 22 confidential residents.</p> <p>The facility failed on 03/07/2025 to ensure 19 of 22 confidential residents were provided, through postings in prominent locations; the Grievance Procedure, were provided access to the Grievance form, were provided information regarding who the facility grievance officer was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance.</p> <p>This failure could place the residents at risk of unresolved grievances and decreased quality of life.</p> <p>Findings included:</p> <p>Interviews and Record Review during Resident Council on, 03/06/2025 at 10:30am, 19 of 22 confidential residents, stated they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council did not know where to acquire a grievance form, who to turn the form into, and what happens once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Nineteen Residents attended the meeting, the 19 Residents in attendance had all been Residents of the facility for 6 plus months.</p> <p>Record Review of the facility Grievance policy on 3/07/2025 at 2:33pm; according to the facilities' Grievance policy a copy of the Grievance/Complaint procedure should be posted in a prominent location.</p> <p>Observed prominent postings on 3/07/2025 at 3:17pm; the facility did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available and there was no access to submit a Grievance anonymously.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the ADM on 3/07/2025 at 1:35pm; the ADM stated he was the Grievance Officer for the facility. The ADM stated he was responsible for the review of Grievances and assign them to department heads. The ADM stated the Grievance form was kept at the Nurses' Station and in the ADM's office. The ADM stated the Residents cannot obtain a Grievance form without asking the ADM or the SW for the form. The ADM stated staff completed Grievance forms for Residents, Residents do not ask for forms and complete them on their own. The ADM stated there was no procedure for Residents to submit Grievances anonymously. The ADM stated the facility has 72 hours to resolve Grievances once they were submitted. The ADM stated he assigned the Grievance to the appropriate department, that department addresses the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook. The ADM stated he monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated he will also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated he was responsible for ensuring staff were trained on the Grievance process. The ADM stated he was not aware the Grievance procedure and it was not being discussed in Resident Council.</p> <p>Grievance Policy</p> <p>Record Review of the Grievance Policy last updated in 2023.</p> <p>Policy Statement:</p> <p>All grievances filed with the facility will be investigated and corrective actions will be taken to resolve the grievance.</p> <p>Policy Interpretation and Implementation:</p> <ol style="list-style-type: none"> 1. The facility will make available information on how to file a grievance available to residents, family, and staff. 2. The Administrator or designed will assign the responsibility of investigating the grievance. 3. Each Resident grievance form will include the date and time and details of the grievance. 4. The Administrator or designee will record and maintain all grievances in the Grievance Log. 5. The Resident Grievance form will be filed with the Administrator or designee and the resolution will be identified within three working days of the concern. 6. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 3 working days of the filing of the grievance. 7. If during the investigation abuse, neglect, misappropriation and/or injuries of unknown source are identified, the facility will refer to the Abuse Policy. <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>b. Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievances for period of no less than 3 years from the issuance of the grievance decision.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927</p> <p>Based on observation, interviews, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 of 32 residents (Resident #2,) reviewed for Respiratory Care.</p> <p>1. The facility failed to follow physician's orders indicating Resident #2's oxygen humidification bottle should be monitored every shift and replaced or refilled as needed on 03/05/2025.</p> <p>2. The facility failed to follow physician's orders indicating Resident #2's nasal cannula and oxygen tubing should be changed weekly on 03/05/2025 and 03/06/2025.</p> <p>These deficient practices have the potential to affect residents by placing them at an increased risk of respiratory infection, respiratory distress, and a diminished quality of life.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet dated 03/07/2025 revealed a [AGE] year-old male with an admitted [DATE] and included the following diagnoses: Acute respiratory failure with hypoxia (when the respiratory system cannot adequately provide oxygen to the body); Other pulmonary embolism without acute cor pulmonale (condition where there is a blockage in the pulmonary artery due to a blood clot in the lungs), Acute upper respiratory infection, unspecified (viruses and bacteria that infect the respiratory tract), Extended spectrum beta lactamase (enzymes that confer resistance to most beta-lactam antibiotics), Shortness of breath, Unspecified diastolic (congestive) heart failure (when the heart does not relax properly between beats), and Essential (primary) hypertension (high blood pressure).</p> <p>Record Review of Resident #2's Care Plan, dated 01/29/2025, revealed the following: The Diagnosis included: Acute respiratory failure with hypoxia, Acute upper respiratory infection, unspecified; A Problem area that stated, Category: Diagnosis with a Goal that stated, Long Term Goal Target Date: 05/01/2025 No Complications and an Approach area that stated, Oxygen therapy/O2 Sats as ordered- AS NEEDED.</p> <p>Record Review of Resident #2's current Physician Orders, undated, revealed the following: Nasal Cannula(Continuous):O2 @ (1-3 __)L/Min, Special Instructions: To keep Oxygen sats greater than 90%, Every Shift, dated 01/21/2025; Change oxygen tubing, Cannula/Mask once a week. Once A Day on Sun Eve 06:00 PM - 06:00 AM, dated 07/21/2023; Monitor oxygen Humidification Bottle every shift. Replace or Refill as required. Every Shift, dated 07/21/2023.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 03/05/2025 at 10:43 AM Resident #2's nasal cannula, oxygen tubing, and oxygen humidification bottle had no date to indicate when they were last changed. Additionally, the oxygen humidification bottle was empty and contained no water. Resident #2 stated Resident #2 could not recall when the oxygen tubing and nasal cannula had been replaced last and stated they were not changed weekly. Resident #2 stated the oxygen humidification bottle was empty all the time, and staff had to be reminded to replace it often.</p> <p>During an observation and interview on 03/06/2025 at 12:20 PM Resident #2's oxygen humidification bottle contained water but had no date indicating when it had been replaced or refilled. Resident #2's nasal cannula and oxygen tubing still contained no date. Resident #2 stated there was a new humidification bottle replaced by a nursing staff on this date, but, he stated, they did not replace the oxygen tubing or nasal cannula. Resident #2 stated Resident #2's nose became dry when the oxygen humidification bottle was empty, and it was preferred by Resident #2 for it to contain water as it became uncomfortable for Resident #2 when it was empty.</p> <p>During an interview on 03/07/2025 at 3:57 PM the DON stated it was the facility's procedure for residents' oxygen tubing to be changed every Sunday evening by nursing staff. The DON stated it was the facility's policy that oxygen tubing be bagged and dated with the date the tubing was changed. The DON stated all residents' oxygen tubing should have contained the date it was last changed, and there should not be an exception to this. The DON stated oxygen humidification bottles should have water in them at all times, especially if ordered by a physician for the resident. The DON stated the purpose of the humidification bottles were to provide humidification to the residents; oxygen as the oxygen can be dry, causing dryness to the resident. The DON stated some residents prefer their oxygen without humidification, but some residents prefer their oxygen with humidification. The DON stated if the residents' order stated they should have a humidification bottle, it should have been maintained to prevent the oxygen from being administered without humidification. The DON stated it was her expectation that the bottle was not empty for any longer than it would take for the bottle to be replaced, and it should have been replaced as soon as possible. The DON stated it was the charge nurse's responsibility to ensure this was monitored on each shift. The DON stated nursing staff were trained upon hire and received regular training in-services regarding residents' oxygen, as recently as last month (February). The DON stated if a resident's oxygen tubing was not changed regularly, it could potentially have caused a respiratory infection. The DON stated oxygen would still function properly without a humidification bottle; however, if it was empty it could cause dryness to the resident's sinuses or possible complications if the resident had COPD (Chronic Obstructive Pulmonary Disease).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/07/2025 at 4:09 PM the ADM stated he believed it was the facility's policy for residents' oxygen tubing to be changed once a week. The ADM stated this was done by charge nurses. The ADM stated he was unsure how often residents' oxygen humidification bottle should be changed, and he referred to the DON for the specific timeframe. The ADM stated the nurse management team was responsible for ensuring oxygen tubing and oxygen humidification bottles were changed, as required, as well as monitoring this on each shift. The ADM stated the ADM and the nurse management team were ultimately responsible for ensuring it was done. The ADM stated he was not certain what the specific purpose of the oxygen humidification bottles was, but he thought it could possibly lead to dryness if the bottles were not maintained. The ADM stated it was his expectation that nursing staff monitored oxygen humidification bottles on each shift and changed out oxygen tubing as required. The ADM stated nursing staff received regular in-service trainings by the nurse management staff pertaining to resident's oxygen use. The ADM stated if oxygen tubing was not changed out regularly, this could lead to some type of infection for the residents.</p> <p>During an interview on 03/07/2025 at 5:00 PM the ADON stated she worked on the floor as a charge nurse regularly. The ADON stated all residents' oxygen tubing should have been dated with the date it was changed, with no exceptions. The ADON stated oxygen tubing and oxygen humidification bottles were changed weekly on Sunday evenings, or more often as needed. The ADON stated only nurses could change the oxygen tubing and humidification bottles, but any nursing staff could have monitored these items to determine if they needed to be replaced or if they were missing a date and reported this back to the nurse. The ADON stated all nursing staff received regular in-service training regarding residents' oxygen needs. The ADON stated if a resident's oxygen humidification bottle was empty, it could cause dryness to the resident's nose which could cause discomfort to the resident. The ADON stated if a resident's oxygen tubing was not changed out as required, this could have caused an infection for the resident as the oxygen tubing can become dirty and breakdown.</p> <p>Record review facility policy titled Oxygen Administration, dated February 2025 revealed the following:</p> <p>Policy:</p> <p>Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.</p> <ol style="list-style-type: none"> 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 2. Personnel authorized to initiate oxygen therapy include physicians, RNs, LVNs, and respiratory therapists. 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: <ol style="list-style-type: none"> b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Use only sterile water for humidification. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41480</p> <p>Based on observation, interview, 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 reviewed for dietary services, in that:</p> <p>1. The facility failed to change gloves and wash hands while preparing snack sandwiches on 03/05/2025 at 11:15 AM.</p> <p>These failures could place residents at risk for food contamination and foodborne illness.</p> <p>The findings included:</p> <p>During an observation on 03/05/25 at 11:15 AM DA A was preparing sandwiches on prep table. DA A had gloves on. DA A left the prep table with gloves on and walked to the dry storage room. DA A returned to prep table with same gloves on and opened bag of potato chips and using gloves hand put potato chips in Styrofoam container with sandwich. DA A put right gloved hand into pocket to get sharpie marker. DA A wrote on Styrofoam container and placed marker back in pocket. DA A left prep table with gloves on and went into DM office. DA A returned to prep table with same gloves on and being preparing sandwiches placing them on cookie sheet lined with wax paper. DA A left prep table with gloves on and went to refrigerator. DA A returned to prep table with same gloves on and began placing sandwiches in plastic bag. DA A placed gloved hand in pocket for sharpie marker and hand to DA B. DA A left prep table with gloves on and walked to the dishwashing area with DA C and placed right gloved hand on DA C right shoulder. DA A returned to prep table with same gloves on and continued placing sandwiches in bags.</p> <p>During an interview on 03/06/25 at 10:45 AM with the DA A, she stated she should have changed her gloves and washed her hands anytime she left the prep table or changed task. She stated she had been trained on proper hand hygiene and when to change her gloves. She stated she had no reason for not changing her gloves. She stated the potential negative outcome could be cross contamination.</p> <p>During an interview on 03/07/25 01:55 PM with the DM, she stated gloves should have been changed and hands washed anytime staff leave the prep table, place hands in pockets or change a task. She stated all staff have been trained. She stated she was responsible for monitoring staff and training staff. She stated she expects staff to follow policy and procedure when preparing food. She stated the potential negative outcome could be bacteria on food and cross contamination.</p> <p>During an interview on 03/07/25 at 02:01 PM with the ADM, he stated gloves should have been change and hands washed when DA left the prep table and placed her hand in her pocket. He stated not changing gloves and not washing hands was a problem. He stated he was responsible for monitoring and training dietary staff. He stated the potential negative outcome could be cross contamination and a resident could get sick.</p> <p>Record review of the facility policy, titled Handwashing, undated reflected the following:</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Objective: Use proper hand washing technique to keep hands and exposed portions of the arms clean.</p> <p>Procedure: .</p> <p>Employees should wash their hands: .</p> <p>After visiting resident rooms, when re-entering the kitchen, and prior to any food production.</p> <p>During food preparation, as often as necessary to prevent cross contamination when changing tasks .</p> <p>After engaging in any other activity that may contaminate the hands .</p> <p>Glove Use: .</p> <p>Change gloves any time the team member completes a task .</p> <p>Change gloves after touching an unsanitized item or surface or when gloves are soiled or torn .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150</p> <p>Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of communicable diseases for 4 of 6 residents (Resident #2, Resident #63, Resident #71, and Resident #86) and 3 of 3 staff (LVN E, CNA H, CNA I) reviewed for infection control.</p> <ol style="list-style-type: none"> CNA H failed to follow policy and procedure for handwashing while providing peri care for Resident #2, during observations of peri care on 03/06/2025 at 1:42 PM. LVN E failed to follow policy and procedure for handwashing while providing wound care for Resident #63, during observations of wound care on 03/05/2025 at 11:33 AM. CNA I failed to follow policy and procedure for handwashing while providing peri care for Resident #71, during observations of peri care on 03/05/2025 at 10:50 A. LVN E failed to follow policy and procedure for handwashing while providing wound care for Resident #86, during observations of wound care on 03/07/2025 at 11:01 AM. <p>These failures could place residents at risk for spread of infection and cross contamination.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of Resident #2s face sheet undated revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: Partial intestinal obstruction (something blocking the intestines), Herpes viral infection , Urinary tract infection, Herpes viral vesicular dermatitis (a skin infection caused by herpes simplex type 1), Severe sepsis with septic shock, Bacteremia (the presence of viable bacteria in the bloodstream), Methicillin resistant Staphylococcus aureus infection (a type of staph bacteria that is resistant to many antibiotics), Infection and inflammatory reaction due to indwelling urethral catheter, Benign prostatic hyperplasia with lower urinary tract symptoms (prostate gland enlargement), obstructive and reflux uropathy (when urine cannot drain through the urinary tract), Shortness of breath, Acute embolism and thrombosis of deep veins of left lower extremity (blood clot), Cellulitis of left upper limb (potentially serious bacterial skin infection). <p>Record review of Resident #2's admission MDS dated [DATE] revealed a BIMS score listed as 14 meaning cognitive intact. The MDS under Bowel and Bladder listed Resident #2 as having an indwelling catheter and urinary catheter was listed as a 9 meaning not rated. Under bowel continence Resident #2 was listed as a 0 meaning always continent.</p> <p>Record review of Resident #2's Care Plan dated 09/24/24, revealed that Resident #2 was listed as Enhanced Barrier Precautions with the interventions of staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>requiring a dressing, device care or use (central line, urinary catheter, feeding tube, trach care).</p> <p>Record review of Resident #2's Care Plan dated 07/16/24, revealed that Resident #2 was listed as having indwelling catheter.</p> <p>Record review of Resident #2's Care Plan dated 07/16/24, revealed that Resident #2 was listed as being at risk for urinary tract infection.</p> <p>Record review of Resident #2's Care Plan dated 07/16/24, revealed that Resident #2 was listed as Resident #2 was bowel incontinent.</p> <p>During an observation on 03/06/2025 at 1:42 PM, CNA H prepared to provide peri care to Resident #2. CNA H did not wash hands or use hand sanitizer prior to gathering peri care supplies. CNA H placed on a yellow gown, face mask, and face shield. CNA H washed her hands for 10 seconds with soap and friction before rinsing under water. CNA H used a clean paper towel to dry her hands. CNA H used a separate clean paper towel to turn off the water faucet. CNA H placed on a pair of clean disposable gloves. CNA H shut the resident's door and closed the privacy curtain completely. CNA H removed her gloves and disposed of them in the trash. CNA H used hand sanitizer and placed on a new pair of clean disposable gloves. CNA H put a towel on the bedside table to provide a barrier for the peri care supplies. CNA H removed her gloves and disposed of them in the trash. CNA H had used hand sanitizer and put on a pair of clean disposable gloves. CNA H prepared Resident #2 for peri care by removing the pillows under legs, wedges, blankets, raise the bed, removing Resident #2's pants, and provided privacy with a towel. CNA H placed a clean towel underneath Resident #2. CNA H removed gloves and disposed of them in the trash. CNA H put on hand sanitizer and placed on a clean pair of disposable gloves. CNA H used a clean wipe to clean the catheter tubing going from the insertion site downward away from insertion site, while holding the tubing in place. CNA disposed of the wipe in the trash. CNA H repeated this step four times. CNA H completed all steps of peri care for a male. CNA H covered Resident #2 with a towel. CNA H removed her gloves and discarded in the trash. CNA H used hand sanitizer and put on a pair of clean disposable gloves. CNA H asked Resident #2 to turn on his side so that she could clean the backside of the resident. CNA did not clean the right side of the buttock, just the left side and the anus area. CNA H removed gloves and disposed of them in the trash. CNA H used hand sanitizer. CNA H put on a clean pair of disposable gloves. CNA H used blue tape to tape the catheter tubing to the resident's leg. CNA H completely dressed the resident. CNA H gathered dirty towels and placed in the bag. CNA H gathered all trash and gathered in the bag. CNA H removed dirty gloves and disposed in the trash. CNA H used hand sanitizer and placed on clean gloves. CNA H used the urinal to empty the catheter bag and then used a clean wipe to wipe the urinal spout and shut the spout. CNA H emptied the urinal in the toilet and flushed. CNA H did not rinse out the urinal before placing the urinal on the nightstand. CNA H removed dirty gloves and discarded in the trash. CNA H used hand sanitizer and put on clean disposable gloves. CNA H took and disposed of all of the trash in the resident's room. CNA H used hand sanitizer and put on clean gloves. CNA H wet a paper towel with water and wiped down the bedside table. CNA H removed dirty gloves and disposed of them in trash. CNA H washed her hands for 29 seconds with soap before rinsing her hands. CNA H used three clean paper towels to dry her hands and then disposed of them in the trash. CNA H used a clean paper towel to turn off the faucet.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/06/2025 at 3:37 PM, CNA H stated that she had training for hand washing through in-services, monthly and competency checks every other week. CNA H stated that the policy says to wash hands for 30-60 seconds. CNA H stated that she got nervous being watched and knows that she had messed up a few times. CNA H stated that the negative potential outcome of not washing hands as the policy stated could cause the spread of infection and cross contamination.</p> <p>2. Record review of Resident #63s face sheet undated revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: Nontraumatic intracerebral hemorrhage in hemisphere (most commonly results in hypertensive damage in blood vessel walls), Type 2 diabetes mellitus, Pressure ulcer of sacral region, stage 4, Acute kidney failure, Urinary tract infection, hyperlipidemia (high levels of fat particles in the blood), Methicillin resistant Staphylococcus aureus infection (a type of staph bacteria that is resistant to many antibiotics), Overactive bladder (a problem with bladder function that causes sudden need to urinate), Hyperkalemia (high potassium), Hypertension (high blood pressure), Elevated white blood cell count,</p> <p>Cholecystitis (gallbladder inflammation), Anemia (iron deficiency), Morbid (severe) obesity due to excess calories, Abnormal posture, need for assistance with personal care, Pressure ulcer of sacral region, Sepsis, chronic kidney disease, Tachycardia (fast heart rate), Muscle wasting and atrophy.</p> <p>Record review of Resident #63's quarterly MDS dated [DATE] revealed a BIMS score listed as 15 meaning Resident #63 had cognitively intact. Under skin conditions in the MDS, Resident #63 was listed as being a risk of developing a pressure ulcer and listed Resident #63 as having one pressure ulcer upon admission at a stage four.</p> <p>Record review of Resident #63's Care Plan dated 06/06/23, revealed that Resident #63 was listed as enhanced barrier precautions due to a wound and a suprapubic catheter.</p> <p>Record review of Resident #63's Care Plan dated 06/06/23, revealed that Resident #63 was listed as having a has a pressure ulcer to Sacrum. Resident #63 was at risk for further breakdown r/t incontinence, decreased mobility and Diabetes.</p> <p>Record review of Resident #63's Physician Orders dated 02/13/2025, revealed: wound treatment order for sacrum, cleanse with normal saline/ wound cleanser, collagen, calcium alginate, cover with silicone absorbent dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 03/05/2025 at 11:33 AM, LVN E put on hand sanitizer and pair of clean disposable gloves to prep wound care supplies of several pairs of disposable gloves, wax paper on bedside table, 4 x 4 bordered bandage, plastic cup with gauze and normal saline, several gauze pads (dry), calcium alginate, collagen, and bordered dressing, green pad, and trash bag. LVN E disposed of gloves in the trash. LVN E used hand sanitizer and put on a pair of clean disposable gloves. LVN E cut pieces of calcium alginate and collagen and placed on the supply table. LVN E placed a clear trash bag over the clean supplies. LVN E disposed of gloves in the trash. LVN E put on hand sanitizer. LVN E put on yellow gown and clean disposable gloves for enhanced barrier precautions. LVN E set up supplies next to resident and provided privacy. LVN E removed disposable gloves and discarded in the trash. LVN E turned on water faucet to wash hands. LVN E put one squirt of soap in hands and for six seconds before rinsing hands under water. LVN E used clean dry paper towel to dry hands. LVN E used a clean paper towel to turn off the faucet. LVN E put on pair clean disposable gloves. LVN E removed Resident #63 blanket, raised bed, provided privacy, removed pillows from under legs, unfastened the front end of resident's brief. LVN E turned Resident #63 on the side to the left. LVN E removed gloves and disposed in the trash. LVN E washed hands with soap for five seconds before rinsing under water. LVN E used a clean dry paper towel to dry hands and disposed in the trash. LVN E used a clean paper towel to turn off the water faucet and disposed in the trash. LVN E put on pair clean disposable gloves. LVN E placed a blue pad under Resident #63. LVN E placed resident on left side. LVN E removed gloves and disposed in the trash. LVN E washed hands for four seconds with soap before rinsing under water. LVN E used a clean dry paper towel to dry hands and disposed in the trash. LVN E used a clean dry paper towel to turn off the water faucet. LVN E used gauze with normal saline to clean wound from inside, outward wound with one swipe, and discarded of gauze. LVN E removed gloves and disposed in the trash. LVN E washed hands with soap without lathering with and immediately rinsing underneath the water for three seconds. LVN E used a clean paper towel to dry hands and discarded in the trash. LVN E used a clean paper towel to turn off faucet. LVN E used dry gauze to pat dry wound one time per gauze and discarded in the trash. LVN E removed gloves and discarded in the trash. LVN E washed hands for five seconds with soap before rinsing under water. LVN E used a clean paper towel to dry hands and discarded in the trash. LVN E used a clean paper towel to turn off the water faucet and discarded in the trash. LVN E put on clean disposable gloves. LVN E put the collagen and calcium alginate on the wound. LVN E placed the bandage with date and initials on the wound. LVN E fastened Resident #63's brief and pulled up pants. LVN E covered resident with blanket. LVN E gathered trash and discarded in the biohazard trash. LVN E removed gloves and discarded them in trash. LVN E had ran out of soap in the resident's bathroom. LVN E went to the meeting room to wash hands. LVN E washed hands with soap for three seconds before rinsing under water. LVN E used a clean dry paper towel to dry hands and discarded paper towel in the trash. LVN E used a clean paper towel to turn off the water faucet and disposed in the trash.</p> <p>During an interview on 03/06/2025 at 5:00 PM, LVN E stated that policy stated that she should wash her hands with soap for 20 seconds before rinsing. LVN E stated that she did not know why she did not wash hands for the 20 seconds that policy stated. LVN E stated that she had been trained in hand washing through in-services, monthly. LVN E stated that she had competency checks completed, monthly. LVN E stated that it is the responsibility of the DON to oversee the training. LVN E stated that the negative potential outcome of not following the handwashing policy could be a risk for infection and the spread of germs.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #71s face sheet undated revealed a [AGE] year-old female with an admitted [DATE] with the following diagnoses: Alzheimer's disease, muscle weakness, hyperlipidemia (high levels of fat particles in the blood), depression, high blood pressure, atrioventricular block (a heart rhythm disorder), tubule-interstitial nephritis (kidney condition that causes swelling in the spaces between the kidney tubules which can impair kidney function).</p> <p>Record review of Resident #71's admission MDS dated [DATE] revealed a BIMS score listed as 3 meaning cognitive impairment. The MDS under functional abilities for toileting (The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment), listed Resident #71 as a 3 meaning: Partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Resident #71 was listed under bowel and bladder as being always incontinent for bowel and bladder.</p> <p>Record review of Resident #71's Care Plan dated 08/13/24, revealed that Resident #71 was listed as being at risk for Pressure Ulcer Development due to occasional episodes of incontinence.</p> <p>Record review of Resident #71's Care Plan dated 08/13/24, revealed that Resident #71 was listed as being occasionally incontinent and require assistance at times with incontinent care.</p> <p>Record review of Resident #71's Care Plan dated 08/13/24, revealed that Resident #71 was listed as needing assistance with ADL's.</p> <p>During an observation on 03/05/2025 at 10:50 AM, CNA I put on hand sanitizer in the hallway and gathered peri care supplies that included: clear trash bag, two towels. CNA I went into resident's room and shut the door. CNA I washed hands with soap for nine seconds before rinsing under water. CNA I used a clean paper towel to dry hands and disposed in the trash. CNA I used a clean paper towel to turn off the faucet and disposed in the trash. CNA I put on clean gloves and shut the middle privacy curtain and shut the blinds; however, the blinds were pulled up a quarter of the way from the bottom and were not shut. CNA I uncovered resident and unfastened her brief. CNA I provided peri care to the front area. CNA I removed gloves and disposed in the trash. CNA I washed hands with soap for nine seconds before rinsing under water. CNA I used a clean paper towel to dry hands and disposed in the trash. CNA I used a clean paper towel to turn off the faucet and dispose in the trash. CNA I put on clean gloves and turned Resident #71 to the left side to clean the backside of the resident. CNA I put a clean brief on Resident #71, laid her back, and fastened brief. CNA I gathered all trash. CNA I removed gloves and disposed in trash. CNA I took all of the trash that had been gathered from the resident's room and disposed in the trash. CNA I did not wash her hands.</p> <p>During an interview on 03/05/2025 at 3:25 PM, CNA I stated that the hand washing policy stated that she should wash her hands for twenty seconds. CNA I stated that she did not wash her hands at the end because she had forgotten to do it when she went to throw the trash. CNA I stated that she had been trained in hand washing through competency checks with the educator, two to three times a month. CNA I stated that policy stated that she should wash her hands before, during, and after peri care. CNA I stated that she did not do that because she was nervous. CNA I stated that the negative potential outcome of not following the hand washing policy would have been the spread of germs and infections. CNA I stated that the resident's need to be clean.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Record review of Resident #86's face sheet undated revealed a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: Multiple sclerosis, Urinary tract infection, Elevated urine levels of drugs, medicaments and biological substances, osteomyelitis (inflammation of the bone caused by infection), Pressure ulcer of heel, Elevated white blood cell count, Obstructive and reflux uropathy (when urine cannot drain through the urinary tract), Hyperglycemia (high blood sugar), Tachycardia (fast heart rate), acid reflux, Hypotension (low blood pressure), Calculus of kidney (hard deposit that forms in the kidneys), Muscle weakness, high blood pressure, Pressure ulcer of left buttock, stage 4, retention of urine (difficulty of urinating and completely emptying the bladder), reduced mobility, Need for assistance with personal care, Pressure-induced deep tissue damage, Hypothyroidism (a condition which the thyroid does not produce enough thyroid hormone), Polyneuropathy (peripheral nerve disorder that causes multiple nerves to malfunction simultaneously), Paraplegia (affects all or part of the trunk, legs, and pelvic organs).</p> <p>Record review of Resident #86's Care Plan dated 10/08/24, revealed that Resident #86 was listed as enhanced barrier precautions due to a wound.</p> <p>Record review of Resident #86's Care Plan start date of 10/08/24 and edited on 02/26/2025, revealed that Resident #86 had a pressure ulcer to left buttocks.</p> <p>Record review of Resident #86's Care Plan start date of 10/08/24 and edited on 02/26/2025, revealed that Resident #86 had a pressure ulcer to right buttocks.</p> <p>Record review of Resident #86's Care Plan start date of 10/08/24 and edited on 02/26/2025, revealed that Resident #86 was at risk for further breakdown or new pressure ulcer due to bedfast / mobility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 03/07/2025 at 11:01 AM, LVN E washed hands with soap for eight seconds before rinsing under water. LVN E used clean paper towel to dry hands and disposed in the trash. LVN E used a clean paper towel to turn off the faucet and disposed in the trash. LVN E used hand sanitizer. LVN E put a clear trash bag over the bedside table. LVN E put on clean gloves and gathered supplies of handful of gauze pads in clear plastic cup with normal saline, disposable gloves. LVN E removed gloves and discarded in the trash. LVN E used hand sanitizer and put on clean disposable gloves. LVN E grabbed silicone absorbent dressing (6 x 6), calcium alginate, collagen. LVN E removed gloves and discarded in the trash. LVN E used hand sanitizer. LVN E put on clean pair of disposable gloves. LVN E grabbed blue pad and used a clear plastic bag to cover the supplies. LVN E removed gloves and disposed in the trash. LVN E pushed the bedside table into the resident's room. LVN E washed her hands by putting soap in her hands and rubbing together without lathering and immediately rinsing for three seconds. LVN E left resident's room to put on yellow gown and gloves for PPE. LVN E went back into resident's room, shut the door, and pulled the privacy curtain. LVN E removed gloves and disposed in the trash. LVN E washed hands for three seconds, with soap, before rinsing under running water. LVN E used clean paper towel to dry hands and discarded in the trash. LVN E used a clean paper towel to turn off water faucet and disposed in the trash. LVN E put on clean pair of disposable gloves. LVN E removed pillows from under resident's feet and behind her back. Resident #86 did not have a bandage on. LVN E stated that the bandage must have come off during the shower. Wound was open in a portion of the wound and entire wound was approximately 6 X 3. LVN E disposed of gloves in the trash. LVN E washed hands with soap for two seconds and then rinsed under running water. LVN E used a clean paper towel to dry hands and disposed in the trash. LVN E used a clean paper towel to turn off faucet and disposed in the trash. LVN E put on pair of clean disposable gloves. LVN E used gauze with normal saline to clean the inner open part of the wound and discarded in trash. LVN E disposed of gloves in the trash. LVN E washed hands with soap for seven seconds before rinsing under running water. LVN E used a clean paper towel to dry her hands and disposed in the trash. LVN E used a clean paper towel to turn off the faucet and disposed in the trash. LVN E used a clean gauze with normal saline to clean the other side of the inner wound and discarded in the trash. LVN E disposed of gloves in the trash. LVN E washed hands with soap for five seconds before rinsing under running water. LVN E used a clean paper towel to dry hands and disposed of paper towel in the trash. LVN E used a clean paper towel to turn off water faucet and dispose in the trash. LVN E used dry gauze to pat dry the wound and disposed in the trash. LVN E put on clean pair of disposable gloves. LVN E put calcium alginate on two parts of the wound. LVN E covered the wound with the bandage that was dated and initialed. LVN E removed blue pad and disposed in the trash. LVN E laid resident back, fastened her brief, pulled up her pants, and covered her with a blanket. LVN E gathered trash and disposed of trash in biohazard bag. LVN E removed all PPE and disposed in biohazard bag. LVN E washed hands with soap without lathering and immediately rinsing under water. LVN E used a clean paper towel to dry hands and disposed in the trash. LVN E used a clean paper towel to turn off faucet and disposed in the trash.</p> <p>During an interview on 03/07/2025 at 3:27 PM, The DON and the Administrator were interviewed together. The DON stated that the nurse educator provides training with competency checks a couple times a month for hand washing. The DON stated that as per policy the staff should properly wash their hands with soap and water, after using hand sanitizer three times. The DON stated she expects the staff to follow the policy for peri care, wound care, and hand washing. The DON stated that the negative potential outcome would be increase in infections. The Administrator stated it would be the responsibility of the Administrator to oversee the training and infection control. The Administrator stated, It's always the Administrator.</p> <p>Record review of the facility-provided policy titled, Hand Hygiene, undated, revealed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Heritage Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 University Ave Lubbock, TX 79413	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Objective: Use proper hand washing techniques to keep hands and exposed portions of the arms clean.</p> <p>Procedure:</p> <p>Employees should wash their hands: Before starting work, after visiting resident rooms, and after engaging in any other activity that may contaminate the hands.</p> <p>Handwashing Technique:</p> <p>Turn on warm water.</p> <p>Rinse hands under clean, warm running water.</p> <p>Apply soap.</p> <p>Rub all surfaces of the hands and fingers together vigorously with friction for at least 15 to 20 seconds, giving particular attention to the area under the fingernails, between the fingers/ fingertips, and surfaces of the hands.</p> <p>Rinse under clean, warm running water.</p> <p>Leave water running, dry hands with paper towel. Cloth towels are not permitted to dry hands and do not use apron or uniform.</p> <p>Avoid recontamination of hands and arms by using a paper towel, when turning off hand sink faucets or touching the handle of a restroom door.</p> <p>Discard used paper towels in step trash can.</p> <p>Glove use:</p> <p>Always wash hands before putting on a new pair of gloves.</p> <p>Change gloves any time the team member completes a task.</p> <p>Change gloves after touching an un-sanitized surface or when gloves are soiled or torn.</p> <p>Gloves and hand sanitizers do not replace handwashing with soap and water.</p> <p>Remember, using gloves is not a substitute for proper handwashing with soap and water.</p> <p>Record review of the facility-provided policy titled, Enhanced Barrier Precautions, date revised on 1/20/2023, revealed:</p> <p>Policy Statement:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistance organisms.</p> <p>3. Implementation of Enhanced Barrier Precautions:</p> <p>a. Make gowns and gloves available immediately near or outside of the resident's room.</p> <p>b. PPE for enhanced barrier precautions is only necessary when performing high contact care activities and ma does not need to be donned prior to entering the resident's room.</p> <p>c. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room).</p> <p>d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.</p> <p>e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.</p> <p>f. Provide education to residents and visitors.</p> <p>g. Do not restrict room placement or out of room activities due to enhanced barrier precautions.</p> <p>4. High contact resident care activities include:</p> <p>a. dressing</p> <p>c. transferring</p> <p>d. providing hygiene.</p> <p>e. changing linens.</p> <p>f. changing briefs or assisting with toileting.</p> <p>g. device care or use; central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes.</p> <p>h. Wound care: any skin opening requiring a dressing.</p> <p>9. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at a higher risk.</p> <p>Record review of the facility-provided policy titled, Perineal Care, date revised 01/20/2023, revealed:</p> <p>Policy Statement:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Perineal Care is providing cleanliness and comfort to the resident, to prevent infections, skin irritation, and to observe the resident's skin condition.</p> <p>Steps in the Procedure:</p> <ol style="list-style-type: none"> 1. Introduce self to the resident and explain that will be provided. 2. Provide privacy; (pull curtain, and close door) 3. Perform hand hygiene and don gloves. 4. Arrange the supplies so that they can easily be reached. 5. Adjust bedding to resident's comfort and provide dignity during care. 6. Remove clothing enough to perform peri-care. Avoid unnecessary exposure of the resident's body. 7. Remove the soiled clothing, linens, and brief. Place items in the proper receptacle. 8. Encourage the resident to participate in care as able. 9. Provide the steps to peri care for either male or female. 10. Dry area thoroughly. 11. Discard disposable. 12. Remove gloves and discard into designated container. 13. Perform hand hygiene. 14. Reposition bed covers. Make the resident comfortable. 15. Place the call light within easy reach for the resident. 16. Perform hand hygiene. <p>Record review of the facility-provided policy titled, Infection Control Plan, dated July 2024, revealed:</p> <p>Infection Control:</p> <p>The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>5. Written standards, policies, and procedures for the program include but are not limited to:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>f. The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>Record review of the Centers for Disease Control website (www.cdc.gov) article titled Clinical Safety: Hand Hygiene for Healthcare Workers, dated February 27, 2024, revealed:</p> <p>Know how to wash hands with soap and water.</p> <p>3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.</p> <p>Record review of the facility-provided policy titled, Wound Care, date revised 2022, revealed:</p> <p>Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.</p> <p>Steps in the Procedure:</p> <ol style="list-style-type: none"> 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Perform hand hygiene. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on clean gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Perform hand hygiene. 6. Put on clean gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 7. Use no touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. 8. Pour liquid solutions directly on gauze sponges on their papers. 9. Wash around in a circular motion from the inside out with ordered wound cleanser. Use additional gauze and repeat as needed with fresh gauze each time. 10. Apply treatments and dress wound as ordered by physician. 11. [NAME] tape with initials, time, and date and apply dressing. 12. Remove the disposable cloth next to the resident and discard into the designated container. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>13. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Perform hand hygiene.</p> <p>14. Reposition the bed covers. Make the resident comfortable. Use supportive devices as instructed.</p> <p>15. Place the call light within easy reach of the resident.</p> <p>16. Sanitize overbed table.</p> <p>17. Return the overbed table to its proper position.</p> <p>18. Sanitize scissors.</p> <p>19. Perform hand hygiene.</p> <p>20. If the resident desires, return the door and curtains to the open door and curtains to the open position and if visitors are waiting, tell them that they now enter the room.</p>