

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675810	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2025
NAME OF PROVIDER OR SUPPLIER Lancaster Ltc Partners, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 N Elm St Lancaster, TX 75134	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and received adequate supervision 2 of 9 residents (Resident's #1 and #2) reviewed for accident hazards.1. The facility failed to immediately fix a broken window in the Memory Care Unit's dayroom. Resident #1 grabbed a shard of the glass and attempted to remove it. The Surveyor intervened to get the resident to stop grabbing it.An Immediate Jeopardy (IJ) was identified on 07/17/25. The IJ template was provided to the facility on [DATE] at 4:55 PM . While the IJ was removed on 07/18/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.2. The facility failed to ensure Resident #2 did not elope from the facility on 06/05/25. The resident was returned to the facility by the police on 06/05/25.An Immediate Jeopardy (IJ) was identified on 07/31/25. The IJ template was provided to the facility on [DATE] at 11:00 AM. While the IJ was removed on 08/01/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.These failures could place residents at risk for injury up to and including death due to the sharp glass and elopement.Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and residents received adequate supervision for 2 of 9 residents (Residents #1 and #2) reviewed for accident hazards.1. The facility failed to immediately fix a broken window in the Memory Care Unit's dayroom. Resident #1 grabbed a shard of the glass and attempted to remove it. The Surveyor intervened to get the resident to stop grabbing it.An Immediate Jeopardy (IJ) was identified on 07/17/25. 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While the IJ was removed on 08/01/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.These failures could place residents at risk for injury up to and including death due to the sharp glass and elopement.The findings included:1. Record review of Resident #1's quarterly MDS assessment, dated 06/17/25, revealed the resident was a [AGE] year-old male admitted on [DATE]. His BIMS score was 3 indicating his cognitive ability was severely impaired. His diagnoses included seizure disorder and schizophrenia (a serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior.) The resident required set-up assistance for wheelchair mobility.Record review of Resident #1's Care Plan, dated 06/19/25, reflected:The resident was at risk for falls.Facility interventions included:The resident needed a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, and personal items within reach.An observation and interview on 07/17/25 at 10:50 AM revealed Resident #1 was in the Memory Care Unit dayroom with 2 other residents. Resident #1 was in his wheelchair sitting next to a table close to the exit door. The window next to the exit door was broken and had a large piece of triangle shaped glass sticking straight up. There were also multiple pieces of glass sticking up and there was one large piece of glass laying in the windowsill. Pictures of the window were taken. Resident #1 said the window had been broken for 2-3 days after an unknown resident in a wheelchair hit it. The resident said he had never cut himself on the window.An interview on 07/17/25 at 10:53 AM with LVN A in the Memory Care Unit revealed she did not know the window was broken. She was walking through the day room. LVN A left the Memory Care Unit.An observation and interview on 07/17/25 at 10:55 AM revealed CNA B entered the day room. She sat in a chair at the table that was blocking the window. She said she would be staying in the day room until maintenance came to fix the window. Resident #1 was in his wheelchair next to her. She said she did not know about the broken window. The Surveyor walked around the corner to the nurse station. An interview with RN C</p>		