

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675842	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2026
NAME OF PROVIDER OR SUPPLIER MI Casita Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Quaker Ave 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record reviews, the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of 4 of 24 confidential residents in that: The facility failed to ensure staff were not on their personal cell phones while providing care, which included peri-care to residents. This could place residents at risk for diminished quality of life and loss of dignity and self-worth. Findings include: The four confidential residents at an undisclosed date and time four confidential residents stated the use of cell phones by CNAs while performing care made them feel ignored, not a priority, embarrassed, concerned the CNA could make a mistake due to distraction by the cell phone conversation, and, most of all, their privacy was violated. During an interview with four confidential residents stated the use of cell phones by CNAs occurred on every shift. Confidential residents also stated staff utilize their cell phones while feeding residents during meals; residents stated the use of the cell phones while feeding residents forced those residents to have significant wait times between bites. The four confidential residents stated they did not know the names of the CNAs who utilized their cell phones while performing care. The confidential residents stated cell phone usage of the CNAs while performing care happened in the facility happened so often, they said every CNA in the facility utilized their cell phone while performing care. During an interview on 03/27/26 at 3:33pm, the ADM stated residents should be provided with privacy during resident care. She stated all staff were trained on privacy, resident rights, dignity, and cell phone usage during orientation and through continuous education by department heads and the ADM. She stated staff were monitored by making rounds and correcting any issues found, and by addressing complaints and grievances concerning cell phone usage by staff while performing resident care. She stated cell phones should never be used in resident rooms, hallways, or nurses' stations. She stated the potential negative outcome could be mistakes and HIPAA violations. Record review of the undated facility policy titled Resident Rights revealed the following: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence to be treated with respect, kindness, and dignity. t. privacy and confidentiality		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 2 (Residents #7 and #40) of 22 residents reviewed for care plans. 1. The facility failed to develop a care plan for oxygen administration for Resident #7.2. The facility failed to implement the smoking care plan for Resident #40. This failure could place residents at risk of not receiving the care required to meet their individualized needs.1. Record review of the admission record for Resident #7, dated 03/27/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: chronic respiratory failure (a condition where the lungs cannot adequately supply oxygen to the blood), malignant neoplasm of the lung (lung cancer), heart failure and anemia (blood disorder leading to reduced oxygen to tissues). Record review of the significant change MDS assessment for Resident #7, dated 03/10/26, revealed Resident #7 had a BIMS score of 03 indicating she had severe cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #7 used oxygen therapy while a resident. Record review of the comprehensive care plan for Resident #7, last reviewed on 03/25/26, revealed no care plan for the administration of oxygen therapy. Record review of #7's current Physician Orders dated 03/27/26 revealed the following: May use oxygen at 2L per minute via cannula (tube in nostrils)/mask by concentrator/tank, with a start date of 02/02/26. Record review of Resident #7's Nurse Administration Record dated 03/01/26-03/31/26, revealed oxygen administration was signed for daily between 03/04/26-03/27/26. Observation and interview during the initial tour on 03/25/26 at 11:06 AM, Resident #7 was not wearing oxygen, but she stated she frequently wore oxygen while in bed. An oxygen concentrator with attached tubing was observed at Resident #7's bedside. Telephone interview on 03/27/26 at 4:09 PM, the MDS Coordinator stated she was responsible for resident care plans. She stated she must have overlooked adding Resident #7's care plan for oxygen. She stated she usually checked physician's orders and the 24-hour report daily to update residents' care plans. The MDS Coordinator stated the care plan is used by all nursing staff and interdisciplinary team members to know the proper care of the resident. She stated a potential negative outcome for failure to develop a complete care plan, including oxygen therapy, was that staff may not know the resident required oxygen which could cause respiratory issues. Interview on 03/27/26 at 4:10 PM, the ADM stated she was not aware Resident #7's care plan did not include oxygen therapy. She stated the completeness of the care plan was important, so nursing staff and IDT members were aware of how to care for the resident. The ADM stated her expectation of staff was that care plans were accurate and complete. She stated a potential negative outcome for failure to include oxygen therapy in the care plan was nursing staff and IDT members may not be aware of the resident's need for oxygen. 2. Record review of the admission record for Resident #40, dated 03/25/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: chronic atrial fibrillation (irregular heart rate), acute lower respiratory infection, and chronic obstructive pulmonary disease (lung disease). Record review of the comprehensive MDS assessment for Resident #40, dated 06/06/25, revealed Resident #40 had a BIMS score of 12 indicating his cognition was intact. The MDS further revealed Resident #40 currently used tobacco. Record review of the care plan for Resident #40, last reviewed on 12/24/25, revealed, Focus: Smoker: [Resident #40] is a smoker and is safe to smoke unsupervised. Intervention/Tasks: The resident's smoking supplies are stored at the nurses' station with an initiation date 07/01/25. Interview during the initial tour on 03/25/26 beginning at 9:30 AM, Resident #40 stated he was allowed to keep a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cigarette and lighter on his person and he had one in his front shirt pocket at that time. Resident #40 stated none of the staff members had told him that he was not allowed to have a cigarette and lighter on him. Observation on 03/27/26 at 9:20 AM, Resident #40 was observed to have 1 cigarette and 1 lighter in a cigarette box in his front shirt pocket. Interview on 03/27/26 at 9:23 AM, LVN B stated she had been trained to look at the Kardex which was a simplified version of the care plan, but it had been a while since her last training. LVN B stated she did not know why Resident #40 had a cigarette and lighter in the front pocket of his shirt. LVN B stated sometimes Resident #40 was non-compliant with the smoking policies in the facility. LVN B stated a potential harm to the residents was their care plan not being followed. Interview on 03/27/26 at 11:05 AM, the DON stated the staff had been trained to check the care plans for the residents. The DON stated she did not know the last time the staff had been trained on following the care plans. The DON stated she did not know why the smoking care plan for Resident #40 was not being followed. The DON stated a potential negative outcome to the residents was that the residents could not get the care they needed. In an additional interview on 03/27/26 at 3:48 PM, the DON stated she did not know why Resident #7's care plan did not include oxygen therapy. She stated the care plan should have been added when the physicians order was received. She stated she and the MDS Coordinator were responsible for the accuracy and completeness of resident care plans. The DON stated the care plan was used by all staff for information on how to care for a resident. Interview on 03/27/26 at 1:41 PM, the ADM stated she expected the nursing staff to check the care plans and follow them. The ADM stated the nursing staff was trained on care plans, but she did not know when. The ADM stated she did not know why the nursing staff did not follow the smoking care plan for Resident #40. The ADM stated there was a potential risk for danger with the smoking care plan not being followed. Record review of the undated facility-provided policy titled, Policy and Procedure Comprehensive Care Planning, revealed: Purpose: Ensure every resident has a comprehensive, complete, accurate and all inclusive specific care plan written timely to [NAME] all requirements of the RAI and regulatory process to include input from all the IDT members. Procedure.8. Every resident will have all needs/specialized services care planned.and revised routinely.		

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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 observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #40) reviewed for smoking. The facility failed to ensure Resident #40's smoking items were kept at the nursing station. This failures could place the residents at risk of inadequate supervision, accidents, and burns which could result in injury. Findings Included: Record review of the admission record for Resident #40, dated 03/25/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: chronic atrial fibrillation (irregular heart rate), acute lower respiratory infection, and chronic obstructive pulmonary disease (lung disease). Record review of the comprehensive MDS assessment for Resident #40, dated 06/06/25, revealed Resident #40 had a BIMS score of 12 indicating his cognition was intact. The MDS further revealed Resident #40 currently used tobacco. Record review of the care plan for Resident #40, last reviewed on 12/24/25, revealed, Focus: Smoker: [Resident #40] is a smoker and is safe to smoke unsupervised. Intervention/Tasks: The resident's smoking supplies are stored at the nurses' station with an initiation date 07/01/25. Record review of Resident #40's Safe Smoking Assessment, dated 03/11/26, revealed: .B. Summary:4. All smoking materials will be kept at the nurse's station was checked off. Interview during the initial tour on 03/25/26 beginning at 9:30 AM, Resident #40 stated he was allowed to keep a cigarette and lighter on his person and he had one in his front shirt pocket at that time. Resident #40 stated none of the staff members had told him that he was not allowed to have a cigarette and lighter on him. Resident #40 was observed with oxygen on via nasal cannula at 3 liters per minute. Observation on 03/27/26 at 9:20 AM, Resident #40 was observed to have 1 cigarette and 1 lighter in a cigarette box in his front shirt pocket. Resident #40 was observed with oxygen on via nasal cannula at 3 liters per minute. Interview on 03/27/26 at 9:23 AM, LVN B stated she had been trained on the smoking policy at the facility recently. LVN B stated she did not know why Resident #40 had a cigarette and lighter in the front pocket of his shirt. LVN B stated sometimes Resident #40 was non-compliant with the smoking policies in the facility. LVN B stated that sometimes the families will bring cigarettes to the residents and no one will tell the staff about it. LVN B stated a potential harm to the residents was possible burning themselves or combustion if a resident was on oxygen. Interview on 03/27/26 at 11:05 AM, the DON stated the staff had been trained on the smoking policy at the facility last month. The DON stated the residents were not supposed to have smoking supplies on their person, but sometimes it was difficult to manage with the independent residents who smoke. The DON stated Resident #40 probably had his smoking supplies on him because he did not give it back to the nurses. The DON stated the staff were trained to look for smoking supplies with the residents. The DON stated a potential negative outcome to the residents was they could forget and try to light a cigarette in their room. Interview on 03/27/26 at 1:41 PM, the ADM stated she expected the residents and staff to follow the smoking policies and procedures. The ADM stated all staff were responsible to monitor for smoking supplies and should know that all smoking supplies was kept in the med room at the nurse's station. The ADM stated she did not know why Resident #40 had his smoking supplies on his person, unless he did not give them back to the nurses after he went outside to smoke. The ADM stated there was a potential risk for danger with cigarettes, lighters and oxygen use. Record review of the facility in-service titled, Smoking Policy, dated 2/1/26 revealed the signature for LVN B. Record review of the facility policy titled, Smoking Policy - Residents with a revised date of 10/23 reflected the following: Policy Statement: This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation:.14. All smoking items shall be kept at the facility designated area. This includes but not limited to lighters, cigarettes.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 2 (Resident #1 and #17) of 8 residents reviewed for respiratory care. The facility failed to ensure that Resident #1 and Resident #17's oxygen tubing were replaced every seven (7) days, according to physician's orders. This failure could place residents at risk for respiratory compromise and infection. Resident #1 Record review of Resident # 1's face sheet dated 03/27/26 reflected a [AGE] year-old male with an original admission date of 07/14/15. Resident #1 had diagnoses which included: right heart failure (condition where the right side of the heart cannot effectively pump blood to the lungs), acute and chronic respiratory failure (condition where the lungs cannot adequately supply oxygen to the blood), peripheral vascular disease (a progressive circulation disorder), acute pulmonary edema (sudden buildup of fluid in the lungs causing severe breathing difficulties), and dependence on supplemental oxygen. Record review of Resident #1's annual MDS dated [DATE] reflected a BIMS score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #1 used oxygen therapy while a resident. Record review of Resident #1's comprehensive care plan, revised 02/26/26, reflected Resident #1 required oxygen therapy related to shortness of breath. Interventions included: OXYGEN SETTINGS: Oxygen: May have oxygen at 1-5L via cannula/mask by concentrator/tank. To initial when using oxygen. Record review of Resident #1's current Physician Orders dated 03/27/26 reflected the following: Oxygen: May have oxygen at 1-5L via cannula (tube in nostrils)/mask by concentrator/tank. Oxygen: To change oxygen equipment and clean filters weekly, every night shift every Sunday. Record review of Resident #1's Nurse Administration Record dated 03/01/26-03/31/26, reflected an order to change oxygen equipment and clean filters weekly, every night shift every Sunday. The following dates were initialed: 03/01/26, 03/08/26, 03/15/26, and 03/22/26. During an observation and interview on 03/25/26 at 10:55 AM, Resident #1 had oxygen being administered at 3 L/minute via nasal cannula. The oxygen tubing was dated 03/15/26. Resident #1 stated staff usually changed out his oxygen tubing, but he did not recall when staff had last changed it. During an observation on 03/26/26 at 12:15 PM, Resident #1's oxygen tubing was dated 03/15/26. Resident #17 Record review of Resident # 17's face sheet dated 03/27/26 reflected a [AGE] year-old female with an original admission date of 01/17/18. Resident #17 had diagnoses which included: chronic obstructive pulmonary disease (a progressive lung disease that causes obstructed airflow), acute and chronic respiratory failure (condition where the lungs cannot adequately supply oxygen to the blood), heart failure (a progressive condition where the heart does not pump blood efficiently), peripheral vascular disease (a progressive circulation disorder), and dependence on supplemental oxygen. Record review of Resident #17's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #1 used oxygen therapy while a resident. Record review of Resident #17's comprehensive care plan, revised 09/09/25, reflected Resident #17 required oxygen therapy related to ineffective gas exchange. Interventions included: OXYGEN SETTINGS: Oxygen: May have oxygen at 1-5L via cannula/mask by concentrator/tank. To initial when using oxygen. Record review of #17's current Physician Orders dated 03/27/26 reflected the following: Oxygen: May have oxygen at 1-5L via cannula (tube in nostrils)/mask by concentrator/tank. Oxygen: To change oxygen equipment and clean filters weekly, every night shift every Sunday. Record review of Resident #17's Nurse Administration Record dated 03/01/26-03/31/26, reflected an order to change oxygen equipment and clean filters weekly, every night shift every Sunday. The following dates were initialed: 03/01/26, 03/08/26, 03/15/26, and 03/22/26. During an observation and interview on 03/25/26 at 11:22 AM, Resident #17 had oxygen (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being administered at 3L/min via nasal cannula. The oxygen tubing was dated 3/15/26. She stated that she does wear her oxygen. She stated that one staff member was really good about changing the tubing and adding water to the canister, but not all staff did. During an observation on 03/26/26 at 12:16 PM, Resident #17's oxygen tubing was dated 03/15/26. During an interview on 03/27/26 at 3:25 PM, the ADON stated she worked as the charge nurse part of the night shift on 03/22/26, which was a Sunday. She stated 03/22/26 was the scheduled date for oxygen tubing changes for Resident #1 and Resident #17. The ADON stated Sunday was the designated day for weekly oxygen equipment changes and night shift charge nurses were responsible for completing the task. She stated she took care of Resident #1 and Resident #17 during the shift, and she got busy and failed to change the oxygen tubing for Resident #1 and #17 and failed to report to the oncoming nurse that the task had not been completed. She stated a potential negative outcome for failure to change oxygen tubing, according to orders was residents could have respiratory complications. During an interview on 03/27/26 at 3:48 PM, the DON stated the facility policy was for oxygen tubing to be changed every week on Sunday. She stated the night shift charge nurses were responsible for changing tubing and documenting the tubing change. She stated nursing administration was responsible for assuring oxygen equipment was changed timely, according to orders. The DON stated oxygen tubing and equipment was spot checked by nursing administration while on rounds in the facility. She stated a potential negative outcome for failure to change oxygen tubing according to physicians orders was infection issues. During an interview on 03/27/26 at 4:10 PM, the ADM she was not aware oxygen tubing changes for Residents #1 and #17 had not been completed on the scheduled date. She stated her expectation of staff was to follow physicians orders for each resident. The ADM stated the charge nurse was responsible for oxygen tubing changes and nursing administration was responsible for monitoring the completion of the task. The ADM stated a potential negative outcome for failure to change oxygen tubing, according to orders, was infection. Record review of the facility-provided policy titled Administration of Oxygen and Maintenance of Tubing and Equipment, dated 10/2017 revealed: Administration of Oxygen 1) Oxygen will be administered per physician order. Maintenance of Tubing and Equipment. 2) Tubing will be dated, and will be changed weekly.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 6.06% based on 2 out of 33 opportunities, for 2 of 3 Residents (Residents #33 and #36) reviewed for medication administration, in that:-The facility failed to ensure Med Aide C provided a full dose of the medication Polyethylene Glycol 3350 Powder (MiraLAX) 17 grams to Resident #36. -The facility failed to ensure Med Aide C provided the correct eye drop medication to Resident #33. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: Resident #36 Record review of Resident #36's admission record, dated 03/26/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: pneumonia (lung infection), acute cystitis without hematuria (bladder infection), and constipation. Record review of Resident #36's physician orders, dated 03/26/26, revealed an order for Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 gram by mouth one time a day related to constipation, mix with 4-6 oz of water with a start date of 01/08/26. During a medication administration observation on 03/26/26 at 8:14 AM, for Resident #36, Med Aide C was observed dispensing polyethylene glycol 3350 powder by filling the bottle cap half full in the white area. The powdered medication did not reach the top of the white section in the bottle cap. Med Aid C then mixed the powder with approximately 4 oz. of water and administered to Resident #36. Review of the back of the Polyethylene Glycol 3350 Powder medication label revealed the directions: Fill the provided cap to the top of the white section (marked 17g). During an interview on 03/26/26 at 8:20 AM, Med Aide C stated she did not know that the polyethylene glycol 3350 powder needed to reach the top of the white section of the bottle cap as no one had ever told her. Med Aide C stated a potential negative outcome to the resident was not getting the full effect of the medication. Resident #33 Record review of Resident #33's admission record, dated 03/26/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: fracture of coccyx, lack of coordination, and dry eye syndrome of bilateral lacrimal glands. Record review of Resident #33's physician orders, dated 03/26/26, revealed an order for Artificial Tears Ophthalmic Solution 1 % (Carboxymethylcellulose Sodium (Ophth[almic])) Instill 1 drop in both eyes three times a day for dry eyes with a start date of 07/20/24. During a medication administration observation on 03/26/26 at 8:33 AM, for Resident #33, Med Aide C was observed administering Redness relief eye drops 1 drop per eye. During an interview on 03/26/26 at 12:01 PM, Med Aide C stated she noticed the Redness relief eye drops were different than Artificial Tears eye drops. Med Aide C stated she administered the Redness relief eye drops because that was provided to her by the facility. Med Aide C stated a potential negative outcome to the resident was possible adverse reactions. During an interview on 03/27/26 at 11:05 AM, the DON stated she expected the staff to observe the 5 rights for medication administration. The DON stated Med Aide C had told her the reason she did not fill up the Polyethylene Glycol 3350 Powder to the top of the white section in the bottle cap was because she was afraid of the medication overflowing and making a mess. The DON stated the nurses and medication aides were trained on proper dosing of medications, but she did not know when the last training was. The DON stated the residents had a risk of constipation with not getting a full dose of Polyethylene Glycol 3350 Powder. The DON stated artificial tears were difficult to locate and that was why Redness relief eye drops were provided to the facility. The DON stated a potential negative outcome to the resident was the Redness relief eye drops would not help his dry eyes. During an interview on 03/27/26 at 1:41 PM, the ADM stated the DON oversees the medication administration at the facility. The ADM stated she knows the staff was trained on medication administration, but she did not know when the last training for medication administration was provided. The ADM stated Med Aide C was probably nervous. The ADM stated a potential negative outcome to the residents with not (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting a full dose of medication was it could not be effective. The ADM stated a potential negative outcome to the residents with getting the wrong medication was that the resident could not get the correct effect from the medication that was needed. Record review of facility policy titled, Administering Medications with a revised date of 01/01 reflected the following: Policy Statement: Medications will be administered in a timely manner and as prescribed by the resident's attending physician or the facility's medical director. Policy Interpretation and Implementation: 8. The individual administering the medication must ensure that the right medication, the right dosage, are verified before the medication is administered (e.g. review of the drug label, physician orders, etc.)		

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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. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 4 medication carts (Med Cart A and Med Cart B) and 1 of 2 medication rooms (Med Room C) reviewed for medication storage. The facility failed to ensure Med Cart A did not have loose pills in the drawers. The facility failed to ensure Med Cart A, Med Cart B and Med Room C did not have expired medications and supplies. These failure could place residents at risk of medication errors or adverse effects. The findings included: During an observation of Med Cart A on 03/27/26 at 11:17 AM with the DON, 2 loose pills were found in the second drawer. 1 pill was oblong and was light gray in color. 1 pill was oblong and was yellow/orange in color. During an interview on 03/27/26 at 11:26 AM, the DON stated she believed the light gray pill that was found in Med Cart A was memantine and she thought the yellow/orange pill was a different dose of memantine. During an observation of Med Cart B on 03/27/26 at 11:23 AM with the DON, 32 sureprep pads with an expiration date of 11/15/25 were found in the bottom drawer, aloe vera hand sanitizer 2 fluid oz. with an expiration date of 08/22 and a 30 mL medicine cup with 15 mL full of a white powder, unlabeled was in the top small drawer and eucalyptus hand sanitizer 32 fluid oz. with an expiration date of 08/22 was sitting on top of the medication cart. During an interview on 03/27/26 at 11:29 AM, LVN D stated the medicine cup of white powder in the top drawer of Med Cart B was miralax that a resident had asked for and then refused when he took it to them. LVN D stated he did not want to waste the medication, so he put it back in the medication cart. During an observation of Med Room C on 03/27/26 at 11:35 AM with the DON revealed, 4 packs of povidone-iodine swab sticks with an expiration date of 05/25 was observed on a shelf. 4 bottles of Glucerna hunger smart shakes 10 fluid oz. with an expiration date of 07/01/25 were found in the refrigerator in Med Room C. During an interview on 03/27/26 at 11:47 AM, the DON stated the medication aides and the nurse's were responsible for ensuring loose pills and expired items were not in the medication carts or the medication rooms. The DON stated she did not know why expired items were found in Med Cart B or Med Room C. The DON stated the staff were trained on medication storage but she did not have an exact date on when the last training was. The DON stated a potential negative outcome to the residents was the expired supplies could not work as well. The DON stated a potential negative outcome to the residents with improperly labeled medications was medication errors. During an interview on 03/27/26 at 1:41 pm, the ADM stated the DON was responsible for medication storage and labeling. The ADM stated she expected for expired items to be pulled off the shelf before the expiration date. The ADM stated she did not know why some medications were not labeled properly or why some items were expired, maybe was an oversight. The ADM stated a potential negative outcome to the residents was the expired items may not be as effective. The ADM stated a potential negative outcome to the residents with unlabeled medications was the residents could be short pills. Record review of the facility policy titled, Storage of Medications with a revised date of November 2020 reflected the following: Policy heading: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation:.2. Drugs and biologicals are stored in packaging, containers or other dispensing system in which they are received. Only the issuing pharmacy is authorized to transfer medication between containers.4.Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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.1. The facility failed to ensure red onions with sprouts and mold were removed from the dry pantry.These failures could place residents at risk for foodborne illness. On 3/25/26 an initial kitchen observation tour from 9:47 AM to10:30 AM revealed the following:The dry pantry had a plastic bin dated 2/24/26 with red onions in it. There were 6 red onions found to have green sprouted shoots and were soft to touch. There were 4 red onions with dark black and grey molded areas and were soft to touch.During an interview on 3/25/26 at 10:05 AM the DS stated that staff were to check the red onions every day. She stated, it was likely the red onions had not been checked in the past couple of days. She stated that the date on the plastic bin, 2/24/26, was when the red onions were received. She stated the kitchen was very hot and the dry pantry was hot and the temperature could cause the red onions to go bad faster. She stated the red onions should have lasted 2 weeks in the dry pantry with the heat. She stated she would have a staff member sort the red onions in the bin and throw away the spoiled red onions.During an interview on 3/25/26 at 11:46 AM the DS stated all the red onions were thrown away and new red onions were ordered.During an interview on 3/27/26 at 3:55 PM Corporate Account Manager stated that the red onions should have been checked daily and dietary staff should discard any that were spoiled. She stated that the heat could cause the red onions to ruin faster as well as moisture. She stated additional education would be provided to dietary staff.During an interview on 3/27/26 at 5:00 PM the ADM stated the company had the ADM do a walk through in the kitchen every week. She had completed the walk through on Monday and did not see the spoiled red onions in the dry pantry.Record review of the facility's Use by date Guide used to determine a use by date when labeling opened and unopened food that must be used within a certain time frame.Item/Category - produce, fresh fruits and vegetables, Use By- Check daily for freshness.Record review of the facility's policy titled Food receiving and storage dated, 2001 and revised date November 2022, revealed in part:Policy Statement: Food shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation:4. Food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times.Dry Food Storage:4. Dry foods and goods in storage must be checked weekly for perishable or changes to the integrity of the food product. Food products in which the integrity of the food has changed since arrival must be disposed of properly.5. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in - first out system		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 2 (Residents #1 and #17) of 22 residents reviewed for clinical records. The facility failed to accurately document oxygen tubing changes for Residents #1 and #17 This failure could place residents at risk of inaccurate and incomplete care. Resident #1 Record review of Resident # 1's face sheet dated 03/27/26 reflected a [AGE] year-old male with an original admission date of 07/14/15. Resident #1 had diagnoses which included: right heart failure (condition where the right side of the heart cannot effectively pump blood to the lungs), acute and chronic respiratory failure (condition where the lungs cannot adequately supply oxygen to the blood), peripheral vascular disease (a progressive circulation disorder), acute pulmonary edema (sudden buildup of fluid in the lungs causing severe breathing difficulties), and dependence on supplemental oxygen. Record review of Resident #1's annual MDS dated [DATE] reflected a BIMS score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #1 used oxygen therapy while a resident. Record review of Resident #1's comprehensive care plan, revised 02/26/26, reflected resident #1 required oxygen therapy related to shortness of breath. Interventions included: OXYGEN SETTINGS: Oxygen: May have oxygen at 1-5L via cannula/mask by concentrator/tank. To initial when using oxygen. Record review of #1's current Physician Orders dated 03/27/26 reflected the following: Oxygen: May have oxygen at 1-5L via cannula (tube in nostrils)/mask by concentrator/tank. Oxygen: To change oxygen equipment and clean filters weekly, every night shift every Sunday. Record review of Resident #1's Nurse Administration Record dated 03/01/26-03/31/26, reflected the ADON inaccurately signed for an oxygen tubing change on 03/22/26 for Resident #1, that did not occur. During an observation on 03/25/26 at 10:55 AM, Resident #1 had oxygen being administered at 3 L/minute via nasal cannula. The oxygen tubing was dated 03/15/26. During an observation on 03/26/26 at 12:15 PM, Resident #1's oxygen tubing was dated 03/15/26. Resident #17 Record review of Resident # 17's face sheet dated 03/27/26 reflected a [AGE] year-old female with an original admission date of 01/17/18. Resident #17 had diagnoses which included: chronic obstructive pulmonary disease (a progressive lung disease that causes obstructed airflow), acute and chronic respiratory failure (condition where the lungs cannot adequately supply oxygen to the blood), heart failure (a progressive condition where the heart does not pump blood efficiently), peripheral vascular disease (a progressive circulation disorder), and dependence on supplemental oxygen. Record review of Resident #17's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #1 used oxygen therapy while a resident. Record review of Resident #17's comprehensive care plan, revised 09/09/25, reflected Resident #17 required oxygen therapy related to ineffective gas exchange. Interventions included: OXYGEN SETTINGS: Oxygen: May have oxygen at 1-5L via cannula/mask by concentrator/tank. To initial when using oxygen. Record review of #17's current Physician Orders dated 03/27/26 reflected the following: Oxygen: May have oxygen at 1-5L via cannula (tube in nostrils)/mask by concentrator/tank. Oxygen: To change oxygen equipment and clean filters weekly, every night shift every Sunday. Record review of Resident #17's Nurse Administration Record dated 03/01/26-03/31/26, reflected the ADON inaccurately signed for an oxygen tubing change on 03/22/26 for Resident #1, that did not occur. During an observation on 03/25/26 at 11:22 AM, Resident #17 had oxygen being administered at 3L/min via nasal cannula. The oxygen tubing was dated 3/15/26. During an observation on 03/26/26 at 12:16 PM, Resident #17's oxygen tubing was dated 03/15/26. During an interview on 03/27/26 at 3:25 PM, the ADON stated she worked as the charge nurse part of the night shift on 03/22/26, which was a Sunday. She stated (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sunday was the designated day for weekly oxygen equipment changes and night shift charge nurses were responsible for completing the task. She stated she took care of Resident #1 and Resident #17 during the shift and signed for oxygen tubing changes on the MAR for each of those residents and intended to change the tubing later in the shift. The ADON stated she got busy and failed to change the oxygen tubing for Resident #1 and #17 during her shift and failed to report to the oncoming nurse that the task had not been completed. She stated she had been trained during her nursing education to sign for procedures after completing the task. The ADON stated she was trying to be helpful to the oncoming nurse to get tasks completed and inadvertently failed to complete the task she signed for. She stated a potential negative outcome for inaccurate documentation was residents could have incomplete care or miss essential care that is ordered by the physician. During an interview on 03/27/26 at 3:48 PM, the DON stated she was not aware oxygen tubing changes for Residents #1 and #17 had been inaccurately documented. She stated documentation should be accurate for all residents at all times. She stated a task should be signed for only after being completed or should have a strikeout by staff if a task was not completed. She stated documentation was monitored by nursing administration and by the regional nurse during onsite visits. The DON stated a potential negative outcome for inaccurate documentation was care that was ordered for a resident could be missed if signed for and not completed. During an interview on 03/27/26 at 4:10 PM, the ADM stated she was not aware oxygen tubing changes for Residents #1 and #17 had been inaccurately documented. She stated her expectation of staff was to accurately document all care in a timely manner. The ADM stated the system for monitoring the accuracy of documentation was through random checks of the health record by nursing administration and the regional nurse. She stated a potential negative outcome for inaccurate documentation was that the resident may not get care tasks completed according to orders. Record review of the facility-provided policy titled Charting and Documentation, revised July 2017, revealed: Policy Statement .The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 7. Documentation of procedures and treatments will include care specific details, including: a. The date and time the procedure/treatment was provided.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #32) reviewed for infection control. The facility failed to ensure LVN B washed her hands after entering the room to provide wound care to Resident #32. This failure could place residents at risk for cross contamination and infection. The findings included: Record review of the face sheet for Resident #32, dated 03/25/26 revealed an [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: chronic obstructive pulmonary disease (lung disease), pressure ulcer of right heel stage 3, and peripheral vascular disease (poor blood circulation). Record review of the comprehensive MDS assessment for Resident #32, dated 01/17/26 revealed Resident #32 had a BIMS score of 09 which indicates his cognition was moderately impaired. The MDS further revealed Resident #32 had a Stage 3 Pressure ulcer. Record review of the order summary report for Resident #32, dated 03/25/26, revealed an order: Tx [treatment] to right outer heel stage 3 pressure ulcer: Cleanse, pat dry, apply iodosorb and calcium alginate, clover and secure with bordered gauze. Every dayshift with a start date of 01/09/26. Record review of the care plan for Resident #32, last care plan review completed 03/05/26 revealed: Focus: The resident has actual pressure injury development to his right heel. During an observation of wound care on 03/26/27 at 10:02 AM, LVN B gathered her supplies on a tray at the wound care cart and entered Resident #32's room for wound care. LVN B set her supplies down, put on a clean gown and gloves and began performing wound care for Resident #32's Right heel wound. LVN B did not wash her hands after entering the room and before putting on clean gloves. During an interview on 03/26/27 at 10:12 AM, LVN B stated she had been trained to wash her hands before providing care to the residents. LVN B stated she was last trained a few months ago on infection control. LVN B stated she washed her hands at the sink before the surveyor began watching the wound care observation. LVN B stated it had slipped her mind to wash her hands after entering the room. LVN B stated a potential negative outcome for the residents was an increased risk for infection. During an interview on 03/27/26 at 11:05 AM, the DON stated she expected the staff to wash their hands before starting any care. The DON stated she did not know why LVN B did not wash her hands after going in the room to provide care for Resident #32. The DON stated LVN B was last trained on infection control in February of 2026. The DON stated a potential negative outcome to the residents was an infection control risks to the residents. During an interview on 03/27/26 at 1:41 PM, the ADM stated she expected the staff to wash their hands before providing care to the residents. The ADM stated the DON manages infection control concerns in the facility. The ADM stated she knows LVN B had been trained on infection control at the facility, but the DON would have that information. The ADM stated a potential negative outcome to the residents was a possible infection. Record review of the facility's in-service document titled, Handwashing/Gloves, dated 02/16/26 revealed LVN B's signature. Record review of the facility's policy titled, Policies and Practices - Infection Control with a revised date of 10/18 reflected the following: Policy Statement: This infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage the transmission of disease and infections. Record review of the facility's policy titled, Handwashing/Hand Hygiene with a revised date of 10/23 reflected the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident. 5. The use of gloves does not replace hand washing/hand hygiene.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review the facility failed to provide 80 square feet of floor space per resident in 10 of 40 semi-private resident rooms containing two beds (Rooms #1, 3, 5, 8, 27, 29, 30, 31, 32, and 33) in that: Rooms #1, 3, 5, 8, 27, 29, 30, 31, 32, and 33 semi-private rooms did not have 80 square feet per resident. This failure could result in overcrowding in resident rooms and possible diminished quality of life. The findings included: Record review of Texas Health and Human Services Form 3740 (Bed Classifications (Numbers and Location) dated 01/8/25 documented that rooms #1, 3, 5, 8, 27, 29, 30, 31, 32, and 33 were listed as a Title 18/19 bed classification semi-private rooms for two residents. During an interview on 03/27/26 at 10:15am with the Administrator, she was asked if she wanted to apply for the room size waiver she stated, Yes, I want to apply for the waiver. She stated rooms #1, 3, 5, 8, 27, 29, 30, 31, 32, and 33 had a waiver for years and there has been no change to the floor plan. During a general observation tour on 03/27/26 between 2:30pm and 3:00pm, it was noted that 10 of 40 semi-private rooms had 154 square feet instead of the required 160 square feet for 2 residents: (Rooms) #1, 3, 5, 8, 27, 29, 30, 31, 32, and 33. During an interview on 03/27/26 at 3:33pm with the Administrator, regarding the risk of residents not having the appropriate space, she stated there have been no issues with the room size in the past 34 plus years. She stated there was no facility policy for room size waiver.		