STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675853	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hansford County Hospital District Dba Lakeridge Nu	4403 74th St Lubbock, TX 79424

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 3 of 3 residents (Resident #1, Resident #2 and #3) reviewed for infection control.1. CNA A failed to change gloves when going from dirty to clean when providing incontinence care for Residents #1, #2, and #3. These failures could place residents at risk for cross contamination and infection. The findings include: Resident #1 Record review of the admission record for Resident #1, dated 09/05/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: cerebral palsy (a group of permanent movement disorders that affect brain-controlled muscle functions), schizoaffective disorder, bipolar type (mental health disorder) and anemia (not enough red blood cells to carry oxygen throughout the body). Record review of the quarterly MDS assessment for Resident #1, dated 08/27/25 revealed Resident #1 was always incontinent of bladder and bowels. Record review of the current care plan for Resident #1, last reviewed on 06/27/25, revealed there was a focus area: Bladder/Bowel Incontinence: I have bowel and bladder incontinence. During an observation on 09/05/25 at 11:30 AM, CNA A provided incontinence care and catheter care for Resident #1 with the help of CNA B. CNA A and CNA B washed their hands with soap and water and put on a clean pair of gloves. CNA A then unfastened the brief for Resident #1 and began cleaning his groin area with wipes. Resident #1 was turned on his side and CNA A removed the old brief. CNA A then wiped Resident #1's buttocks and placed a clean brief under Resident #1. CNA A secured the new brief and pulled up Resident #1's pants with the help of CNA B. CNA A then removed her gloves and used hand sanitizer to clean her hands. CNA A did not change her gloves and perform hand hygiene before going from dirty to clean during the procedure. Resident #2 Record review of the admission record for Resident #2, dated 09/05/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: atherosclerotic heart disease (thickening or hardening of the arteries) dysphagia (difficulty swallowing), and aphasia (a language disorder that makes it difficult to communicate). Record review of the quarterly MDS assessment for Resident #2, dated 08/17/25, revealed Resident #2 was always incontinent of bladder and bowels. Record review of the current care plan for Resident #2, last reviewed on 09/04/25, revealed there was a focus area: [Resident #2] has bladder incontinence r/t history of UTI (Urinary Tract Infection). During an observation on 09/05/25 at 11:00 AM, CNA A provided incontinence care for Resident #2 with the help of CNA B. CNA A and CNA B washed their hands with soap and water and put on clean gloves. CNA A then unfastened Resident #2's brief and cleansed his groin with wipes. Resident #2 was turned on his side and CNA A wiped his buttocks with wipes. CNA A then removed the dirty brief and placed a clean brief under Resident #2 without changing her gloves. CNA A then secured Resident #2's brief and pulled his pants up. CNA A then transferred Resident #2 to his wheelchair and removed her gloves. CNA A then used hand sanitizer to cleanse her hands. CNA A did not change her gloves and perform hand hygiene before going from dirty to clean during the procedure. Resident #3 Record review of the admission record for Resident #3, dated 09/05/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: cerebral palsy (a group of permanent movement disorders that affect brain-controlled muscle functions), strabismus (crossed eyes or squint), and mild intellectual disabilities. Record review of the comprehensive MDS assessment for Resident #3, dated 07/30/25, revealed Resident #3 was frequently incontinent of bladder and always incontinent of bowels. Record review of the current care plan for Resident #3, last reviewed on 09/04/25, revealed there was a focus area: [Resident #3] has bowel and bladder incontinence. During an observation on 09/05/25 at 11:45 AM, CNA A provided incontinence care for Resident #3 with the help of CNA B. CNA A and CNA B washed their hands with soap and water and put on clean gloves. CNA A pulled down Resident #3's shorts and then unfastened Resident #3's brief. CNA A then cleansed Resident #3's groin with wipes. CNA A then removed Resident #3's old brief and then wiped his buttocks with wipes. CNA A placed a clean brief under Resident #3. CNA A secured Resident #3's brief and pulled up Resident #3's shorts. CNA A then transferred Resident #3 to his wheelchair. CNA A then removed her gloves and used hand sanitizer to cleanse her hands. CNA A did not change her gloves and perform hand hygiene before going from dirty to clean during the procedure. During an interview on 09/05/25 at 11:53 AM, CNA A stated she had received