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	05/01/2026

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

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record review, the facility failed to ensure all residents were treated with respect and dignity for 1 of 7 residents (Resident # 1) reviewed for dignity.LVN A failed to treat Resident #1 with respect and dignity when she told Resident #1 to go to his room or to go outside and smoke when he asked for medications and when he was talking to staff and visitors in the dining room. This failure placed residents at risk of emotional distress, embarrassment, and lower self-esteem. Findings included:Record review of Resident #1's face sheet dated 4/30/26, revealed Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: Acute respiratory failure with hypoxia (lack of oxygen in the bloodstream), chronic pain due to trauma, major depressive disorder (mental illness), chronic obstructive pulmonary disorder (severe breathing difficulties), anoxic brain damage (damage to the brain due to loss of oxygen), other seizures (uncontrolled convulsions and loss of consciousness), dysphagia (difficulty swallowing), muscle weakness, muscle spasm (involuntary contractions of the muscle), cognitive communication deficit (trouble organizing thoughts, managing conversations, or understanding information), dysarthria (speech disorder caused by brain damage), anarthria (severe speech disorder resulting in complete inability to produce speech, and myoclonus (involuntary jerking muscle spasms caused by nervous system disorder).Record review of Resident #1's annual MDS Assessment, dated 3/01/2026 revealed a BIMS Score of 13 which indicated the resident's cognition was intact. Record review of Grievance Log, dated April 2026, revealed Resident #1 submitted a grievance on 4/12/26, night nurse treats him like a kid and gives his meds last [name of LVN A]. ADM spoke with nurse and she stated she just passes meds and resident demands his meds all the time. Explained to nurse that he may want his at a certain time and to try and give his first sometimes. Nursing administration will monitor closely and talk with resident at random times. signed by Former ADM During an interview on 4/30/26 at 10:00 AM, the Former ADM stated Resident #1 received his medications from the nurse (LVN A) because he wanted his medications given to him at a certain time. The Former ADM stated since then Resident #1 said he always gets his medication last.During an interview on 4/30/26 at 11:00 AM, Resident #1 stated last night (4/28/26) LVN A parked her cart long-ways in the Station 1 hall when she passed out medications, and he could not get past it in his wheelchair. He stated he asked her to move it, and she got mad and told him to go outside and smoke. He stated he told LVN A he was going to smoke but still needed to get by to go back to his room after he was done. He stated last night (4/28/26) in the dining room, he stopped and talked to a CNA eating chicken with their family member in the common dining room and LVN A approached all three of them and told him he needed to leave them alone, so he left the area. Resident #1 stated LVN A zig zagged rooms when passing out medication and would skip his room and gave his medication last during the medication pass between 8:00 PM and 10:00 PM. He stated when he had approached her at the nurse's station desk to ask for his medication, and she told him to go to his room or go to smoke. Resident #1 stated when he asked for things, LVN A often told him to wait and go smoke, and she would have it ready when he came back from smoking. Resident #1 stated he (continued on next page)

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

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported this to the DON, and she told him she would talk to LVN A and straighten it out. He said he also told the Former ADM who told him he would talk to LVN A. Resident #1 stated he believed LVN A treated him like this because one time he called her a name. Resident #1 stated he got upset when LVN A was rude to him and felt like she treated him like a child. During an interview on 4/30/26 at 2:58 PM, Resident #6 stated she felt LVN A did not like Resident #1. Resident #6 stated Resident #1 had asked LVN A for his medications when it was time for him to receive them, but LVN A told Resident #1 he had to wait and she also told Resident #1 he had to wait when he asked for his shower. Resident #6 stated she felt LVN A had a grudge against Resident #1 because he called her a curse name one time. Resident #6 stated she felt Resident #1 did not irritate LVN A when he asked for his medications as he just simply asked for them because it was time. During an interview on 4/30/26 at 4:43 PM, the Former ADM stated Resident #1 believed LVN A passed his medications last on purpose, so he told LVN A to give his medications first sometimes. The Former ADM stated he had not been told Resident #1 had issues with being told to wait to take showers. The Former ADM stated LVN A told him Resident #1 demanded his medications when he wanted them. The former ADM stated he did not think LVN A was rude but there may have been concerns with her approach, as she was sometimes short in her responses, which could be considered rude.During an observation on 4/30/26 at 9:05 PM, LVN A was in the Station 1 hallway in the process of passing out medications to residents when Resident #1 approached his bedroom doorway and asked for his PRN pain medication. LVN A told Resident #1 she would look into it and told Resident #1 to go back into his room and watch television.During an interview on 4/30/26 at 9:57 PM LVN A stated she was the charge nurse on Station 1. She stated she parked the cart long ways in the hall instead of against the wall so she could see both sides of the hall in front of her because she was doing rounds at the same time. She stated Resident #1 was in and out of his room all night and she would move the cart and or he would go around it, but she realized this was his home and he should not have to move things to get around the facility and that the hallways should be kept free of clutter. She stated she told Resident #1 to go to his room when he came out of his room to ask for his medication so he could relax and wait on her so she could check to make sure his medication was due. She stated Resident #1 frustrated others sometimes, for example last night (4/29/26), a CNA was having dinner with their family member in the dining room. LVN A stated she saw Resident #1 talking to them in the dining room so she approached them and she told Resident #1 to move away from them and go to his room or go outside and smoke so they could eat. LVN A stated there was a breakroom for staff to eat in, but they were eating in the resident dining room since her family member was there, so she allowed them to sit in the dining room. She stated she now realized this was the resident's home and he had the right to talk to people in the dining room. LVN A stated the Former ADM told her to be more patient with Resident #1, but she was not told why she needed to be more patient with him. LVN A stated she was not told Resident #1 complained that she gave his medication last. LVN A stated Resident #1 sometimes refused to shower. LVN A stated she did not recall if Resident #1 called her a curse name in the past. During an interview on 4/30/26 at 9:57 PM CNA B stated she believed there was something going on back and forth between Resident #1 and LVN A. CNA B stated Resident #1 followed CNA A when she passed medications. CNA B stated LVN A had asked Resident #1 not to follow her and he told her he needed his medication. CNA B stated Resident #1 would quit following LVN A after he got his medication. CNA B stated Resident #1 went to the nurse's station around 11:30 PM to ask for his PRN pain medication and LVN A took it to him in his room.During an interview on 5/1/26 at 12:20 PM, the sister facility ADM stated Resident #1 approached her this morning and expressed some concerns about LVN A and that he felt LVN A treated him like a child. During an interview on 5/1/26 at 2:50 PM, the DON stated staff had been in-serviced on being mindful of tone and language and to be respectful of residents. The DON stated she was only aware that Resident #1 had previously complained that LVN A skipped him on the medication pass and gave his medications last. The DON stated she talked to LVN A who explained she was passing medications on a rotation and not purposely skipping (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1. The DON stated she instructed LVN A to make sure she went in order if that was what she was doing but not to skip him. The DON stated she was aware LVN A had told Resident #1 to go to his room before and she told LVN A to be more mindful of how she spoke to the resident. The DON stated sometimes going out of order when passing out medications could cause the staff confusion and that could be why the staff did not want to give medications out of order. She stated she was not aware of an incident when LVN A told Resident #1 to go to his room or go outside and smoke when she saw him talking to a staff and their family member that were eating in the dining room. She stated staff had been trained in how to treat residents with dignity. The DON stated the ADON, the DON, and the ADM were all responsible to ensure staff treated residents with respect and dignity. The DON stated sending Resident#1 to their room or to go smoke was not the appropriate way to redirect the resident. The DON stated it was not appropriate for staff to redirect a resident from talking to staff eating in the dining room, this was their home, staff could eat other places such as outside, in their car, or other areas designated for staff such as the breakroom if they did not want to be interrupted by residents. She stated she expected staff to treat residents with respect and dignity. The DON stated a potential negative outcome was that it could cause residents emotional distress and make them feel uncomfortable here and this could also have caused Resident #1 to feel isolated if he felt he must stay in his room.Record Review of the facility provided policy, Resident Rights, revised February 2021, revealed in part: Policy Statement Employees shall treat all residents with kindness, respect, and dignity.Policy Interpretation and Implementation1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;c. be free from abuse, neglect, misappropriation of property, and exploitation;d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms;e. self-determination;f. communication with and access to people and services, both inside and outside the facility;Record Review of the facility provided policy, Administering Medications, revised April 2019, revealed in part: Policy Statement: Medications are administered in a safe and timely manner and as prescribed.Policy Interpretation and Implementation5. Medication administration times are determined by resident need and benefit, not staff convenience.Factors at are considered include:a. Enhancing optimal therapeutic effect of the medication;b. Preventing potential medication or food interactions; andc. Honoring resident choices and preferences, consistent with his or her care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, observation, and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of all medications to meet the needs of the residents and establishes a system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation for 1 of 1 medication pass reviewed for pharmaceutical services in that:1. LVN A failed to document medications given on the EMAR immediately after administration to each resident during the nighttime medication administration on 4/30/26.2. LVN A failed to use the EMAR when she administered medications to residents during the nighttime medication administration on 4/30/26 and instead used a handwritten log as reference.These failures could place residents at risk of having their medications diverted and/or receiving the incorrect dosage.Findings included: Record review of LVN A's handwritten medication log, undated, revealed each resident's name and room number, and an abbreviated medication name was listed on the document. The handwritten medication log did not reveal the physician, time, dosage amount of each medication to be given. Additionally, some of the medication names were crossed out in black ink. During an interview and observation on 4/30/26 at 8:33 PM, LVN A stated she was responsible for the Station 1 medication cart. A handwritten medication log that contained resident's names, room numbers, and abbreviated medication names was observed sitting on top of the medication cart. LVNA stated she wrote medications for residents that she needed to give on a handwritten piece of paper because she did not have access to the EMAR on the tablets that were on the medication carts.During an observation on 4/30/26 from 9:00 PM to 9:47 PM, LVN A passed out medications to residents during the nighttime medication pass. LVN A was observed referring to and comparing the handwritten medication log to the label on each resident's medication blister packs. LVN A popped the pills in a cup and then gave them to each resident. LVN A then returned to the medication cart and crossed out the name of the medications on her handwritten log that she gave to each resident. During an interview on 4/30/26 at 9:57 PM LVN A stated she was the charge nurse in Station 1 hall. LVN A stated to prepare for passing medications, she went to the desktop computer and looked up each resident's EMAR in their computer system called Point Click Care and wrote down all the medications she was going to pass to each resident on a piece of paper. She stated she was unable to access the EMAR from the tablet that was on the medication cart that staff were supposed to use when passing medications. She stated she had access to the EMAR on the desktop computer but could not log in on the tablets on the medication carts. LVN A stated after she wrote everything down, she looked at her handwritten medication log and looked for a resident's medication on the medication cart; then she compared them again to her handwritten medication log and popped the medications in the cup. She stated then she gave the medications to the resident. She stated she made sure the residents took the medications and gave them water. LVN A stated she then marked a line through the medications given on her handwritten log. LVN A stated she was not sure of the policy requirements for passing and documenting medications. She stated she had not been told anything about writing her own medication pass log, however the DON most likely did not know she was doing that. She stated she charted the medications she gave to the residents on the desktop computer after she was done passing out all the medications. She stated she had never thought about it being risky to do it that way, but she still did not see any risk in her doing it that way. She stated she was responsible for all medications on that cart. LVN A stated she received training and in-services on medication pass and she was supposed to chart the medications in the EMAR when she gave them to the residents. LVN A stated a potential negative outcome was that the wrong medication could be given or a medication could be missed and they could have a bad reaction to the medications. She stated she told someone that she did not have access to EMAR on the Station 1 medication cart but could not remember who or when she told them. During an interview on 4/30/26 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 2:50 PM, the DON stated when passing out medications staff were to open the resident's EMAR and check the name, medication, dose, amount, and allergies before administering medications to residents. The DON stated staff were to explain the medications being given to the residents and document the medications that were being given in the EMAR as they were popped in the cup, then administer the medication, then return to the EMAR and save or make changes of refused if needed. She stated she was not aware staff wrote and used handwritten medication pass logs to pass medications. She stated she was not aware staff documented in residents' EMAR's after they completed the medication pass for all residents. She stated she was not aware of any staff who could not access the EMAR on the tablet on the medication carts. She stated the system in place to ensure medication pass documentation was timely and accurate was for staff to use the tablet that was attached to the medication carts. She stated she expected staff to use the tablets to document medications given to residents in real time on the tablets. The DON stated staff were not supposed to hand write their own medication pass logs and then use them to administer medications. The DON stated staff were not supposed to post-document medications and were expected to document as they were being administered. The DON stated herself and the ADON were responsible to ensure medication pass was documented timely, properly, and accurately in the EMAR. She stated staff had not been trained in documenting medications during the medication pass process since she started working here. She stated staff had been trained to use the EMAR when passing medications. She expected staff to use the EMAR and document as they were passing meds to residents. She stated a potential negative outcome was that medication errors could happen, dosages could be wrong, and it was not safe.Record Review of the facility provided policy, Administering Medications, revised April 2006, revealed in part: 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 Implementation8. The individual administering the medication must ensure that the right medication; right dosage, right time and right method of administration are verified (e.g., review of drug label, physician's order, etc.) before the medication is administered.9. The individual administering the medication must initial the resident's MAR on the appropriate line and date for that specific day before administering the next resident's medication.13. When medications are administered, the individual administering the medication must record in the resident's medical record:a. The date and time the medication was administered;b. The dosage;c. The route of administration;d. The injection site (if applicable);e. Any complaints or symptoms for which the drug was administered;f. Any results achieved and the time such results were observed; andg. The signature and title of the person administering the drug.Record Review of the facility provided policy, Charting and Documentation, revised July 2017, revealed in part: Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation2. The following information is to be documented in the resident medical record:a. Objective observations;b. Medications administered;c. Treatments or services performed;3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 1 medication carts (Station 1 Cart) observed in the facility. The facility failed to ensure the Station 1 medication cart was secured when unattended on 4/30/26.This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversion. Findings included: During an observation on 4/30/26 at 8:14 PM the Station 1 medication cart was observed in the station 1 hallway with the lock popped out unattended and without a staff present. LVN A was observed coming out of a resident room and approaching the medication cart.During an observation and interview on 4/30/26 at 8:33 PM the Station 1 medication cart was observed in Station 1 hallway with the lock popped out unattended and without a staff present. LVN A was observed in Resident room [ROOM NUMBER]-B helping another staff transfer a resident into their bed with a mechanical lift. As the Surveyor was waiting by the Station 1 medication cart, Resident #2 and their family approached the medication cart and waited next to it. LVN A then exited Resident room [ROOM NUMBER]-B with the mechanical lift and proceeded to approach the medication cart. She then moved the medication cart, and Resident #2 and their family member went on into Resident #2's bedroom. LVN A parked the lift at the end of the Station 1 hallway and then approached the medication cart. LVN A stated she was the charge nurse and was assigned to the Station 1 medication cart. The surveyor pulled on all the drawers and all of drawers opened. The drawer that contained the narcotic medications opened however the lock box was secure. Various cards and bottles of medications and medical supplies were observed in the drawers of the medication cart that opened. LVN A stated she was in the process of passing out medications to residents but went to help transfer a resident to their bed.During an interview on 4/30/26 at 9:57 PM LVN A stated she was the charge nurse during the shift. She stated she was responsible for the Station 1 medication cart. She stated she was trained and had been in-serviced that medication carts were supposed to be always locked, the narcotic box was supposed to be locked, and the keys were to always be with her. She stated she was in the middle of passing out medications when she went to help another staff transfer a resident with the mechanical lift. She stated she forgot to lock the medication cart and should have locked the cart, and she took responsibility for that. She stated she was responsible for all medications on that cart and could get into trouble for not locking it. She stated a potential negative outcome was that confused residents could get medications and take them, someone could steal the medications, or there could be drug diversion. She stated residents would go without their medications if they were lost or stolen, and this could affect residents financially if they had to pay for the missing medications. During an interview on 5/1/26 at 2:50 PM, the DON stated the policy was that medication carts should be locked anytime they were unattended and that there were frequent rounds completed by staff to ensure carts were locked. The DON stated she was not aware night staff left medication carts unlocked and unattended. She stated that she and the ADM were responsible for ensuring medication carts were locked when unattended. The DON stated in-services had been provided to staff to ensure they locked the medication carts. She stated she expected staff to lock the carts for safety when they were left unattended. The DON stated a potential negative outcome was that especially confused residents, visitors, and staff could take medications that were not theirs and it was a safety issue as there could be negative interactions with their other medications.Record Review of the facility provided policy, Storage of Medications, revised November 2020, revealed in part: Policy Heading: The facility stores all drugs and biologicals in a safe, secure, and orderly manner.6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, [NAME], and boxes) containing drugs and biologicals are locked when (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not in use. Unlocked medication carts are not left unattended.Record Review of the facility provided policy, Administering Medications, revised April 2019, revealed in part: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview the facility failed to 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 5 of 7 residents (Residents #1, #2, #3, #4, #5) and 1 of 1 staff (LVN A) reviewed for infection control. LVN A failed to sanitize hands between residents during medication administration for Residents #1, # 2, #3, #4, and #5 on 4/30/26.This failure could place residents at risk for spread of infection and cross contamination. Findings included:During an observation of medication pass on 4/30/26 at 9:00 PM, LVN A prepared medications for Resident #1 and administered medications. LVN A did not sanitize her hands before or after medication administration. During an observation of medication pass on 4/30/26 at 9:13 PM, LVN A prepared medications for Resident #2 and administered medications. LVN A did not sanitize her hands before or after medication administration. During an observation of medication pass on 4/30/26 at 9:18 PM, LVN A prepared medications for Resident #3 and administered medications. LVN A did not sanitize her hands before or after medication administration. During an observation of medication pass on 4/30/26 at 9:22 PM, LVN A prepared medications for Resident #4 and administered oral pill medications then LVN A administered one drop of eye drop medication in each eye. LVN held Resident #4's top eye lids open during the administration with her bare hand. LVN A did not sanitize her hands before or after medication administration nor did she wear gloves. During an observation of medication pass on 4/30/26 at 9:29 PM, LVN A prepared crushed medications mixed in jelly for Resident #5 and administered medications into the resident's mouth with a wooden spoon. LVN A did not sanitize her hands before or after medication administration. During an interview on 4/30/26 at 9:57 PM LVN A stated she was the charge nurse on Station 1. She stated if she remembered she would sanitize her hands between medication passes of residents. She stated she did not sanitize her hands every time between each resident because she forgot to do it. She stated she was trained to sanitize her hands between each resident even if she did not have any physical contact with them. LVN A stated she only sanitized between two of the residents because she remembered to do it but then she forgot again. She stated it was typical of her to forget to sanitize her hands during medication pass. LVN A stated she was not sure of the policy requirements for passing medications. She stated she was probably supposed to wear gloves when she administered eye drops, but she did not sanitize before or after she administered the eye drops on Resident #4 during medication pass. She stated she also gave Resident #5 their medication without sanitizing her hands after she gave Resident #4 their eyedrops. LVN stated this was concerning because the residents were fragile and it should not have happened that way. LVN A stated she was aware that not sanitizing between residents caused a risk of cross contamination and she could spread germs to residents and get them sick.During an interview on 5/1/26 at 2:50 PM, the DON stated the policy for hand hygiene during medication pass was that staff were expected to sanitize before and after passing medications to each resident. The DON stated she excepted staff to do hand hygiene and wear gloves when administering eye drops. She stated she was not aware a staff was not doing hand hygiene when administering eye drops and between medication passes. The DON stated staff were trained in hand washing and infection control during orientation training prior to training on the floor with residents. She stated she was responsible for ensuring staff completed hand hygiene and wore proper personal protective equipment during medication administration. She stated she expected staff to follow medication pass rights and chart in real time. She stated she expected staff to wear gloves and complete hand hygiene during med pass. The DON stated a potential negative outcome was that staff could spread infection to residents. She stated staff had been in-serviced on Enhanced Barrier Precautions as well.Record review of the facility's policy titled, Policies and Practices - Infection Control, revised October 2018, revealed in part: Policy Statement This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable (continued on next page)

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	05/01/2026

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	environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation2. The objectives of our infection control policies and practices are to:a. Prevent, detect, investigate, and control infections in the facility;b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public;c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions;d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard and Transmission-Based Precautions;e. Maintain records of incidents and corrective actions related to infections; andf. Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment.Record review of the facility's policy titled, Handwashing/Hand Hygiene, revised October 2023, revealed in part: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation Administrative Practices to Promote Hand Hygiene1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.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 Hygiene1. Hand hygiene is indicated:a. immediately before touching a resident;b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device);c. after contact with blood, body fluids) or contaminated surfaces;d. after touching a resident;e. after touching the resident's environment;f. before moving from work on a soiled body site to a clean body site on the same resident; andg. immediately after glove removal.Record Review of the facility provided policy, Administering Medications, revised April 2006, revealed in part: 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.11. Established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) must be followed during the administration of medications.