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	05/12/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming, and personal hygiene for 1 of 7 residents (Resident #1) reviewed for ADL care.The facility failed to ensure Resident #1 was cleaned of bowel movement and urine on 5/10/2026 and on 5/11/2026.This failure could place the residents at risk for skin breakdown, infection and poor self-esteem.The findings include:Record review of Resident #1's face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of cerebral ischemia (lack of blood flow deprives the brain of vital oxygen and glucose) , unspecified dementia (when a patient exhibits clear signs of cognitive decline such as memory loss, impaired reasoning, or personality changes severe enough to affect daily life), encounter for attention to other artificial opening of urinary tract (management, cleansing, or changing of surgical urinary appliance such as a Urostomy (a surgical procedure that creates an alternate route for urine to exit the body)), muscle weakness and need for assistance with personal care.Record review of Resident #1's admission MDS dated [DATE], indicated in Section C- Cognitive patterns revealed a BIMs score of 4 which indicated Resident #1 had severe cognitive deficits. Section GG- functional abilities revealed Resident #1 was depended for personal hygiene, toileting, and shower/bathing. Section E- Behavior Section E0800 Rejection of care- Presence and Frequency revealed Did the resident reject evaluation or care (.ADL assistance) that is necessary to achieve the resident's goals for health and well-being? 0. Behavior not exhibited. Section H- Bladder and Bowel Appliances revealed resident had a urinary ostomy (a surgically created opening in the abdomen that bypasses the natural intestinal or urinary tract) and resident was always incontinent of bowel.Record review of Resident #1's care plan focus dated 4/22/2026 revealed [Resident #1] have an ADL self-care performance deficit r/t [related to] dementia. [Resident #1] will maintain my current level of function through the review date.provide supportive care. Care plan focus dated 5/05/2026 revealed [Resident #1] continuously removed clothes and urostomy bag, Monitor behavior episodes and attempt to determine underlying cause. Care plan focus dated 5/11/2026 revealed [Resident #1] REMOVED FECES FROM HER BRIEF SMEARED IT, WHEN STAFF ATTEMPTED TO REDIRECT PT [patient] BECAME AGITATED AND PHYSCIALLY AGGRESSIVE. The resident will have no evidence of behavior problems (smearing feces and becoming physically aggressive) . Anticipate and meet the resident's needs.Record review of grievance report dated 5/10/2026 by Resident #1's family member revealed Nature of complaint: Family came in on 5/10/2026 and [Resident #1] had dried feces (a solid or semi-solid waste material expelled from the body through the rectum and anus during defecation) on hands, vaginal area and buttocks.How the complaint was investigated: Interviewed staff.Findings of investigation: Resident hitting and aggressive refusing to allow staff to provide care.Solution: Family notified.Record review of Resident #1's progress notes dated 5/10/2026 at 7:39am revealed This nurse [LVN A]. was notified by CNA [unknown] that [Resident #1] family was in room and [family member] wanted to speak to a nurse [LVN A]. This nurse [LVN A] entered room and [Resident #1] appeared to have been playing in feces prior to family arriving. [Resident #1 family] states I am not mad at you or your (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff but [Resident #1] had to have done this sometime last night. Look at how hard this poop is on her hands and body. This nurse [LVN A] assessed [Resident #1]; [Resident #1] had feces all over body and had feces all over bed rails. [Resident #1] was asleep at this time. This nurse [LVN A] and CNA [unknown] gave [Resident #1] a bed bath at this time. [Resident #1] was cleaned up, nails cleaned, and clothes changed. [Resident #1] had also pulled urostomy bag off; this nurse [LVN A] placed new bag. This nurse spoke to family and family states they understand she is not the only resident in facility, and they know this is what she has been doing lately [lately]. Family asked if they could place a complaint. This [LVN A] nurse notified .ADON and was given a complain sheet for family to fill out. Family filled out sheet and returned to this nurse [LVN A] who turned it into ADON. Family apologized and stated they were not sure why [Resident #1] continues to play in feces. Family educated.Record review of Resident #1's POC Response History Task: Toileting Hygiene revealed Resident #1 received toileting hygiene on 5/10/2026 at 4:16am. The POC Response History Task: bowel and bladder elimination revealed on 5/10/2025 at 4:18am Resident #1 had a large BM [bowel movement]. There were no documented Resident #1 refusals for either task for this date. There were no further task documentations that showed Resident #1 had been provided toileting hygiene after 4:18am and before 7:00am on 5/10/2026.Record review of Resident #1's progress notes for dates 5/09/2026-5/10/2026 did not reveal any documentation that stated resident had refused to be changed or refused toileting hygiene care prior to 7:00am on 5/10/2026.During an interview on 5/12/2026 at 10:33am, CNA E stated he had worked on 5/10/2026 day shift. He stated he entered Resident #1's room at approximately 7:15am to help CNA F. He stated when he entered the room, he saw Resident #1 had poop pasted on her. He stated family was in the room with CNA F because they had found Resident #1 in that state. He stated he felt Resident #1 had been laying in BM for a while because the feces appeared dry. He stated Resident #1 was given a bed bath by CNA F and LVN A in order to remove the feces from Resident #1. He stated the night CNAs were CNA G and CNA H. He stated the oncoming CNAs and off going CNAs should be rounding together and checking their assigned residents but that did not always happen. He stated he did not know if CNA F had checked Resident #1 before 7:15am. He stated the night CNAs usually conduct their last rounds at approximately 5:30AM but was not sure what time CNA G or CNA H had done their last night rounds. He stated he did not see skin breakdown or any redness on Resident #1's buttocks. He stated he had been trained to check on residents every two hours and more frequently on residents who may have behaviors. He stated residents being left in that manner was not okay and that is why they needed to do end of shift rounds with the oncoming staff, so things like this don't happen.During an interview on 5/12/2026 at 12:09pm, CNA F stated she had been assigned to care for Resident #1 on 5/10/2026 day shift. She stated when she arrived on shift at 6:00am she did lay eyes on Resident #1, but she was ensuring Resident #1 was in bed and that she was okay. She stated she did not check her brief at that time she just made sure Resident #1 was breathing and was safe. She stated that morning [5/10/2026] it was approximately 7:00am when Resident #1's family member told her Resident #1 had poop dried up on her. She stated she and LVN A went into the room to clean Resident #1. She stated it did appear Resident #1 had been laying in feces for a while because the feces was stuck and dried on the bed handrails. She stated during the shift change report, CNA G and CNA H had not mentioned that Resident #1 had refused to be cleaned up and had a current BM. She stated she felt that they should have checked on Resident #1 more often but during shift change, they only check to ensure residents are breathing and alive. She stated she did not believe the night shift staff had checked on Resident #1 as they should have before leaving the shift because between 6am to 7am the feces would not have been that dried. She stated she was not sure when nightshift would have done their last rounds, but they had to scrub the feces off Resident #1 during her bed bath. She stated residents with behaviors should be checked on for often than every two hours but sometimes they get busy assisting other residents and the two hours goes by quickly.During an interview on 5/12/2026 at 12:19pm, CNA H stated she had worked the night of 5/9/2026 to 5/10/2026 in the morning. She (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated when they arrive on shifts all the residents are checked on and any needs are addressed such as changing, bathing, or getting them settled in bed for sleep. She stated rounds are done every two hours or more frequently if needed. She stated that morning [5/10/2026] she had done her last rounds at approximately 5am. She stated they had changed Resident #1 early in the shift and she had cleaned her hands because they had feces on them but after that CNA G did rounds on that side of the hall. She stated at 5am she did her last rounds and asked CNA G if she had checked on Resident #1 and CNA G told her she already had. CNA H stated she did not inquire further about Resident #1 because she took CNA G's word for it and left Resident #1 alone. She stated she asked CNA G about Resident #1 at approximately 5:30am but was not sure what time CNA G had actually rounded on Resident #1 or if she had needed any form of incontinence care. She stated when she returned for her next shift that night, she had been told Resident #1 had been found with dried feces on her and when she asked CNA G, CNA G told her don't worry I got you (the speaker has a situation completely under control and will take care of the problem on your behalf). CNA H stated she didn't know why CNA G was saying that, but she was upset that Resident #1 had been found that way and she did not want to get in trouble for something that was not her fault.Attempted interviews on 5/12/2026 with CNA G at 12:03pm, 12:08pm and 1:00pm, were unsuccessful. CNA G did not return any calls or messages. During an interview on 5/12/2026 at 2:00pm, LVN A stated she had been working on 5/10/2026 day shift. She stated she had been in the dining room helping with breakfast when CNA F told her Resident #1's family member wanted to speak to her. She stated she went to speak to Resident #1's family member and he was upset that Resident #1 had feces on her that was hard, so she had to receive a bed bath. She stated Resident #1 does have a behavior of grabbing her BM and smearing it on herself that requires her to be cleaned often. She stated she offered a complaint form to the family, and she returned the filled form to the ADON. She stated she did speak to the CNAs on that shift and educated on ensuring residents were being checked on earlier. She stated even though the feces was hard she could not place blame on day shift or night shift. She stated they were able to soak the BM off of Resident #1. She stated rounds should be done when the CNAs first get on shift and she has asked them to look at the briefs and below the sheets to ensure residents are clean. During the observation of a video dated 5/11/2026 at 1:33pm, the video revealed Resident #1's family member entering Resident #1's room. The video revealed Resident #1 resting in bed with a black/gray cover pulled up to her chest, a blue fall mat on the floor and the bed in a low position. The family member stated so I just got to [Resident #1] as soon as I walked into the room it smells like pee. Looks like she has been sitting in pee for quite a while because the bedsheets are dry from urine. The video focuses on the large urine stain on the sheet Resident #1 is lying on top of. The urine stain appeared to be dry. In a second video dated 5/11/2026 at 1:35pm it revealed Resident #1's saying tengo mucho frio (I am very cold) and the family member replying I know you're cold. It looks like her sheets been having pee forever and it's super dry, the video showed Resident #1's family member pulling the blanket down to show Resident #1's clothes. The clothes mid- abdomen and above were a shade of white with small sea/ocean designs. From the mid abdomen down, a yellowish stain was visible on the same shirt. The family members pulled the shirt down to show the shirt appeared to be dry where the stain was visible.Record review of Resident #1's progress notes for date 5/11/2026 did not reveal any documentation that stated resident had refused to be changed or refused hygiene care prior to 3:30pm on 5/11/2026.Record review of Resident #1's POC Response History Task: Toileting Hygiene and bowel and bladder elimination for 5/11/2026 did not reveal Resident #1 had received toileting hygiene or bowel and bladder elimination and there were no documented Resident #1 refusals of hygiene care. During an interview on 5/11/2026 at 6:10pm with LVN C, she stated she had been the charge nurse for the day. She stated when she arrived at her shift on 5/11/2026 she had laid eyes on Resident #1 and did not see anything out of the ordinary. She stated around lunch time, CNA D had gone into Resident #1's room and she was clean and dry. LVN C stated, next thing I know [Resident #1's family member] told CNA D she wanted Resident #1 out of here. She stated she called ADON and explained (continued on next page)

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