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	12/09/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43150 Based on observation, interview and record review, the facility failed to provide a private space for the resident's monthly Resident Council meetings for 13 of 13 anonymous residents who attended Resident Council meetings. (Resident Council 12/04/2024). The facility failed to provide a private place for residents to be able to hold Resident Council Meetings monthly. This failure could result in issues affecting the residents' feeling that their grievances are not being acted upon and could place all residents who attend the Resident Council meetings at risk for feelings of powerlessness and decreased self-worth. The Findings included: During the confidential Resident Council interview on 12/04/2024 at 9:45 AM. the thirteen residents in attendance stated they had no privacy during their meetings. The meeting space was arranged by the Activity Director and the meeting space was held in the front lobby. The front lobby had the front door, the Administrator's office, and the BOM's office. Even though there was a sign on the wall outside of the front door informing staff the Resident Council was meeting staff and visitors continued to enter the front door, Administrator's, and BOM's office. The residents stated that normally the resident council meeting is held in the dining room where all staff come and go through the duration of the meeting. The residents in the meeting stated it was communal area for staff to interrupt them during their monthly Resident Council meetings and they did not feel the meetings were private. The stated they would prefer the meetings to be private and only staff they invited be allowed to hear what they discussed. A total of seven observations were made of facility staff and visitors entering and exiting the front door, Administrator's office, the BOM's office, and coming in the front area from the facility during the confidential Resident Council interview on 12/04/2024. Observation of Resident Council Meeting on 12/4/2024 at 9:45 AM. The Activity Director had set up the meeting in the front lobby by the front door for 13 Residents to attend. Observed staff walking in and out during the meeting. Observed that the front lobby was next to the Administrator's office and the BOM's office. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Activity Director on 12/06/2024 at 10:31 AM. The Activity Director stated she is responsible for setting up the resident council meetings and the place in which they are held. The Activity Director stated that the policy stated that the resident council meetings should be provided with privacy with no staff being able to interrupt the meetings. She stated that many of the residents had voiced their concern with staff members walking in and out of the meetings. She stated that the residents voiced their concern of the staff hearing what they were talking about and retaliating against them for it. The Activity Director stated that her biggest concern since she took the position is the privacy not being provided during resident council meetings. She stated that she had mentioned her concerns with the Administrator, and he had stated that she would need to get with the physical therapy team to see if that room could be used for the meetings. She stated that she was not sure why the meetings had not been moved to a private area for the residents. She had stated that she brought the privacy concern up to the Administrator twice and it had not been taken care of. The Activity Director stated that this had not been accommodated for the residents. She stated that the negative potential outcome of the residents not being provided privacy during resident council meetings is that the residents may get upset and feel that the staff will retaliate against them. During an interview with the Administrator on 12/09/2024 at 11:00 AM. The Administrator stated that the facility only has the physical therapy room that would accommodate the privacy for the meetings. The Administrator stated that the Activity Director had been told to get with physical therapy to see if the Resident Council meetings could be held in there. The Administrator stated that the negative outcome of not being able to provide privacy for the Resident Council meetings would cause the residents to not freely voice their concerns and to feel that their rights had been taken away. Record review of facility provided policy on 12/12/2024, titled, Resident Council, date revised in February 2021, stated: Policy Statement: The facility supports resident rights to organize and participate in the resident council. The purpose of the resident council is to provide a forum for: a. residents, families, and resident representative to have input in the operation of the facility. b. discussion of concerns and suggestions for improvement. c. consensus building and communication between residents and facility staff, and d. disseminating information and gathering feedback from interested residents. 2. All residents are eligible to participate in the resident council. The facility staff encourages residents who are willing to participate. Staff, visitors, or other guests may attend resident council meetings if invited by the respective resident group. 3. The resident council group is provided with space, privacy, and support to conduct meetings. 5. Council meetings are scheduled monthly or more frequently if requested by residents. The date, time, and location of the meetings are noted in the activities calendar. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the items of concern.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on interviews, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 1 of 1 resident (Resident #51). The facility failed to ensure 1 of 1 resident were provided a copy of the grievance that Resident #51 had filed, upon request, Resident #51 had the right to obtain a written decision related to their grievance. This failure could place the residents at risk of unresolved grievances, decreased quality of life, and feeling of hopelessness. Findings included: Resident #51: Resident #51: Record review of Resident #51 face sheet revealed an admitted [DATE] with a BIMS (Brief Interview for Mental Status) of thirteen, meaning that Resident #51's cognition is intact. Resident #51 had a diagnosis that included: acute respiratory failure (cannot maintain normal levels of oxygen and carbon dioxide in the blood), pain in the left wrist, morbid obesity, major depression disorder, dysthymic disorder (mild but long term form of depression), heredity & idiopathic neuropathy (sensory and motor nerves of the peripheral nervous system are affected and no underlying etiology is found), high blood pressure, gout (form of arthritis that causes severe pain, swelling, redness and tenderness in the joints), osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), muscle weakness, rotator cuff tear or rupture (a tear in the tissues connecting muscle to bone (tendons) around the shoulder joints), mass and lump in lower limb, edema (swelling). During an interview with Resident #51 on 12/05/2024 at 2:12 PM. Resident #51 stated that he had asked the Social Worker for a copy of the grievance that he had filed, and she stated that the Administrator told her to not give him a copy. Resident #51 was frustrated and stated, I would like to know what they are doing with the grievance that I filed. This grievance was an individual grievance filed by the resident. During an interview with the Social Worker on 12/09/2024 at 10:29 AM. The Social Worker stated that when Resident #51 had asked her for a copy of his grievances, she had asked the Administrator. She stated the Administrator stated the resident does not get a copy, so she told the resident that they do not give a copy. The Social Worker stated that she was not sure what the policy stated about giving a copy of grievances to the resident. The Social Worker read the policy in front of Surveyor. Social Worker stated that the policy stated that a copy should be provided to the resident. There was no resolution listed to the grievance. The Social Worker stated that the negative potential outcome of not providing a copy of the grievances would be that it may make the resident upset and it is impeding on resident rights. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 12/09/2024 at 11:00 AM. The Administrator stated that he does not know what the policy stated about providing a copy, but he is sure that he does not have to provide one. The Administrator read the policy in front of Surveyor. The Administrator stated that he did not realize that he had to provide a copy of the grievances, but he did see in the policy where he was supposed to provide a copy of the grievances. The Administrator stated that he had never had to give a copy of the grievances to a resident. The Administrator stated that the policy stated that he should provide a copy of the grievances to the resident. The Administrator stated that the negative potential outcome of not providing a copy of the grievance to a resident could make the resident feel as though the grievances are not being taken care of or addressed. The Administrator stated that it is a Resident Rights issue. The Administrator stated that it is the responsibility of the Administrator or the Social Worker to provide a copy of the grievances to the resident. Record review of facility provided policy on 12/5/2024, titled, Filing Grievances/Complaints, date revised in December 2004, stated: Policy Statement: Our facility will assist residents, their representatives (sponsors), other interested family members, or resident advocates in filing grievances or complaints when such requests are made. 1. Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form. 3. Grievances and or complaints may be submitted orally or in writing. Written complaints or grievances must be signed by the resident or the person filing the grievance or complaint on behalf of the resident. 4. The Administrator has been delegated as the Grievance Official for the facility. 5. Upon receipt of a written grievance and/or complaint, the social worker will investigate the allegations and submit a written report of such findings to the administrator within three working days of receiving the grievance and/or complaint. 6. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. 7. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee, within three working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the resident, and a copy will be filed in the business office.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** 42515 Based on observations, interviews, and record review, the facility failed to ensure that each residents environment remained as free from accident hazards as possible for 4 of 27 residents (Resident #12, Resident #28, Resident #61 and Resident #123) reviewed for accidents. 1. The facility failed to ensure 3 resident rooms (rooms [ROOM NUMBER]) did not have electrical outlets protruding from the wall. 2. The facility failed to ensure 1 resident room (room [ROOM NUMBER]), where Resident #12 resided, did not have an electrical outlet protruding from the wall with exposed wires. Resident #12 had a BIMS score of 03, indicating she had severe cognitive impairment, and she was able to self-ambulate in her wheelchair. An Immediate Jeopardy was identified on 12/03/24. The IJ template was provided to the facility Administrator on 12/03/24 at 8:46 PM. While the immediate jeopardy was removed on 12/05/24, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of pattern, due to the facility's need to evaluate the effectiveness of their plan of correction to prevent future concerns. This failure could place residents at risk for fires, physical harm, electrocution, pain, mental anguish, emotional distress, and serious injury. Findings included: Resident #61 Record Review of Resident #61's face sheet dated 12/06/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: multiple sclerosis (chronic disease that affects the central nervous system), nicotine dependence, and pain. Record review of Resident #61's significant change MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated Resident #61 had intact cognition. The MDS further revealed Resident #61 used a motorized wheelchair and was independent in the ability to wheel at least 150 feet in a corridor or a similar space. Resident #123 Record Review of Resident #123's face sheet dated 12/04/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: type 2 diabetes mellitus (blood sugar problems), unspecified mood disorder, and generalized anxiety disorder (feeling of unease). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #123's comprehensive MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated Resident #123 had intact cognition. The MDS further revealed Resident #123 used a manual wheelchair and required set-up help or supervision in the ability to wheel at least 150 feet in a corridor or a similar space. Observation on 12/03/24 at 3:07 PM in room [ROOM NUMBER] on Hall B next to the head of the bed on A side, an electrical outlet was noted protruding out from the wall with a phone charger plugged into the top outlet and a cpap machine (medical device used to help breath at night) was plugged into the bottom outlet. Resident #61 was noted to be in wheelchair on B side of room watching TV. Interview on 12/03/24 at 3:14 PM, LVN A stated she was unaware of any electrical outlets protruding from the wall and stated the staff put all maintenance requests in the maintenance work order book. Record review on 12/03/24 at 3:18 PM of the maintenance work order book for B-Hall revealed no work orders for electrical outlets in room [ROOM NUMBER]. Interview on 12/03/24 at 3:35 PM, Resident #123 stated her and her family member were concerned about using the electrical outlet hanging out from the wall by the head of her bed when she first arrived to the facility. Resident #123 stated a CNA or a nurse was in the room as she expressed her concerns for the electrical outlet and the staff member stated the plug was ok to use and plugged in the phone charger and cpap machine for the resident. Resident #123 stated she could not remember the staff member that plugged the items into the protruding outlet. Resident #123 stated she could not remember the exact date this happened on. Resident #12 Record Review of Resident #12's face sheet dated 12/04/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: unspecified dementia (loss of thinking, remembering, and reasoning interferes with daily life activities), general anxiety disorder (feeling of fear, dread, and uneasiness) and unsteadiness on feet. Record review of Resident #12's comprehensive MDS assessment dated [DATE] revealed a BIMS score of 03 which indicated Resident #12 had severe cognitive impairment. The MDS further revealed Resident #12 used a manual wheelchair and was independent in the ability to wheel at least 150 feet in a corridor or a similar space. Observation on 12/03/24 at 3:19 PM revealed an electrical outlet detached and hanging from the wall in room [ROOM NUMBER] on A side. Access to exposed wires was noted in the back of the electrical outlet. A privacy curtain was observed hanging between the hanging electrical outlet and between the wall. A chair and a card table were noted in place of where a bed would be on A side of room [ROOM NUMBER]. Resident #28 Record Review of Resident #28's face sheet dated 12/09/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: chronic respiratory failure (breathing difficulties), major depressive disorder (mood disorder), and cognitive communication deficit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #28's comprehensive MDS assessment dated [DATE] revealed a BIMS score of 13 which indicated Resident #28 had intact cognition. The MDS further revealed Resident #28 used a manual wheelchair and required substantial assistance in the ability to wheel at least 150 feet in a corridor or a similar space. Observation on 12/03/24 at 3:39 PM revealed an electrical outlet box hanging from the wall in room [ROOM NUMBER] on A side by the door. Interview on 12/03/24 at 6:42 AM, the ADM stated the Maintenance Supervisor has been out sick for the past 2 days but should be back to work tomorrow. The ADM stated the Maintenance Supervisor was supposed to make rounds weekly on rooms to check for preventative maintenance issues. The ADM stated he will go and check rooms himself daily for any maintenance issues. The ADM stated there is a maintenance work order book on each hall and the staff are to write all of their maintenance concerns in the work order book. This was determined to be an Immediate Jeopardy (IJ) on 12/03/24 at 8:45 PM. The Administrator was notified and provided with the IJ Template on 12/03/24 at 8:46 PM. The following Plan of Removal was submitted by the facility and was accepted on 12/04/24 at 11:45 AM. Record review of the facility Plan of Removal reflected the following: (Facility Name and Address) Plan of Removal for Immediate Jeopardy F689 Impact Statement Accidents: Facility failed to provide the necessary care and service to prevent and maintain an environment free of hazards. Identify residents who could be affected All Residents are at risk for potential adverse outcomes due to electrical outlet exposures that pose a risk for possible serious injury, harm or death due to electrical exposure, tripping hazards and a risk of fire. Problem The facility failed to maintain an environment free of hazards. Action Taken (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The following is a plan of removal, which was immediately implemented to remedy the Immediate Jeopardy which was imposed 12/3/24 at 8:46 PM. On 12/3/24 an standard recertification/re-licensure survey was initiated. On 12/3/24 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to residents' health and safety. All items listed will be completed by 5:00PM on 12/4/24 with continued follow-up for scheduled staff. 1. room [ROOM NUMBER] hazard identified prompted immediate removal of residents on 12/3/24 and closure of room until electrician arrived. Electrician provided fix on 12/4/24 under the direction of corporate maintenance director. 2. All outlets in the facility will be reviewed by the administrator under the direction of the corporate maintenance director on 12/4/24. Any negative findings will be documented on the facility map with location identified with immediate correction for removal of hazard. 3. RNC (regional nurse-corporate) completed an in-service with the Administrator regarding accident and incident prevention policy and procedure with focus on hazards on 12/4/24. 4. RNC (Regional nurse-corporate) completed an in-service with all staff regarding policy and procedure for Accidents and Incidents on 12/4/24. Any oncoming shifts will be in-serviced prior to the start of resident assignment until completion. 5. A audit of the last 90 days entry log for the maintenance book was initiated by the administrator on 12/4/24. Any identified issues will be notated for completion by the facility designee under the direction of the corporate maintenance director. 12/4/24. All residents in the facility have the potential to be affected by this alleged failure regarding physician order implementation. If staff are unable to attend any of the in-services they will be required to complete before starting their assigned shift. Any new staff or agency staff will be in-serviced prior to shift assignment. The Medical Director was initially made aware of the immediate jeopardy 12/4/24 at 8:09 am and has been involved in the development of the plan to removal. To monitor for compliance the Administrator and/or designee will daily review all work orders in the maintenance log and follow up accordingly regarding completion. To further monitor for compliance the administrator will perform 3 day a week rounds of resident rooms and access areas for hazard identification. This will be dated and documented on the facility map for tracking. The IDT will review and assess the maintenance log weekly to determine what further actions/intervention changes if needed are necessary. Members of this meeting are to include the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Worker, and Therapy Representative, RNC, maintenance director/designee and RDO. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	This plan was initially implemented 12/4/24 and will be monitored through completion by corporate and regional staff. Plan of Removal completion date is 12/4/24 by 5:00 pm with continuation of oncoming staff and follow up. Interview on 12/03/24 at 8:48 PM, the ADM stated Resident #12 would be moved to a different room for the night and an electrician would be at the facility in the morning to work on the hanging/protruding electrical outlets. The ADM stated tape would be placed across room [ROOM NUMBER] so no other staff or residents enter the room before the electrician got to the facility. Observation on 12/03/24 at 8:58 PM, Resident #12 was transferred to a room on A-Hall for the night. No concerns noted with transfer of resident. Observation on 12/04/24 at 10:08 AM, an electrician was noted working on the hanging electrical outlet in room [ROOM NUMBER]. The electrician stated there was a possibility for electrical arcing due to the exposed wires on the hanging electrical outlet box. Interview on 12/04/24 at 10:56 AM, the ADM stated there was a maintenance order on 10/31/24 for room [ROOM NUMBER] regarding an electrical outlet and it was in regard to a different outlet. The ADM stated the hanging electrical outlet in room [ROOM NUMBER] on the head wall on A side was missed when the other electrical outlet was removed from her room. The POR was monitored as follows: Interview on 12/04/24 at 5:10 PM, LVN E stated she was recently in-serviced on accident hazards regarding wobbly outlets/broken outlets. LVN E stated if an electrical outlet was broken or wobbly, the resident or residents are to be removed from the room immediately to prevent any accidents. LVN E stated once the resident is secured in a different area, then the electrical outlet needs to be reported immediately to the Maintenance Supervisor and the ADM and a work order needs to be written in the maintenance book. LVN E stated the staff are to follow up on the electrical outlet to ensure it gets fixed and if it has not, then she is to call Corporate with the concerns. Interview on 12/04/24 at 5:14 PM, CNA G stated she was in-serviced today on broken electrical outlets and accident hazards. CNA G stated if she notices a broken electrical outlet, the residents are to be removed from that room right away. CNA G stated she will then report the broken electrical outlet to the ADM and DON right away and put a work order in the maintenance book. CNA G stated she will then follow up on the electrical outlet and if it does not get fixed, she will call corporate. Interview on 12/04/24 at 5:16 PM, the Social Worker stated she was in-serviced today regarding accident hazards and electrical outlets. The Social Worker stated if she notices a broken electrical outlet, the residents are to be removed from the room immediately and the ADM and DON notified right away. The Social Worker stated she will write an order in the maintenance book and follow up on the electrical outlet. The Social Worker stated she will call corporate if the electrical outlet did not get fixed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 12/04/24 at 5:21 PM, CNA A stated she was in-serviced today on accident hazards with electrical outlets. CNA A stated she will remove any residents from the room if she notices a broken electrical outlet and tell the ADM and DON right away. CNA A stated she will then write an order in the maintenance book and call corporate if the electrical outlet isn't followed up on. Interview on 12/04/24 at 5:23 PM, MA B stated she was in-serviced today on accident hazards with electrical outlets. MA B stated if she notices a broken electrical outlet, the resident will be removed from that room right away and the ADM and DON will be notified. An order will be placed in the maintenance book and followed up on. MA B stated she is to call corporate if the electrical outlet does not get fixed in a timely manner. Interview on 12/04/24 at 5:26 PM, CNA J stated she was in-serviced today on accident hazards with electrical outlets. CNA J stated she is to remove any residents from the room if she notices a broken electrical outlet and tell the ADM and DON as soon as possible. CNA J stated she will then write an order in the maintenance book and call corporate if the electrical outlet isn't followed up on. Observation on 12/05/24 at 9:02 AM revealed the electrical outlet in room [ROOM NUMBER] attached to the wall and no longer hanging. Interview on 12/05/24 at 9:12 AM, Laundry Aide A stated she was in-serviced yesterday on electrical outlets and the risks for accidents. Laundry Aide A stated she is to remove any residents from the room if she notices a broken electrical outlet and tell the ADM and DON as soon as possible. Laundry Aide A stated she will then write an order in the maintenance book and call corporate if the electrical outlet isn't followed up on. Laundry Aide A stated Corporates number has been posted all over the facility. Interview on 12/05/24 at 9:14 AM, LVN F stated she was in-serviced today on accident hazards and electrical outlets. LVN F stated she is to report any electrical issues to Maintenance and the ADM. LVN F stated she is to remove the residents from the room right away. LVN F stated she will then write a work order in the maintenance book and call corporate if the issue is not followed up on. LVN F stated Resident #12 is wheelchair bound and is able to propel herself in her wheelchair. LVN F stated Resident #12 has been seen by the card table in her room on A side on the head of bed wall. LVN F stated Resident #12 can be confused most of the time. Interview on 12/05/25 at 9:18 AM, Dietary Aide A stated he was in-serviced today on electrical outlets. Dietary Aide A stated he is to check for broken electrical outlets in the facility throughout his shift and let the ADM know right away if any electrical outlets have issues. Dietary Aide A stated the electrical outlets are not to be used and a work order will be placed in the maintenance book. Dietary Aide A stated corporate will be called if the ADM does not follow up on any broken electrical outlets or accident hazards. Interview on 12/05/24 at 9:58 AM, the Rehab Director stated she was in-serviced that morning regarding accident hazards and electrical outlets. The Rehab Director stated any residents in a room with a broken electrical outlet are to be removed immediately form the room. The Rehab Director stated the ADM and DON need to be notified immediately and a work order placed in the maintenance book. The Rehab Director stated she was instructed to call corporate if she feels like the ADM and Maintenance Supervisor are not following up on the electrical hazard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 12/05/24 at 10:00 AM, the ADON stated she was in-serviced on accident hazards with electrical outlets. The ADON stated she is to report any electrical outlet problems immediately, write a work order in the maintenance book, and keep the residents safe by removing them from the area. The ADON stated she was instructed to follow up on any electrical outlet concerns and call Corporate if needed. The ADON stated Resident #12 has days where she is mobile and days where she is not. The ADON stated Resident #12 has a lot of strength when she gets mad and will pull whatever is near her. Interview on 12/05/24 at 10:24 AM, the DON stated the Corporate Nurse in-serviced her yesterday on accident hazards and electrical outlets. The DON stated she is to monitor the residents and facility for any electrical hazards or accident hazards. The DON stated if an accident hazard is noted, the resident is to be removed from the area right away and the ADM and Maintenance Supervisor will be notified immediately. The DON stated she was in-serviced to train all of her staff regarding accident hazards in the facility. The DON stated Resident #12 has a history of behaviors that include pulling wires and cords out of the walls when she gets upset. The DON stated Resident #12 is able to move on her own in her wheelchair and will even get up and stand if she is really upset. The DON stated she understood the concerns for risks with a hanging electrical outlet in a resident room. Interview on 12/05/24 at 10:38 AM, the ADM he was in-serviced by the Corporate Nurse regarding any accident hazard and electrical outlets in the facility. The ADM stated the resident needs to be removed from the accident hazard right away and he will call someone out to fix the issue. The ADM stated the staff have been trained to follow up on any accident hazard concerns and call corporate if he does not fix the issue. The ADM stated Resident #12 is able to move around by herself in the wheelchair and has a history of behaviors that include pulling cords/computers out of the walls. The ADM stated the electrical outlets in Rooms 109, 123 and 128 had been fixed. The ADM stated he understood the risks to the residents for the hanging electrical outlet with exposed wires that include electrocution, fire, and smoke inhalation. Observation on 12/05/24 at 1:28 PM revealed the electrical outlet in room [ROOM NUMBER] was firmly attached to the wall. Observation on 12/05/24 at 1:32 PM revealed the electrical outlet in room [ROOM NUMBER] was no longer protruding from the wall. Record review on 12/05/24 at 2:00 PM of the Electronic Medical Record Bulletin on Point Click Care revealed a message to all staff regarding Accident Hazards and Electrical Outlets. Record review of the facility in-service titled, Accident and Incident Prevention Policy and Hazards dated 12/04/24 performed by the Corporate Nurse revealed signatures for the ADM and DON both dated 12/04/24. Record review of the facility in-service titled, Accidents and Incidents performed by the Corporate Nurse revealed signatures from staffing in all departments. Record review of the facility policy and procedure titled Safety Precautions, Electrical with a revised date of 01/11 reflected the following: Policy Statement - Electrical safety precautions have been established for all personnel to follow. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Policy Interpretation and Implementation - The following electrical safety precautions have been established for all personnel to follow. These precautions are not all-inclusive. Others may be added or amended as necessary. 5. Report any plug that is broken, bent, loose. 7. Report all worn, cut, frayed, spliced, exposed, or burned power cords. 18. Report any and all unsafe electrical hazards to your supervisor immediately Record review of the facility policy and procedure titled Hazardous Areas, Devices and Equipment with a revised date 07/17 reflected the following: Policy Statement - All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Record review of the facility policy and procedure titled Accidents/Incidents with a revised date of 04/13 reflected the following: Policy Statement - Our facility shall provide a safe and secure environment for staff and residents The Administrator was informed the Immediate Jeopardy was removed on 12/05/24 at 2:03 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy, and a scope of pattern, due to the facility's need to evaluate the effectiveness of their plan of correction to prevent future concerns. Interview on 12/09/24 at 11:36 AM, the ADM the Maintenance Supervisor was responsible for electrical outlet concerns. The ADM stated the facility currently did not have a Maintenance Supervisor but was in the process of hiring someone. The ADM stated he was overseeing maintenance issues at this time. The ADM stated the hanging electrical outlets were probably missed due to not being diligent enough and not enough rounds in the facility. The ADM stated it was possible that the electrical outlet was pulled away from the wall by staff or residents but was unsure exactly what happened. The ADM stated the residents bump into the electrical outlets often. The ADM stated the risks to the resident was electrocution or injury. Interview on 12/09/24 at 11:55 AM, the DON stated she did not know exactly what happened to the electrical outlet box in room [ROOM NUMBER], but Resident #12 may have done it as she has a history of unplugging items frequently. The DON stated all of the staff have been trained and Resident #12's daughter was made aware. The DON stated there was a potential for injury to the residents due to accident hazards.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 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 for 3 (Resident #50, Resident #68, Resident #35) of 7 residents reviewed for respiratory care. The facility failed to follow their policy for proper storage of oxygen tubing for Resident #50, Resident #68, and Resident #35. This failure could place residents at risk for respiratory compromise and infection. Findings included: Resident #50 Review of Resident #50's face sheet revealed a [AGE] year-old female with an original admitted [DATE] with the following diagnoses: Atherosclerotic Heart Disease (disease of the heart's major vessels), Cognitive Communication Deficit (inability to effectively communicate needs), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Type II Diabetes Mellitus (abnormally elevated blood sugar levels), Heart Failure (heart condition), Kidney Failure (condition causing kidneys to not function properly), Gastroesophageal Reflux Disease (digestive condition), and Hypertension (high blood pressure). Record review of Resident #50's significant change MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #50 used oxygen therapy while a resident. Record review of Resident #50's comprehensive care plan, dated 10/15/24, revealed resident #50 may use oxygen therapy related to Chronic Obstructive Pulmonary Disease. Record review of Resident #50's current Physician Orders dated 12/09/24 revealed an order for oxygen to be administered at 2-3 liters per minute per nasal cannula (tube in nostrils) every shift as needed. During an observation and interview on 12/03/24 at 9:01 AM, Resident #50 was resting in bed. The resident's oxygen cannula and tubing were observed laying on the floor. The resident's oxygen concentrator was on at 3 liters per minute. No bag for storage of oxygen tubing was observed. Resident #50 stated staff usually change the tubing and humidifier, but she did not recall staff placing a bag to store the oxygen tubing in while it was not in use. Resident #50 stated, that is probably why it ends up on the floor. During an observation on 12/06/24 at 10:47 AM, there was no bag for oxygen tubing storage observed in the room of Resident #50. Resident #68 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #68's face sheet revealed a [AGE] year-old male with an admitted [DATE] with the following diagnoses: Dementia (loss of thinking, memory, and reasoning skills), Atrial Fibrillation (irregular heart rate which causes poor blood flow), Type II Diabetes Mellitus (abnormally elevated blood sugar levels), Depression, Malignant Neoplasm of lung (lung cancer), and Hypertension (high blood pressure). Record review of Resident #68's significant change MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #68 used oxygen therapy while a resident. Record review of Resident #68's current Physician Orders dated 12/09/24 revealed an order for oxygen to be administered at 2 liters per minute as needed for shortness of breath. During an observation on 12/03/24 at 9:07AM, Resident #68 was out of the facility. The resident's oxygen cannula was observed laying across the bed with the tubing laying on the floor. No bag for storage of oxygen tubing was observed. During an observation and interview on 12/03/24 at 11:26 AM, Resident #68 was observed sitting on the side of his bed with oxygen on at 2 liters per minute via nasal cannula. The resident stated, to his knowledge, there was not a bag for storage of his oxygen tubing when it was not in use. The resident stated, I usually just put it wherever when I take it off. I don't know where it's supposed to go. Resident #35 Review of Resident #35's face sheet revealed a [AGE] year-old male with an original admitted [DATE] with the following diagnoses: Chronic Kidney Disease (long-standing disease of the kidneys, leading to kidney failure) Atherosclerotic Heart Disease (disease of the heart's major vessels), Cognitive Communication Deficit (inability to effectively communicate needs), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Type II Diabetes Mellitus (abnormally elevated blood sugar levels), Heart Failure (heart condition), Absence of kidney, Gastroesophageal Reflux Disease (digestive condition), and Dependence on Supplemental Oxygen. Record review of Resident #35's quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #50 used oxygen therapy while a resident. Record review of #35's current Physician Orders dated 12/09/24 revealed an order for oxygen to be administered at 2-3 liters per minute as needed for Chronic Obstructive Pulmonary Disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/03/24 at 9:01 AM, Resident #35 was in bed watching tv with oxygen on at 3 liters per minute via nasal cannula. Resident #35 had a motorized wheelchair with a portable oxygen tank attached. The cannula and tubing from the portable oxygen tank were observed laying on the floor. The resident stated he does not have a bag to place his oxygen tubing in. He stated staff usually change the tubing and humidifier bottle on Sunday nights, but they do not always bring a bag for the tubing to be stored in. No storage bag was observed on concentrator or portable oxygen tank. Resident #35 stated he does not have anywhere to put his oxygen tubing when he gets up. The resident stated, I usually just throw it over the bed or hang it on the back of the wheelchair but a lot of times it ends up on the floor. During an observation on 12/06/24 at 10:35 AM, Resident #35 was observed resting in bed with oxygen on at 3 liters per minute via nasal cannula. No bag was observed for oxygen tubing storage on concentrator or portable oxygen tank. Oxygen tubing from portable tank on the resident's wheelchair was observed touching the floor. During an interview on 12/06/24 at 10:36 AM with LVN A, she stated oxygen tubing should be kept in plastic bags when not in use and should be changed out with the tubing and humidifier bottles every Sunday on the night shift. She stated she was not sure why there would not be bags available in resident rooms who were on oxygen. She stated oxygen tubing should not be on the floor or be placed anywhere that it could become contaminated. She stated a potential negative outcome for failure to properly store oxygen tubing was infection. During an interview on 12/06/24 at 10:41 AM with CNA A, she stated the night shift was responsible to make sure bags were placed in the rooms of residents who were on oxygen. She stated she was assigned to the hall for Resident # 50, Resident #68 and Resident #35. She stated she had just returned from her days off and today was her first day back at work. She stated she had not checked the oxygen storage bags today because she had not had time yet. She stated bags should be checked daily and changed every Sunday night. She stated it was the responsibility of all staff to make sure bags were available for storage of oxygen tubing. She stated oxygen tubing should never be on the floor or anywhere that it could pick up germs. She stated she had been trained by the facility on proper oxygen tubing storage. She stated a potential negative outcome of failure to properly store oxygen tubing was infection. During an interview on 12/09/24 at 11:16 AM with the ADM, he stated he was not aware that residents requiring oxygen did not have storage bags for oxygen tubing. He stated the facility's policy was that oxygen tubing was stored in bags when not in use. He stated storage bags for oxygen should be checked daily and changed out weekly. He stated nursing staff was responsible for placing oxygen tubing storage bags in rooms where oxygen was being administered. He stated staff had been trained on proper storage of oxygen tubing by nursing administration. He stated his expectation of staff for proper oxygen tubing storage was that the tubing would be stored in a plastic bag when oxygen was not in use. The ADM stated a potential negative outcome for failure to properly store oxygen tubing would be infection control issues. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/09/24 at 11:27 AM with the DON, she stated she was not aware that residents requiring oxygen did not have storage bags for oxygen tubing. She stated she did not know what the facility policy stated regarding oxygen storage bags. She stated nurses and CNA's were responsible for placing oxygen tubing storage bags in rooms where oxygen was being administered. She stated her expectation of staff for proper oxygen tubing storage was to make sure tubing is stored properly and assure that tubing was not on the floor. She stated a potential negative outcome for failure to properly store oxygen tubing would be the risk of infection to residents. Record review of the facility-provided policy titled, Departmental (Respiratory Therapy- Prevention of Infection, Revised November, 2011 revealed: Purpose The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Steps in the Procedure Infection Control Considerations Related to Oxygen Administration . 8. Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use.

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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. 49305 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 2 of 2 medication carts (Station 1 medication cart, and Station 2 medication cart), reviewed for medication storage. 1. The medication cart assigned to Station 1 had loose pills. 2. The medication cart assigned to Station 2 had loose pills. This failure could place residents at risk of not receiving prescribed medications as ordered and drug diversions. The findings included: 1. On 12/03/24 at 5:44 PM an observation of the medication cart for Station 1 was made with MA A. Three loose pills were found in the medication cart drawer. MA A placed the loose medications in a dispensing cup and the ADM identified the medications as Carbidopa/Levodopa 25-100 (1/2 tablet), Carbamazepine 200 mg (1 tablet) and Xarelto 200 mg (1 tablet). MA A and LVN B destroyed the loose medications in the sharps container and documented the destruction in the electronic record. During an interview on 12/09/24 at 11:23 AM with MA A, she stated there should not be loose medications on the medication cart. She stated she was not sure why there were loose medications on the cart. MA A stated it was her responsibility to check the cart for loose medications before her shift. She stated carts were usually checked once per week for proper storage and cleanliness. MA A stated carts were also audited each month by the pharmacy consultant. She stated she had received training by nursing administration on proper medication storage. MA A stated a potential negative outcome of loose medications on the medication cart would be that the resident may miss the dose of medication. 2. On 12/03/24 at 6:42 PM an observation of the medication cart for Station 2 was made with MA B. Five loose pills were found in the medication cart drawer. MA B placed the loose medications in a dispensing cup and the ADM identified the medications as Levothyroxine 75 mg (1 tab), Ondansetron HCl 4 mg (1 tablet), Gabapentin 300 mg (1 capsule), and Eliquis 2.5 mg (1 tablet) .MA B and LVN B destroyed the loose medications in the sharps container and documented the destruction in the electronic record. During an interview on 12/03/24 at 8:24 PM with MA B, she stated there should not be loose medications on the medication cart. She stated she assumed the medications had been dropped or fell out of the blister packs. MA B stated it was her responsibility to check the cart for loose medications before her shift. She stated carts were usually checked for loose or expired medications and were cleaned every Sunday. She stated she had received training in school and by nursing administration on proper medication storage. MA B stated a potential negative outcome of loose medications on the medication cart would be missed medication doses. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/24 at 11:16 AM, the ADM stated he was not aware there were loose medications on the cart. He stated the policy for proper medication storage is that medications on the cart are secured and the carts were checked daily for loose or expired medications. The ADM stated his expectation of staff regarding proper medication storage is that medication aides and nursing staff properly monitor the medication carts and medication room for proper storage of all medications. The ADM stated a potential negative outcome of loose medications on the medication cart would be missed medication doses or wrong medications given. During an interview on 12/09/24 at 11:27 AM, the DON stated she was not aware that there were loose medications on the medication cart. She stated it was the responsibly of nursing administration to train staff on proper storage of medications on the cart. The DON stated the policy for proper monitoring of medication storage was that carts were checked daily for loose medications. She stated the consultant pharmacist would conduct cart audits during monthly visits to check for proper medication storage. She stated training was conducted through in services and spot checks of medication carts conducted by nursing administration. She stated it was her expectation of staff to check medication carts thoroughly each day for loose medications. The DON stated a potential negative outcome of loose medications on the cart would be that medications were not stored safely and may not be able to be properly identified and that residents may miss doses of medication. Record review of facility provided policy labeled, Storage of Medications, revised November 2020, revealed: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: . 2. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medication between containers. 3. The nursing staff is responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42515 Based on observation, interview, and record review, the facility failed to provide food that was palatable, and at a safe, and appetizing temperature for 3 of 3 food forms (Regular, Mechanical Soft, and Pureed) for 1 of 1 meal reviewed for palatability. 1) The facility failed to provide food that was palatable for 3 of 3 food forms served (Regular, Mechanical Soft, and Puree) at 1 of 1 meal observed (12/03/24 lunch). These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: During confidential individual interviews 5 of 14 residents voiced concerns related to food palatability. The residents stated the food did not taste good and the residents did not like eating the facility food. One resident stated she wasn't sure if the cooks knew how to follow a recipe. One resident stated the food was very bland with no taste. On 12/03/24 at 10:50 AM the Dietary Manager was informed of a request for a test tray for the noon meal. Observation on 12/03/24 at 1:07 PM the test trays arrived at the conference room and sampling began at 1:09 PM with the following results: Regular Meal - Regular Texture Enchiladas - no issues Spanish Rice - very bland, no taste Beans - thick/dry Churro - no issues Regular Meal - Mechanical Soft Texture Enchiladas - no issues Spanish Rice - bland, no taste Beans - thick/dry Regular Meal - Puree Enchiladas - no issues (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Spanish rice - bland, no taste, unappetizing look/lack of color Beans - no issues Interview on 12/03/24 at 1:20 PM, the DM was asked to try the test tray and stated the Spanish rice was a little dry and doesn't really have a flavor and the beans could have been more moist. The DM stated the rice comes in a pre-seasoned pack that she pours out of the bag and lets it cook in the oven. The DM stated she did not add any seasonings to the rice and residents have not complained to her before. The DM stated the beans also come in a bag and all she did was put them in a pot with water and let them cook. Interview on 12/09/24 at 9:34 AM, the DM stated some of the food items come in a pack with seasonings already and she is afraid to over-season the food. The DM stated salt and pepper packets are provided to the residents for extra seasonings if they want. The DM stated she tests food that comes out of the kitchen every now and then. The DM stated she was unaware of any complaints from the residents. The DM stated she has been trained on food palatability. The DM stated she did not know any negative outcomes to the residents because the residents always have alternate choices to choose from if they did not like the meal. Interview on 12/09/24 at 11:36 AM, the ADM stated the DM and the cooks are responsible for food palatability concerns. The ADM stated the dietary staff have been trained on food palatability and stated sometimes it may be a preference problem. The ADM stated all residents prefer different kinds of foods. The ADM stated the residents have a risk of weight-loss and not eating if the food did not taste good to them. Record review of the facility policy and procedure titled, Menu planning, with a revised date of 06/01/19, reflected the following: The facility believes that nutrition is an important part of maintaining the well-being and health of its residents and is committed to providing a menu that is well-balanced, nutritious, and meets the preferences of the resident population 43150

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42515 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 keep refrigerator handles clean 2) The facility failed to properly store a cupcake pan. 3) The facility failed to properly store food in the pantry and refrigerator. These failures could place residents at risk for food contamination and foodborne illness. The findings included: Observation during a kitchen tour on 12/03/24 beginning at 9:20 AM revealed 5 fridge handles that had dry, sticky substances on the inside handle, a cupcake pan stored on the bottom shelf right side up and 1 bag of enriched farina hot cereal, opened date of 12/02/24, observed in a bag that was not fully sealed in the pantry. Interview on 12/03/24 at 9:29 AM, the DM stated she did not know why the refrigerator handles were not clean and stated the refrigerators are cleaned every Sunday. The DM stated the food should be stored fully sealed in the kitchen and stated the bag of enriched farina hot cereal was probably open because she used it earlier that morning. The DM stated the cupcake pan should be stored upside down. Observation on 12/05/24 at 11:09 AM during a return visit to the kitchen revealed a bag of shredded lettuce, open date of 12/02/24, not fully sealed in the refrigerator. Interview on 12/05/24 at 11:10 AM, Dietary Aide B stated she did not know why the bag of lettuce was not fully sealed in the refrigerator. Dietary Aide B stated all foods should be stored fully sealed in the refrigerator, but sometime bags open if they have too much air in them. Dietary Aide B stated she has been trained on properly storing food in the kitchen. Dietary Aide B stated the residents have a risk of cross contamination with food not being sealed all the way when stored. Interview on 12/09/24 at 9:34 AM, the DM stated that she is mainly responsible for ensuring kitchen foods and items are stored properly and kitchen items are cleaned. The DM stated the dietary staff have been trained on food storage and kitchen cleanliness. The DM stated the residents could possibly get sick due to food items not being properly stored, the refrigerator handles not being clean or the pans not being stored properly. Record review of the facility's policy and procedure title, Food Storage with a revised date of 2006, reflected the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Food storage areas shall be maintained in a clean, safe, and sanitary condition. Policy Interpretation and Implementation: 1. Food Services, or other designated staff, will maintain clean food storage areas at all times. 2. Food Service staff will store food or food items not requiring refrigeration .on shelves, racks, dollies or other surfaces .not subject to sewage or wastewater backflow or contamination by condensation, leakage, rodents, or vermin. All package food, canned foods, or food items stored will be kept clean and dry at all times Record review of the facility's policy and procedure titled, General Kitchen Sanitation dated 12/01/11, reflected the following: Policy: .The following guidelines should be used to ensure adequate sanitation practices are in place. Guidelines: 5. After cleaning and until use, all food-contact surfaces of equipment and multi-use utensils are stored and handled in a manner that protects the surfaces from manual contact, splash, dust, dirt, and food particles and otherwise in a clean and sanitary condition. 6. Non-food-contact surfaces of equipment are cleaned at intervals necessary to keep them free from dust, dirt, and food particles and otherwise in a clean and sanitary condition

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 4 of 4 refrigerators reviewed for food safety (room [ROOM NUMBER], 122, 133, 142). The refrigerator located in room [ROOM NUMBER] did not have an up-to-date temperature log nor did it have a thermometer inside of the refrigerator. The refrigerator contained undated perishable food items. The refrigerator located in room [ROOM NUMBER] did not have a temperature log present nor did it have a thermometer inside of the refrigerator. The refrigerator contained undated perishable food items. The refrigerator located in room [ROOM NUMBER] did not have an up-to-date temperature log nor did it have a thermometer inside of the refrigerator. The refrigerator contained undated perishable food items. The refrigerator located in room [ROOM NUMBER] did not have an up-to-date temperature log nor did it have a thermometer inside of the refrigerator. The refrigerator contained undated perishable food items. These failures could place residents at risk for food borne illnesses. Findings included: Observation on 12/03/24 at 9:53 AM of personal refrigerator in room [ROOM NUMBER] revealed a temperature log, dated December 2024, with no temperatures recorded. Personal food items were noted in the refrigerator to include a creamy spinach dip and small squares of cheese. No thermometer was noted inside. Observation on 12/03/24 at 9:56 AM of the personal refrigerator in room [ROOM NUMBER] revealed no temperature log. An open bottle of iced tea with a label that read refrigerate after opening was observed in the refrigerator. No thermometer was located inside. Observation on 12/03/24 at 10:02 AM of the personal refrigerator in room [ROOM NUMBER] revealed a temperature log, dated November 2024, with no temperatures recorded. No December temperature log was observed. Personal food items were noted in the refrigerator to include potato salad, pimiento cheese, an open bottle of soda, an open container of cranberry juice, 3 containers of Jello and an open jar of pickles. No thermometer was noted inside. Observation on 12/03/24 at 10:09 AM of the personal refrigerator in room [ROOM NUMBER] revealed a temperature log, dated December 2024, with no temperatures recorded. No food items were noted in refrigerator at the time of observation. No thermometer was noted inside. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/03/24 at 12:41 PM of the personal refrigerator in room [ROOM NUMBER] revealed a temperature log, dated December 2024, with no temperatures recorded. A partially eaten burrito wrapped in foil was observed inside. No thermometer was noted inside. Observation on 12/05/24 at 8:31 AM of the personal refrigerator in room [ROOM NUMBER] revealed a temperature log, dated November 2024, with no temperatures recorded. Personal food items noted in initial observation remained in the refrigerator to include potato salad, pimiento cheese, an open bottle of soda, an open container of cranberry juice, 3 containers of Jello and an open jar of pickles. No thermometer was noted inside. In an interview on 12/09/24 at 11:16 AM, the ADM stated he was not aware that personal refrigerator temperatures were not being monitored. He stated the maintenance supervisor was responsible for monitoring personal refrigerator temperatures, but he was no longer employed by the facility as of one week ago. The ADM stated personal refrigerator temperatures should be checked and logged daily. He stated, going forward, nursing would be responsible for checking food in personal refrigerators and monitoring daily temperatures. He stated his expectation of staff was to monitor personal refrigerators and report any concerns. The ADM stated a potential negative outcome for failure to monitor temperatures in personal refrigerators was that residents could become ill. In an interview on 12/09/24 at 11:27 AM, the DON stated she was not aware that personal refrigerator temperatures were not being monitored. She stated she was not sure what the policy was for monitoring personal refrigerators. The DON stated she would get with the ADM to establish whose responsibility it was to monitor personal refrigerators, but she assumed it was the responsibility of housekeeping. She stated personal refrigerator temperatures should be checked daily and followed up on. The DON stated a potential negative outcome for failure to properly monitor personal refrigerator temperatures was that the residents could get bacteria in the GI tract and it could be a health issue. Record review of the facility-provided policy titled, Food Receiving and Storage, Revised November 2022 revealed: Policy Statement Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation . 7. Residents may consume foods from sources not procured by the facility (e.g., food brought from family or visitors). . Foods and Snacks Kept on Nursing Units or in Resident rooms 1. All food items to be kept at or below 41 degrees F are placed in the refrigerator located at the nurses' station and labeled with a use by date. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. 3. Refrigerators must have working thermometers and are monitored for temperature according to state-specific guidelines. Temperatures must be monitored. 4. Beverages are dated when opened and discarded after twenty-four (24) hours. 5. Other opened containers are dated and sealed or covered during storage. 6. Partially eaten food is not kept in the refrigerator.

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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** 49305 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 2 (Resident #1 and Resident #61) of 3 residents and 1 (LVN A) of 2 staff reviewed for infection control. LVN A failed to perform hand hygiene between glove changes while providing wound care for Resident #1. LVN A failed to perform hand hygiene following a wound care procedure for Resident #1. LVN A failed to perform hand hygiene between glove changes while providing wound care for Resident #61. These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #1 Record review of face sheet for Resident #1 revealed an [AGE] year-old male admitted to the facility 02/18/22 with the following diagnoses: Senile Degeneration of Brain (mental deterioration associated with advanced age), Dysphagia (difficulty swallowing), Depression, Anxiety Disorder, Hypertension (high blood pressure), Peripheral Vascular Disease (reduced blood flow to the limbs), Atherosclerotic Heart Disease (disease of the heart's major vessels), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Heart Failure (heart condition), Kidney Failure (condition causing kidneys to not function properly), Gastroesophageal Reflux Disease (digestive condition). Record review of Resident #1's current Physician's orders dated 12/09/24 revealed an order for daily wound care to right lower leg. Record review of Resident #1's annual MDS dated [DATE] revealed no BIMS was conducted due to the resident was rarely or never understood. Section M - Skin Conditions revealed Resident #1 was at risk for developing pressure ulcers and received pressure ulcer/injury care. Record review of Resident #1's Comprehensive Care Plan, revised on 08/15/24 revealed the resident was at risk for skin breakdown with approaches to follow skin care protocol and perform weekly skin assessments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/06/24 at 10:03 AM, observed LVN A perform wound care to Resident #1's right lower leg. LVN A sanitized her hands and put on gloves prior to starting wound care. LVN A removed the wound dressing to the right lower leg, then changed her gloves. LVN A put on new gloves and performed care to Resident #1's right lower leg wound, per physician's orders. LVN A then changed gloves and placed a dressing to the right lower leg wound, per physician's orders. LVN A did not perform hand hygiene between glove changes. LVN A repositioned Resident #1 and exited the room. LVN A did not sanitize her hands prior to leaving the room or upon exiting the room. Resident #61 Record review of face sheet for Resident #61 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Multiple Sclerosis (disease of the central nervous system), Asthma (narrowed airways), Unspecified Pain, Muscle Spasm, Arthropathy (disease of the joints), Major Depressive Disorder (persistently low mood), Anxiety Disorder (excessive fear or worry), Gastroesophageal Reflux Disease (digestive condition). Record review of Resident #61's current Physician's orders dated 12/09/24 revealed an order for daily wound care to left heel. Record review of Resident #61's Significant Change MDS dated [DATE] revealed a BIMS of 15, indicating the resident was cognitively intact. Section M - Skin Conditions revealed Resident #61 was at risk for developing pressure ulcers and received pressure ulcer/injury care. Record review of Resident #61's Comprehensive Care Plan, revised on 08/15/24 revealed the resident was at risk for skin breakdown with approaches to follow skin care protocol and perform weekly skin assessments. On 12/06/24 at 10:42 AM, observed LVN A perform wound care to Resident #61's left heel. LVN A sanitized her hands and put on gloves prior to starting wound care. LVN A removed the left heel wound dressing then changed her gloves. LVN A put on new gloves and performed care to Resident #61's left heel wound, per physician's orders. LVN A then changed her gloves and placed a dressing to the left heel wound, per physician's orders. LVN A did not perform hand hygiene between glove changes. LVN A cleansed her hands with soap and water prior to exiting the room. During an interview on 12/06/24 at 10:53 AM with LVN A, she stated she did not sanitize her hands between glove changes while performing wound care for Resident #1 and Resident #61. She stated she did not sanitize her hands after performing wound care for Resident #1. LVN A stated she should have used hand sanitizer or washed her hands between glove changes and after performing wound care. She stated her failure to properly sanitize her hands during and after wound care was just an oversight. LVN A stated she had been trained at the facility on proper hand hygiene by the DON. She stated hand hygiene training occurred approximately once per month. LVN A stated a potential negative outcome for failure to properly sanitize hands during and after wound care would be infection and cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/24 at 11:16 AM with the ADM, he stated he was not aware that staff failed to observe proper hand hygiene during and after wound care. He stated the facility policy was to follow hand hygiene protocol at all times. He stated hands should be sanitized between glove changes. He stated hands should be washed prior to exiting the room after performing wound care. The ADM stated nursing administration was responsible for training staff on proper hand hygiene. He stated his expectation of staff for proper hand hygiene during and after wound care was that staff practice proper hygiene per protocol during all care. The ADM stated a potential negative outcome for failure to observe proper hand hygiene was infection control issues. During an interview on 12/09/24 at 11:27 AM with the DON, she stated she was not aware that staff failed to observe proper hand hygiene during and after wound care. She stated the facility's policy for hand hygiene during and after wound care was that hands were sanitized prior to beginning the procedure and with each glove change, before putting on clean gloves. She stated hands should be washed prior to exiting the room and after performing wound care. The DON stated staff were trained on proper hand hygiene regularly by nursing administration and skills checks were done annually for staff on proper hand hygiene practices. She stated her expectation of staff for proper hand hygiene during and after wound care was that staff practice proper hygiene according to facility-provided education as well as their nursing education. The DON stated a potential negative outcome for failure to observe proper hand hygiene was cross contamination and infection. Record review of the facility-provided policy titled Handwashing/Hand Hygiene; Revised October 2023 revealed: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. . Indications for Hand Hygiene 1. Hand hygiene is indicated: immediately before touching a resident; . d. after touching a resident . f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The use of gloves does not replace hand washing/hand hygiene.

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observations, interviews, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relayed the call directly to a centralized staff work area for 15 of 74 residents (Resident #3, #11, #12, #19, #20, #21, #24, #28, #38, #40, #44, #47, #58, #62, and #65) reviewed for call lights. The facility failed to ensure residents were equipped with a fully functioning call light system in room [ROOM NUMBER] and room [ROOM NUMBER]. Resident #11 had a diagnosis of type 2 diabetes and COPD (Chronic obstructive pulmonary disease), both which would require immediate attention if Resident #11 needed oxygen, or his blood sugar fell too low or got too high. Resident #12 had a diagnosis of type e2 diabetes which would require immediate attention if blood sugar were to get too high or too low. There were no frequent rounds being completed. These failures could place residents at risk of injury, pain, hospitalization , and a diminished quality of life. An Immediate Jeopardy was identified on 12/5/24/ The IJ template was provided to the facility Administrator on 12/5/24 at 4:48 PM. While the immediate jeopardy was removed I on 12/6/24 , the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of pattern, due to the facility's need to evaluate the effectiveness of their plan of correction to prevent future concerns. Findings included: Resident #3: Record review of an Admission Record dated for Resident #3 shows an [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with diagnoses of epilepsy (disorder of the brain characterized by repeated seizures), altered mental status, pain, lack of coordination, feeding difficulties, history of pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot), muscle weakness, insomnia (persistent problems falling asleep), depression, acid reflux, lennox-gastaut syndrome (a rare and severe form of epilepsy that starts in early childhood), eosinophilic esophagitis (chronic allergic immune system disease that affects the esophagus), abdominal hernia (any protrusion of intestine or other tissue through a weakness or gap in the abdominal wall), osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bone wears down) (difficulty swallowing), dysphagia, repeated falls. Record review of a Significant Change in Status MDS (Minimum Data Set) assessment dated [DATE] for Resident #3 indicated a BIM (Brief Interview for Mental Status) of 10 meaning Resident #3 had moderate cognitive impairment. Record review of Resident #3's care plan dated 6/5/2024 indicated Resident #3 had ADL self-care performance deficit due to LENNOX-GASTAUT Syndrome, Epilepsy with interventions of encourage resident to use the call for assistance. If the resident is unable to utilize the call light, staff will provide frequent visual checks. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #3's care plan dated 6/5/2024 indicated Resident #3 had risk for falling due to co-morbid. conditions and impaired mobility with the interventions of call light is within reach and encourage me to use it for assistance as needed. Record review of Resident #3's care plan date revised on 10/3/2024 indicated Resident #3 had risk for Alteration in musculoskeletal status due to contusion of lower back with the interventions of anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Resident #11: Record review of an Admission Record dated for Resident #11 shows an [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with diagnoses of muscle weakness, unsteadiness on feet, hypokalemia, elevated white blood count, age-related physical disability, schizoaffective disorder, neuroleptic induced parkinsonism, type 2 diabetes, major depressive disorder, hypothyroidism, anxiety disorder, hyperlipidemia, paranoid schizophrenia, high blood pressure, chronic obstructive pulmonary disease, benign prostatic hyperplasia. Record review of a Significant Change in Status MDS (Minimum Data Set) assessment dated [DATE] for Resident #11 indicated a BIMS (Brief Interview for Mental Status) of 14 meaning Resident #11 had minimum cognitive impairment. Record review of Resident #11's care plan dated 6/5/2024 indicated Resident #11 had is at moderate is risk for falls due to Psychotropic use, Antidepressant use, and Antianxiety use with the interventions of call light is within reach and encourage him to use it for assistance as needed. Resident #11 needs prompt response to all requests for assistance. Record review of Resident #11's blood sugar for the dates between 4/9/2024 through 12/19/2024, revealed: 12/11/2024 at 19:58 with blood sugar of 78 mg/dl 11/24/2024 at 16:51 with blood sugar of 77 mg/dl 11/23/2024 at 20:37 with blood sugar of 77 mg/dl 11/14/2024 at 20:55 with blood sugar of 76 mg/dl 11/14/2024 at 20:30 with blood sugar of 76 mg/dl 11/08/2024 at 21:31 with blood sugar of 79 mg/dl 11/07/2024 at 10:15 with blood sugar of 68 mg/dl 11/05/2024 at 20:55 with blood sugar of 79 mg/dl 11/03/2024 at 16:46 with blood sugar of 75 mg/dl (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	11/02/2024 at 16:36 with blood sugar of 79 mg/dl 10/22/2024 at 20:26 with blood sugar of 72 mg/dl 10/16/2024 at 20:56 with blood sugar of 76 mg/dl 10/13/2024 at 21:22 with blood sugar of 77 mg/dl 10/12/2024 at 20:49 with blood sugar of 72 mg/dl 10/11/2024 at 11:31 with blood sugar of 79 mg/dl 10/10/2024 at 10:56 with blood sugar of 66 mg/dl 9/28/2024 at 19:45 with blood sugar of 75 mg/dl 9/15/2024 at 19:34 with blood sugar of 65 mg/dl 9/10/2024 at 20:55 with blood sugar of 74 mg/dl 8/30/2024 at 10:07 with blood sugar of 76 mg/dl 8/3/2024 at 19:21 with blood sugar of 77 mg/dl 7/15/2024 at 20:20 with blood sugar of 74 mg/dl 7/10/2024 at 11:51 with blood sugar of 73 mg/dl 7/09/2024 at 11:33 with blood sugar of 71 mg/dl 7/08/2024 at 11:08 with blood sugar of 76 mg/dl 6/29/2024 at 10:18 with blood sugar of 75 mg/dl 6/21/2024 at 21:18 with blood sugar of 75 mg/dl 6/14/2024 at 11:30 with blood sugar of 67 mg/dl 6/3/2024 at 13:10 with blood sugar of 79 mg/dl 6/1/2024 at 20:01 with blood sugar of 75 mg/dl 5/30/2024 at 16:41 with blood sugar of 67 mg/dl 5/27/2024 at 11:47 with blood sugar of 79 mg/dl 5/25/2024 at 20:23 with blood sugar of 77 mg/dl (continued on next page)

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	675853	A. Building B. Wing	12/09/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	5/24/2024 at 11:33 with blood sugar of 79 mg/dl 5/18/2024 at 15:09 with blood sugar of 73 mg/dl 5/18/2024 at 10:50 with blood sugar of 61 mg/dl 5/17/2024 at 10:28 with blood sugar of 76 mg/dl 5/10/2024 at 11:14 with blood sugar of 73 mg/dl 5/2/2024 at 11:24 with blood sugar of 69 mg/dl 5/1/2024 at 19:37 with blood sugar of 68 mg/dl 5/1/2024 at 11:33 with blood sugar of 79 mg/dl 4/26/2024 at 11:10 with blood sugar of 57 mg/dl 4/24/2024 at 10:23 with blood sugar of 57 mg/dl 4/21/2024 at 11:26 with blood sugar of 59 mg/dl 4/19/2024 at 10:35 with blood sugar of 59 mg/dl 4/13/2024 at 16:44 with blood sugar of 73 mg/dl 4/11/2024 at 19:51 with blood sugar of 76 mg/dl 4/9/2024 at 11:25 with blood sugar of 58 mg/dl Record review of Resident #11's Progress Note dated 07/10/2024 stated: Spoke to FNP this morning about changing Resident #11's sliding scale insulin to start at 200. He bottoms out if we give any insulin below that. Received order to discontinue all sliding scale insulin. Record review of Resident #11's Progress Note dated 03/05/2024 stated: This nurse notified, NP regarding this resident having fluctuating blood glucose levels, with no insulin orders or SSI orders in place. This nurse notified Nurse practitioner, insulin and SSI was discontinued in hospital. New order placed; Start back on SSI, with Novolin R 100 units/ML and monitor, per NP, DON, and ADON, notified. Resident #12: Record review of an Admission Record dated for Resident #12 shows a [AGE] year-old female with an admitted [DATE] with diagnoses of dementia, anxiety, unsteadiness on feet, urinary tract infection, schizoaffective disorder, pain, feeding difficulties, muscle weakness, cognitive communication deficit, age-related disability, type 2 diabetes, hyperlipidemia, high blood pressure, A-Fib, arthritis. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of an Annual MDS (Minimum Data Set) assessment dated [DATE] for Resident #12 indicated a BIMS (Brief Interview for Mental Status) of 3 meaning Resident #12 had severe cognitive impairment. Record review of Resident #12's care plan dated 6/5/2024 indicated Resident #12 had is at moderate is risk for falls. due co-morbid conditions and impaired mobility with interventions of call light is within reach and encourage me to use it for assistance as needed. Resident #19: Record review of an Admission Record dated for Resident #19 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of Alzheimer's disease, unsteadiness on feet, anxiety, atrial flutter, paroxysmal tachycardia, chronic obstructive pulmonary disease, psychotic disorder, hyperlipidemia, major depression, neuromuscular dysfunction, feeding difficulties, aphasia, abnormalities of gait and mobility, muscle weakness, lack of coordination, cognitive communication deficit, pain in joint, history of falling. Record review of an Annual MDS (Minimum Data Set) assessment dated [DATE] for Resident #19 indicated a BIMs (Brief Interview for Mental Status) of 3 meaning Resident #19 had severe cognitive impairment. Record review of Resident #19's care plan dated 6/5/2024 indicated Resident #19 had oxygen Therapy due to COPD O2 @ 2-3 Liters Per Minute via NC PRN to keep sats at 90% with interventions of provide reassurance and allay anxiety: Have an agreed-on method for the resident to call for assistance (e.g., call light, bell). Stay with the resident during episodes of respiratory distress. Record review of Resident #19's care plan dated 12/5/2024 indicated Resident #19 had a handbell to use as an auditory alarm with the interventions of do frequent checks to ensure needs are met, ensure handbell is within reach and resident is aware of where the handbell is, ensure staff is aware of the handbell. Record review of Resident #19's care plan dated 5/15/2024 indicated Resident #19 had a risk for falls due to impaired mobility, cognition, and history of falls with interventions of call light is within reach and encourage resident to use it for assistance as needed. Resident needs prompt response to all requests for assistance. If resident is unable to utilize the call light staff will provide frequent visual checks. Record review of Resident #19's O2 SAT Summary between dates of 1/28/2022-10/5/2023, revealed that Resident #19 ran consistently low between 95-90 throughout the entire summary. Resident #20: (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of an Admission Record dated for Resident #20 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of dementia, hypothyroidism, hyperlipidemia, hearing loss, chronic kidney disease, atherosclerotic kidney disease, aortic valve stenosis, acid reflux, atopic dermatitis, osteoporosis, chronic kidney disease, stress incontinence, edema, proteinuria, history of falling. Record review of a Quarterly MDS (Minimum Data Set) assessment dated [DATE] for Resident #20 indicated a BIMS (Brief Interview for Mental Status) of 00 meaning Resident #20 was unable to recall information. Record review of Resident #20's care plan dated 12/12/2023 indicated Resident #20 had a risk for falling due to my co-morbid conditions and impaired mobility. Resident #21: Record review of an Admission Record dated for Resident #21 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of dementia, hypothyroidism, hyperlipidemia, hearing loss, chronic kidney disease, atherosclerotic kidney disease, aortic valve stenosis, acid reflux, atopic dermatitis, osteoporosis, chronic kidney disease, stress incontinence, edema, proteinuria, history of falling. Record review of a Quarterly MDS (Minimum Data Set) assessment dated [DATE] for Resident #20 indicated a BIMs (Brief Interview for Mental Status) of 00 meaning Resident #20 was unable to recall information. Record review of Resident #20's care plan dated 12/12/2023 indicated Resident #20 had a risk for falling due to my co-morbid conditions and impaired mobility. Resident #24: Record review of an Admission Record dated for Resident #24 shows an [AGE] year-old male with an admitted [DATE] with diagnoses of cellulitis, pain, gastrostomy, muscle wasting, supraventricular tachycardia, seizures, allergic dermatitis, high blood pressure, anoxic brain damage, seborrheic dermatitis, high blood pressure, fasciculation, pain in joint, iron deficient anemia, moderate protein calorie malnutrition, anxiety, quadriplegia, acid reflux, constipation, contracture of right and left hand, muscle spasm, dysphagia, flatulence, aphasia, convulsions, traumatic brain injury. Record review of a Quarterly MDS (Minimum Data Set) assessment dated [DATE] for Resident #24 indicated a BIMs (Brief Interview for Mental Status) was left blank and incomplete. Record review of Resident #24's care plan date revised on 9/22/2019 indicated Resident #24 had a has a communication problem due to Head Injury, Weak or absent voice with the allegations of call light in reach. Record review of Resident #24's care plan date revised on 11/15/2024 indicated Resident #24 had a high risk for falls due to balance problems, poor trunk control, no purposeful movement, secondary to traumatic brain injury. Resident #28: (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of an Admission Record dated for Resident #28 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of chronic respiratory failure, major depression, cognitive communication deficit, pain in joint, muscle weakness, feeding difficulties, tinea cruris, candidiasis of vulva, anemia, hypothyroidism, type 2 diabetes, iron deficiency, morbid obesity, hyperlipidemia, insomnia, chronic pain syndrome, peripheral neuropathy, high blood pressure, diverticulosis, gout, plantar fascial fibromatosis, acute kidney failure, urge incontinence, post-menopausal bleeding, dizziness, injury of muscle and tendon of rotator cuff, urinary tract infection, dependence on supplemental oxygen. Record review of a Quarterly MDS (Minimum Data Set) assessment dated [DATE] for Resident #28 indicated a BIMS (Brief Interview for Mental Status) of 13 meaning Resident #28 had mild cognitive impairment. Record review of Resident #28's care plan dated 12/12/2023 indicated Resident #28 had a risk for falling due to co-morbid.conditions and impaired mobility with the allegations of call light is within reach and encourage me to use it for assistance as needed. Resident #38: Record review of an Admission Record dated for Resident #38 shows an [AGE] year-old female with an admitted [DATE] and an original admitted [DATE] with diagnoses of stroke, major depression, high blood pressure, type 2 diabetes, hyperlipidemia, chronic kidney disease, sciatica, hemiplegia & hemiparesis, pain, muscle weakness, lack of coordination, feeding difficulties, age-related physical disability. Record review of a Quarterly MDS (Minimum Data Set) assessment dated [DATE] for Resident #38 indicated a BIMS (Brief Interview for Mental Status) of 12 meaning Resident #38 had mild cognitive impairment. Record review of Resident #38's care plan dated 11/10/2024 indicated Resident #38 had a risk for risk for falling d/t my co-morbid conditions and impaired mobility with interventions of call light is within reach and encourage me to use it for assistance as needed. Resident #40: Record review of an Admission Record dated for Resident #40 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of psychotic disturbance, wheezing, tachypnea, abscess of bursa, unspecified falls, drug induced dyskinesia, torsion dystonia, major depression, Huntington's disease, urinary incontinence, muscle weakness, dysphagia, abnormalities of gait and mobilities, lack of coordination, cognitive communication deficit. Record review of an Annual MDS (Minimum Data Set) assessment dated [DATE] for Resident #40 indicated a BIMS (Brief Interview for Mental Status) of 9 meaning Resident #40 had mild cognitive impairment. Record review of Resident #40's care plan dated 6/15/2022 indicated Resident #40 had behaviors such as (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	physically and verbally aggressive when offered the services with interventions of ensure call light is in reach at all times. Record review of Resident #40's care plan date revised on 11/15/2024 indicated Resident #40 had a risk for falling due to my co-morbid conditions and impaired mobility with interventions of call light is within reach and encourage me to use it for assistance as needed. Record review of Resident #40's care plan dated on 12/5/2024 indicated Resident #40 had a bell in place of a call light. Resident #44: Record review of an Admission Record dated for Resident #44 shows an [AGE] year-old female with an admitted [DATE] with an initial admitted [DATE] with diagnoses of stroke, shortness of breath, anemia, hyperlipidemia, melena, chronic kidney disease, dementia, schizoaffective disorder, edema, dysphagia, unsteadiness on feet, iron deficiency anemia, acid reflux, dermatitis, abnormalities of gait and mobility, weakness, malaise, high blood pressure, aphasia, dysarthria, chronic embolism, pain in joint, muscle weakness, feeding difficulties, lack of coordination, reduced mobility. Record review of an Annual MDS (Minimum Data Set) assessment dated [DATE] for Resident #44 indicated a BIMS (Brief Interview for Mental Status) of 12 meaning Resident #44 had mild cognitive impairment. Record review of Resident #44's care plan dated 6/15/2022 indicated Resident #44 had a risk for falling due to my co-morbid conditions and impaired mobility with the interventions of call light is within reach and encourage me to use it for assistance as needed. Record review of Resident #44's care plan dated 10/2/2023 indicated Resident #44 had an actual fall with no injury with the interventions of all light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Record review of Resident #44's care plan dated 12/5/2024 indicated Resident #44 had a handbell to use as an auditory alarm. Record review of Resident #44's care plan dated 12/7/2022 indicated Resident #44 had an ADL self-care performance deficit r/t cerebral infarction with interventions of encourage Resident #44 to use the call for assistance. If the resident is unable to utilize the call light, staff will provide frequent visual checks. Record review of Resident #44's care plan dated 12/7/2022 indicated Resident #44 is at moderate risk for falls due to impaired mobility with interventions of Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Resident #47: (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of an Admission Record dated for Resident #47 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of fracture of sacrum, pain in joint, muscle weakness, urinary tract infection, nausea with vomiting, hypo-osmolality, major depression, anxiety, high blood pressure, atherosclerotic heart disease, pulmonary hypertension, emphysema, respiratory failure, sacrococcygeal disorders, acute kidney failure. Record review of an Admission MDS (Minimum Data Set) assessment dated [DATE] for Resident #47 indicated a BIMS (Brief Interview for Mental Status) of 10 meaning Resident #47 had moderate cognitive impairment. Record review of Resident #47's care plan dated 4/20/2023 dated on 11/11/2024 indicated Resident #47 was at risk for falls. Interventions included to place Resident #47's call light within reach and encourage to use it for assistance as needed. Resident #58: Record review of an Admission Record dated for Resident #58 shows an [AGE] year-old female with an admitted [DATE] with an original admitted [DATE] with diagnoses of Alzheimer's disease, history of UTI's, restlessness and agitation, intertrochanter fracture of left femur, anxiety, insomnia, unsteadiness on feet, unspecified fall, pain in joint, muscle weakness, lack of coordination, cognitive communication deficit, feeding difficulties, hypothyroidism, dementia, glaucoma, high blood pressure, acid reflux, osteoporosis. Record review of an Significant Change in Status MDS (Minimum Data Set) assessment dated [DATE] for Resident #58 indicated a BIMS (Brief Interview for Mental Status) of 3 meaning Resident #58 had severe cognitive impairment. Record review of Resident #58's care plan dated 4/20/2023 date revised on 10/28/2024 indicated Resident #58 was high at risk for falls due to confusion. Interventions included to place Resident #58's call light within reach and encourage to use it for assistance as needed. Record review of Resident #58's care plan date revised on 7/7/2023 indicated Resident #58 had a cognitive communication deficit due to Alzheimer's with the interventions of Call light in reach. Resident #62: Record review of an Admission Record dated for Resident #62 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of urinary tract infection, bipolar disorder, anxiety, hypokalemia, dementia, diverticulitis, irritable bowel syndrome, pain in joint, muscle weakness, unsteadiness on feet, lack of coordination, cognitive communication deficit, feeding difficulties, hypothyroidism, hyperlipidemia, depression, insomnia, hearing loss, high blood pressure, atherosclerosis of aorta, diarrhea, fracture of sacrum, left ilium, left pubis, falls. Record review of a Significant Change in Status MDS (Minimum Data Set) assessment dated [DATE] for Resident #62 indicated a BIMS (Brief Interview for Mental Status) of 3 meaning Resident #62 had severe cognitive impairment. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #62's care plan date revised on 9/2/2024 indicated Resident #62 was at risk for falls. Interventions included to place Resident #62's call light within reach and encourage to use it for assistance as needed. Record review of Resident #62's care plan date revised on 11/14/2024 indicated Resident #62 had a witnessed actual fall with NO INJURIES ON 11/13 with interventions of call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Record review of Resident #62's care plan date revised on 12/5/2024 indicated Resident #62 had a handbell to use as an auditory alarm with the interventions of ensure handbell is within reach and resident is aware of where the handbell is. Resident #65: Record review of an Admission Record dated for Resident #65 shows an [AGE] year-old female with an admitted [DATE] with diagnoses of atherosclerosis of coronary artery bypass, pain, muscle weakness, unsteadiness on feet, lack of coordination, candidiasis, hyperthyroidism, type 2 diabetes, hyperlipidemia, depression, high blood pressure, angina pectoris, acid reflux, gout, syncope and collapse, history of falling, presence of cardiac pacemaker, essential tremor, heart failure, stroke, acute kidney failure. Record review of an Admission MDS (Minimum Data Set) assessment dated [DATE] for Resident #65 indicated a BIMS (Brief Interview for Mental Status) of 10 meaning Resident #62 had moderate cognitive impairment. Record review of Resident #65's care plan date revised on 10/8/2024 indicated Resident #65 was at risk for falls due to gait problems. Interventions included to place Resident #65's call light within reach and encourage to use it for assistance as needed. Record review of Resident #65's care plan date revised on 10/9/2024 indicated Resident #65 had an alteration in musculoskeletal status due to other specified disorders of bone density and structure with interventions of anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. During an interview with Resident #44 on 12/3/2024 at 11:10 AM. Resident #44 stated that when the call light is used that Resident #44 is not helped a lot of the time. Resident #44 stated that the call light was used on 12/12/2024 to get assistance with a glass of water and no one ever came to help. Resident #44 stated that she had fallen back to sleep without any water. During an interview with Resident #28 on 12/3/2024 at 11:35 AM. Resident #28 stated that it takes the staff a long time to answer the lights and sometimes they do not answer at all. Resident #28 stated that there are times that she is left wet for a while until someone comes to help. Resident #28 stated that it makes her feel like her needs are not important. During night observations and interview on 12/4/2024 at 10:37 PM, Observed room for Resident #44 was on outside of her door but was no sound was triggered at the nurse's station. Resident #44 stated that it takes a long time for staff to answer the call lights. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview with LVN C on 12/4/2024 at 10:52 PM. LVN C stated that the call lights had been messed up for a while. LVN C stated that the staff has to make sure to complete rounds because some of the rooms do not trigger a light or a sound. LVN C stated that maintenance had been notified a long time ago and it continues to not be fixed. During an interview with CNA B on 12/4/2024 at 11:01 PM. CNA B stated that the call lights do not work correctly. CNA B stated that on some of the resident's rooms if you trigger the call light in one room it will also trigger in another room. CNA B stated that most of the time it is hard to get to the resident's needs if she does not know that the call light is being triggered. During an interview with LVN E on 12/5/2024 at 10:00 AM. LVN E stated that when she pushes the call light in room [ROOM NUMBER], it also triggers the light in room [ROOM NUMBER] at the same time. LVN E stated that when she pushes the call light in room [ROOM NUMBER], it also triggers the light in room [ROOM NUMBER]. LVN E stated that the call light in room [ROOM NUMBER] only lights up outside of the room but does not trigger a sound at the nurse's station. LVN E showed Surveyor that all these call lights were not working properly. LVN E stated that the call lights had been not working for about 4 to 6 months. LVN E stated that maintenance requests had been completed. Interview with MA B on 12/5/2024 at 11:18 AM. MA B stated that the call lights had not worked for about 4 to 5 months. MA B stated that it is hard to tell who needs help. MA B stated that the staff has to make more frequent rounds. MA B stated that a resident could get hurt if the staff is not aware that the resident needs help and they try to help themselves. During an observation of expanded sample for call lights on 12/5/2024 beginning at 1:48 PM revealed: During observations it was learned that no other method for the residents to alert the staff. Call lights that had a light but not sounding at the nurse's station: room [ROOM NUMBER] A&B, 103 A&B, 125 A, 131 A, 141 A&B, 146 A Rooms with no call light: room [ROOM NUMBER] had no call light. It had the call light cord plugged in and hanging down and at the end of the cord had frayed wired with no call light button attached. Rooms with lights being triggered in other rooms at the same time: In room [ROOM NUMBER] the call light is triggered and also triggers the light in room [ROOM NUMBER] at the same time. In room [ROOM NUMBER] if the call light is triggered it also triggers the light in 109. Call Light that does not work: room [ROOM NUMBER] some of the time the light will work and some of the time the light would not work. (continued on next page)

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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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview with Resident #11 on 12/5/2024 at 2:38 PM. Resident #11 stated that sometimes the call light works and sometimes it does not. Resident #11 stated that the call light does not work right and sometimes he is not able to get the help that he needs because the call light is not working. Resident #11 stated that it had been not working for about six months. Resident #11 stated that he never knows when it is working and when it is not. Resident #11 stated that the only way to tell that the call light is not working is no one shows up to help. Resident #11 stated that he had diabetes and had issues with his blood sugars falling or at times it will get too high and those times help is needed. Resident #11 stated that help is also needed for brief changes. Resident #11 stated that if no one comes to help he just has to suffer through it. Resident #11 stated that there are times where help is really needed. Resident #11 stated that one time Resident #11's blood sugar had fallen severely low and used the call light but noticed it had been a long time and no one came to help. Resident #11 stated that when Resident #11 started feeling ill because of the drop he yelled out for help and then someone came to help. Resident #11 stated that what would happen if no one had come in to help. Resident #11 stated that he feared that he was going to die that day. During an observation of Resident #11 call light on 12/5/2024 at 3:01 PM showed the call light plugged into port B that did not work. The call light did not light up outside the door and it did not sound at the nurse's station. During an interview with the Administrator on 12/09/2024 at 11:00 AM. The Administrator stated that he was assuming that the maintenance was taking care of the call light situation. The Administrator stated that the Maintenance guy had missed some work due to illness. The Administrator stated that he was not sure how long the call light situation had occurred. The Administrator stated that the negative outcome for the call light not fully functioning is the resident would not be able to get their needs met. Record review of a facility policy titled, Call System, Resident, dated September 2022 stated: Policy Heading: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member of a centralized workstation. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. Call system communication may be audible or visual. The system may be wired or wireless. 3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. 4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communications that is usable for the resident is provided and documented in the care plan. 5. The resident call system is routinely maintained and tested by the maintenance department. (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	12/09/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	6. Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. 7. Call light response times are reviewed as part of the QAPI program. Record review of facility maintenance log dates from 09/20/2024-10/11/2024 stated: 1. 9/20/2024: 126 B- (Description or issue) call light does not work, (Completion Date) stated: repaired 9/23/2024. 2. 9/20/2024: 141 B- (Description or issue) call light does not sound, (Completion Date) stated: Do not know what to do about this. 3. 10/10/2024: 134 B- (Description or issue) call light needs to be fixed, (Completion Date) stated: needs