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	03/05/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly in a locked compartment for 1 of 2 nurse carts (Nurse Cart A) reviewed for medication storage. The facility failed to ensure Nurse Cart A was locked when not in use. This failure could place residents at risk of having access to unauthorized medications and lead to an increased risk for drug diversion and possible harm. The findings included: During an observation on 03/03/26 at 9:38 AM, Nurse Cart A was observed unlocked and unattended on Hall 2. No residents or staff were present by the nursing cart. During an observation on 03/03/26 at 12:15 PM, Nurse Cart A was observed unlocked and unattended on Hall 2. No residents or staff were present by the nursing cart. During an interview on 03/03/26 at 12:18 PM, LVN A stated she did not know why Nurse Cart A was unlocked in Hall 2. LVN A confirmed wound care supplies were available for use in Nurse Cart A by opening the cart. LVN A stated she had been trained on locking the medication and nursing carts when not in use but could not remember when the last training was. LVN A stated a potential negative outcome to the residents was a resident with dementia could get into the cart and get medications or bandages. During an interview on 03/05/26 at 10:23 AM, the DON stated she expected the nursing carts to be locked when not in use. The DON stated the charge nurse was responsible for ensuring the nursing carts were locked when not in use. The DON stated she did not know why Nurse Cart A was unlocked on Hall 2. The DON stated she did not know the last time the nursing staff was trained on locking the nursing carts when they were not in use. The DON stated a potential negative outcome to the residents was they could get into the different supplies in the nursing cart. During an interview on 03/05/26 at 2:13 PM, the ADM stated the nursing carts should be locked when they were not in use. The ADM stated the charge nurse or the medication aide was responsible for locking the medication cart or the nursing carts when they were not in use. The ADM stated the staff were trained on locking the carts when not in use but he could not remember exactly when. The ADM stated a potential negative outcome to the residents was they could get into the medications and it could be harmful to the residents. Record review of the facility policy titled, Storage of Medications with a revised date of November 2020 reflected the following: Policy headingThe facility stores all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and Implementation1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.6. Compartments (including but not limited to.carts.) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide or obtain laboratory services only when ordered by a physician for 1 of 24 residents (Resident #8) reviewed for laboratory results in that:The facility failed to ensure Resident #8's Dilantin (Phenytoin) blood level was drawn monthly on the 21st of each month, as ordered by the physician, in January 2026 or February 2026.The facility failed to ensure Resident #8's Keppra (Levetiracetam) blood level was drawn monthly on the 21st of each month, as ordered by the physician, in January 2026 or February 2026. This failure could place residents with laboratory work orders at risk of not having their medical needs met. Findings include: Resident #8 Record review of Resident #8's electronic face sheet dated 03/03/2026 revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include the following: Epilepsy, unspecified, not intractable without status epilepticus (brain disorder characterized by recurrent episodes of abnormally increased neuronal discharge, leading to transient sensory, motor, or psychic dysfunction), unspecified intracranial injury with loss of consciousness status unknown, initial encounter (Traumatic brain injury), and other seizures. Record review of Resident #8's Order Summary Report dated 03/03/2026 revealed, under Laboratory, Order Summaries stating, Monthly Dilantin Level one time a day starting on the 21st and ending on the 21st every month related to UNSPECIFIED CONVULSIONS., Monthly Keppra Level one time a day starting on the 21st and ending on the 21st every month related to UNSPECIFIED CONVULSIONS. Record review of the clinical record for Resident #8's laboratory record results revealed the following: There were no laboratory record results found for January 2026 or February 2026 for Resident #8. During an interview on 03/04/2026 at 04:00 PM the DON stated she was unable to locate laboratory results for Resident #8 for January 2026 or February 2026, completed by the facility. The DON stated she contacted the laboratory the facility used, and the laboratory results were not drawn for those months by the laboratory. The DON stated she did not know why the laboratory results were not drawn as she was not working at the facility at that time. During an interview on 03/05/2026 at 02:00 PM the DON stated she had worked at the facility as the DON since February 2025. The DON stated the ADON was responsible for ensuring laboratory orders were completed for each resident that had monthly laboratory orders. The DON stated the facility was working on a system for ensuring laboratory results were completed when ordered. The DON stated she received notifications via email when a laboratory order was scheduled. The DON stated she did not know if the ADON received notification of Resident #8's scheduled laboratory orders from January and February 2026 since she was not working at the facility at that time. The DON stated she was not aware the laboratory orders were not completed for Resident #8 for January and February 2026. The DON stated it was her expectation that laboratory orders were completed according to the physician's orders. The DON stated all nursing staff were trained on reviewing physician orders. The DON stated she planned to review all laboratory orders for residents in the future to ensure they were completed. The DON stated it was important to ensure laboratory orders were completed to monitor medication levels so changes could be made, and to prevent incidents from occurring such as seizures. During an interview on 03/05/2026 at 2:15 PM the ADON stated she had worked at the facility since November 2025. The ADON stated it was the previous DON's responsibility to ensure laboratory orders were completed. The ADON stated she was never trained to complete laboratory orders or to ensure they were completed. The ADON stated the facility had a roster of residents with laboratory orders to track current laboratory orders. The ADON stated the facility was working on a new system to ensure laboratory orders were completed. The ADON stated she was not aware laboratory orders were missed for Resident #8 in January and February 2026. The ADON stated she did not receive training from the previous DON on reviewing laboratory orders and the process of ensuring they were completed. The ADON stated it was her (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation that laboratory orders were completed as ordered by the physician. The ADON stated if laboratory orders were missed, the facility could have missed something critical, and it was important to obtain a new laboratory order as soon as possible, if one was missed. During an interview on 03/05/2026 at 02:30 PM the ADM stated the DON and ADON were responsible for ensuring laboratory orders were completed as ordered by the physician. The ADM stated the facility went through a staffing change with the DON, and he was not sure why Resident #8 did not have laboratory results completed for January or February 2026. The ADM stated he did not know what system was in place to ensure laboratory orders were completed, but the facility was working on a new system to monitor it more closely. The ADM stated it was his expectation that every laboratory order was drawn per the physician orders. The ADM stated all nursing staff received training pertaining to following and reviewing physician orders. The ADM stated he was not aware the laboratory results were not completed for Resident #8 for January or February 2026. The ADM stated it was important for laboratory results to be drawn as ordered by the physician to ensure residents were monitored and to prevent injuries and incidents from occurring. Record Review of the facility's policy titled, Lab and Diagnostic Test Results - Clinical Protocol, revealed the following:Assessment and Recognition1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.2. The staff will process test requisitions and arrange for tests.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #41) reviewed for infection control. The facility failed to ensure Resident #41's room had clear signage regarding Enhanced Barrier Precautions (EBP). This failure could place residents at risk for cross contamination and infection. The findings included: Record review of the face sheet for Resident #41, dated 03/05/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: peripheral vascular disease (poor circulation), insomnia (sleep problems), and acute upper respiratory infection. Record review of the quarterly MDS assessment for Resident #41, dated 12/02/25 revealed Resident #41 had a BIMS score of 15 which indicates his cognition was intact. Record review of the order summary report for Resident #41, dated 03/05/26, revealed an order: Enhanced Barrier Precautions: daily wound care every shift with a start date of 01/19/26. Record review of the care plan for Resident #41, last care plan review completed 03/03/26 revealed: Focus: Enhanced Barrier Precautions Will be used due to indwelling and non-intact skin, or when coming in contact with blood, body fluids, mucous membranes or non-intact skin. With an initiation date of 01/19/2026. During the initial tour observations on 03/03/26 at 10:10 AM, Resident #41's room was observed with no PPE box outside the room and no signage on the door regarding EBP. During an observation on 03/03/26 at 11:37 AM, Resident #41's room was observed with no signage on the door regarding EBP. During an interview on 03/03/26 at 11:38 AM, Resident #41 stated sometimes staff wore a gown when providing care to him and sometimes they did not wear a gown. Resident #41 stated he did not know why the staff wore a gown for his care at times and not at other times. During an interview on 03/05/26 at 10:18 AM, LVN B stated the EBP signs were supposed to be taped on the doors to the residents' rooms. LVN B stated sometimes the signs would fall off. LVN B stated the ADM would usually go around the facility to ensure the EBP signs were on the doors they needed to be on. LVN B stated everyone was responsible for ensuring the residents who were on EBP had a sign on their door. LVN B stated a potential negative outcome to the residents was a risk for infection going in their room with no PPE on. During an interview on 03/05/26 at 10:23 AM, the DON stated she was responsible for ensuring EBP signs were replaced when they fell off of a resident's door. The DON stated she did not know about the prior staff training on EBP due to her only being in the DON role for 2 weeks. The DON stated she did not know why Resident #41 did not have a sign for EBP on his door. The DON stated a potential negative outcome to the residents was a risk for infection. During an interview on 03/05/26 at 2:13 PM, the ADM stated he expected residents who were on EBP to have a sign on their door. The ADM stated he walked around the facility every morning and would check for the EBP signs on the doors and would replace them if necessary. The ADM stated the signs would fall off easily due to being taped onto the door. The ADM stated all of the staff were responsible for ensuring the EBP signs were put back on the doors when they fell off. The ADM stated an in-service for EBP was done recently at the facility. The ADM stated a potential negative outcome was the spread of infection. Record review of the facility policy title, Enhanced Barrier Precautions, dated August 2022 reflected the following: Policy StatementEnhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.Policy Interpretation and Implementation1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. Record review of the CDC website regarding EBP guidelines, https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html reflected the following: -Post clear signage on the door or wall outside of the resident room indicating the type of precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and required PPE.-For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves.