STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675925	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Mildred & Shirley L Garrison Geriatric Educati	3710 4th St Lubbock, TX 79415

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident representative when there was a change in the resident's physical, mental, or psychosocial status for 1 resident (Resident #1) of 3 residents reviewed for notification of change of condition. The facility failed to notify Resident's #1 physicians, or representatives that Resident #1 had notified staff of feeling as if something was stuck in her throat, on 4/24/24. This failure could affect residents by causing their physician and representative to be unaware of changes in residents' condition. Findings include: Record Review of Resident #1's undated face sheet revealed a [AGE] year-old female, originally admitted on [DATE]. Resident #1 had a history of cognitive communication deficit, aphasia (inability to swallow), muscle wasting, cerebral infarction (disrupted blood flow to the brain), dysphagia (difficulty swallowing) and esophageal obstruction (malformation in which the esophagus is interrupted). Record review of Resident #1's Minimum Data Set (MDS) dated [DATE], Section C- Cognitive Patterns revealed a (Brief Interview of Mental Status (BIMs) score of 5, which indicates resident had severe cognitive deficit. MDS Section K- Swallowing/Nutritional Status revealed Swallowing disorder, signs and symptoms of possible swallowing disorder . B. Holding food in mouth/cheeks or residual food in mouth after meals. C. Coughing or choking during meals or when swallowing medications. D. Complains of difficulty or pain with swallowing:. Record review of Speech Therapist notes dated 4/24/2024 revealed Resident #1 appropriately engaged in conversation and use intonation well and gestures following cues. Resident #1 fed self slowly. She appeared distracted by TV and benefited from verbal cues. Resident #1 did not consume large amount of her breakfast. She did not demonstrate s/sx (signs and symptoms) of aspiration/penetration today. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 5/3/2024 at 08:30 am of a video time stamped 4/24/2024 at 12:32pm, revealed two staff members (CNA A and CMA A) in Resident #1's room. Resident #1 was offered medication by CMA A and she stated no, no, no. CMA A asked the resident if something was wrong. Resident #1 stated yeah. CMA A asked Resident #1 if she was going to throw up, and Resident #1 stated yeah. CNA A gave Resident #1 the trash can. CMA continued to ask Resident #1 if her throat was hurting, and resident stated yeah. CMA A asked the resident if something was stuck in her throat, and Resident #1 stated yea. CMA A told the resident to hold on. Record review of Resident #1's progress note dated 04/24/2024 author CMA A revealed the following: * 17:03(5:03pm.) Type: eMAR-Medication Administration Note Text: pt not feeling well. *16:16(4:16pm.) Type: eMAR-Medication Administration Note Text: pt not feeling well. Record review of Resident #1's progress note signed by LVN A dated 4/25/2024 revealed 08:15 (8:15am) Type: Nursing Note Text: Resident #1 is complaining of having something stuck in the right side of her throat. Pt has requested to got to the hospital. ADON and family notified. Record review of Speech Therapist notes dated 4/25/2024 revealed .Resident #1 repeatedly pointed to her throat. Speech therapist modeled using the communication board and Resident #1 pointed to the choking. Following question from Speech Therapist, Resident #1 agreed that she felt she had something in her throat . LVN A alerted. Record review of Resident #1's care plan revised on 4/26/2024 and an initial date of 01/17/2019 revealed the following interventions, Monitor/document/report to MD (doctor of medicine) PRN for s/sx (signs and symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Resident #1 had swallowing problem r/t dysphagia & esophageal obstruction. Crush medications per residents' request to assist with swallowing. Record Review of Resident #1's Emergency Center Physician Documentation documented by MD E dated 4/25/2024 at 09:04AM revealed The patient present with throat pain worsening X4 days. Associated difficulty swallowing. EMS reports history of CVA (Cerebral Vascular Accident, interruption of blood flow to the brain), right sided deficits, and esophageal strictures. The onset was 4 days ago. Review of Symptoms revealed Respiratory symptoms: No shortness of breath. Gastrointestinal: No vomiting. On exam, patient is in no acute distress. She is at baseline- able to answer questions with yes/no. No foreign body noted on visual inspection. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with family member (FM D) on 5/1/2024 at 5:08 pm, stated on 4/23/2024 the resident had refused the second spoonful of crushed medication mixed with jelly because she felt that something was stuck in her throat. They stated after that the resident refused her medication and meals and only drank sips of water for the next few days. FM D stated resident had expressed concerns with her throat days before she requested to be taken to the ER. On 4/25/24 they stated a FM D was on the phone with Resident #1 and the family was able to notify the CNA in the room that the resident had something stuck in her throat. They stated when asked if resident wanted to be taken to the ER, the resident said yeah. FM D stated resident was unable to verbalized words but can say yeah and no. They stated Resident #1 had a previous incident years ago where food got stuck in her throat and that was when they found out she had a narrow esophagus. FM D stated resident did not have any respiratory distress and was stable when she was brought into the ER. FM D stated they had cameras in the resident's room and had reviewed the videos of days prior to resident being taken to the ER. During an interview with Resident #1 on 5/1/2024 at 5:44pm, Resident #1 stated no when asked if she had good care at the facility. Resident #1 unable to detail care at the facility due to speech deficit. During an interview with the nurse practitioner (NP A) on 5/2/2024 at 10:35pm, she stated she was not notified of Resident #1 complaining of something being stuck in her throat prior to 4/25/24. She stated she was notified of Resident #1's condition on 4/25/24 after she had been sent to the ER. She stated her expectation of staff at the facility, was to be notified when there are any changes to resident status. She stated she did not believe the facility had fault in the resident going to the hospital as it was a progression of her esophageal stricture, but they should have notified her of resident's symptoms. During an interview with the Speech Therapist (ST A) on 5/2/2024 at 11:30 am, she stated Resident #1 had a history of aphagia and was able to verbalize the words yeah and no. She stated she saw the resident daily and assisted her with her dysphagia, worked through her expressions and utilization of a communication board. She stated on 4/25/2024 Resident #1 pointed to her tongue and teeth and then to the garbage can on her bed. She stated the resident denied being nauseated or throwing up. She stated they utilized the communication board, and the resident was able to point to the choking sign. She stated she encouraged the resident to cough. She stated the resident gestured to having this symptom for the week. She stated she worked with Resident #1 all week and had not seen the resident cough or choke during their time together and Resident #1 never showed any signs of distress, or agitation, so I was surprised to learn she had this issue for almost 3 days. She stated the resident's family member facetimed and stated the resident was not sick, and she had something stuck in her throat. I talked to Licensed Vocational Aide (LVN) A and let her know about the resident and at that point I let the nurse take over. She stated she typically worked with the Resident #1 for 30 minutes every day and prior to 4/25/24, she had seen the resident take her medication without difficulty. She stated the resident does not typically eat the food at the facility and preferred the snacks her family brought, and they do not always line up with scheduled mealtimes. She stated staff will notify the ST if the resident was having trouble with choking or swallowing so they can address the change in status and re-assess as needed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 5/2/2024 at 12:02 pm, she stated she had cared for Resident #1 on 4/24/24 and 4/25/24. She stated on 4/25/2024 the ST had notified her of the resident choking. She stated the resident was able to talk and was gesturing to her throat. I asked her if she was okay, and she said no. When I asked her if she had something stuck in her throat, she said yes. The resident had a drink of water but continued to have the same sensation. I asked her if she wanted to go to the hospital and she said yes. She stated Resident #1's family was on the phone and stated if Resident #1 wanted to go to the ER, then something must be wrong. I notified the ADM, ADON and DON but I myself did not notify the physician. She stated the resident did not exhibit any signs of choking, drooling, or pointing to her throat on 4/24/24. She stated she was unaware CMA A had documented Resident #1 was not feeling well on 4/24/24 at 15:03 (12:03pm). She stated the CMA A should have notified her of Resident #1 not feeling well. During an interview with CMA A on 5/2/2024 at 12:35pm, she stated she had worked 4/23, 4/24 and 4/25/2024. She stated she took care of Resident #1 on 4/24/24. She stated on 4/24/24, Resident #1 had complained of something being stuck in her throat. She stated There was an aide in there helping her, I came in to give her, her meds, she didn't want to take her meds, she was trying to tell us something. I asked her if it was her throat, I asked if it was hurting, and she said yes and then no. She was holding her throat. CNA A called the nurse, and I didn't give her medication and CNA stayed with her. LVN A was the nurse that day. I did not tell LVN A of Resident #1 complaining since the aide was doing it already. During an interview with CNA A on 5/2/2024 at 1:03pm., she stated she took care of Resident #1 on 4/24 and 4/25/24. She stated Resident #1 had not complained of something being stuck in her throat at all until the morning the resident went to the hospital. She stated ST was the one to notify the nurse of the resident's complaint. We asked the resident if she had to throw up and she said yea, so we gave her a trash can. She stated Resident #1 was not struggling to breath and was able to say yeah's and no's in her normal communication manner. She stated the resident was calm even when EMS got there. She stated this occurred shortly after breakfast on 4/24/2024. During an interview with Operations Manager A on 5/2/2024 at 3:30pm, he stated on 4/25/2024 Resident #1's family had face timed the ST and that was when he learned of the issue. He stated he reviewed the speech therapist documentation for the week and there were no issues with the residents swallowing the days prior to 4/25/24. He stated his expectation of his staff was to be notified of changes, and to provide some treatment, call physician and DON. He stated facility staff is trained to report resident changes. He stated negative consequences of not reporting are any number of negative outcomes, depending on the issue. He stated staff communicate verbally and should document that interaction. During an interview with the DON on 5/2/2024 at 3:40pm, she stated Resident #1 had no complaints regarding her swallowing. She stated Resident #1 had been seen by the MD D the day prior to her going to the ER. She stated the resident had been eating fine, and speech therapy worked with her every day and no concerns had come up at that time. She stated she was not surprised that she had this issue due to her history, but it was unexpected that the resident had stated she had this issue for a few days beforehand. She stated once the staff knew the resident was having this issue, the resident was sent to the ER, and she was notified. She stated staff was trained to report change in resident conditions. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on 5/2/2024 at 4:01pm, he stated Resident #1 can alert staff when something was wrong, and she can refuse care that she does not want. He stated on 4/25/24 I was called by the nurse stating Resident #1 wanted to go to the ER and that is out of character for her. By the time I made it here, and I had gone to speech therapy to have them assess her to see what was going on. We were unable to clear her throat, so we sent her to the ED. Resident #1's family called and told us she had a pill stuck in her throat, but her pills had been crushed. The resident did not let us know anything was going on prior to 4/25/24. During an interview with CNA B on 5/3/2024 at 9:46 am, she stated she had worked 4/24/2024 with CMA A, LVN A, and CNA A. She stated any changes in resident status would be reported to LVN A. She stated she took care of Resident #1 on 4/24/24 and the resident did not complain of anything to her. She stated Resident #1 refused her lunch and supper, but she ate her snacks. She stated CNA A did not mention any changes in Resident #1's status that day. She stated she was trained to report, and she would report to her charge nurse, ADON, DON and ADM. She stated residents with a history of esophageal concerns she watched them drink, eat and if they are having trouble swallowing then it should be reported. She stated if a resident stated they had something stuck in their throat, she would automatically get the nurse. During an interview with ADON on 5/03/2024 at 10:09 am, he stated staff should be reporting any Resident changes to the provider, charge nurse and DON. He stated the CNA's report any changes or concerns to the charge nurses. He stated both staff members should have reported and not make assumptions of who is reporting. He stated he was not aware of anything prior to 4/25/2024. During an interview with CMA A on 5/3/2024 at 10:43 am, she stated on 4/24/2024 after Resident #1 told them she had something stuck in her throat, she stated CNA A was calling the charge nurse and she stepped out to complete med pass. She stated she did see CNA A call LVN A and let her know they were in Resident #1's room. She stated she does not remember if Resident #1 had been assessed by LVN A. She stated she was not aware the resident's condition had not addressed until 4/25/24. She stated she assumed they had taken care of her and the issued had been addressed. She stated she was aware of Resident #1's history of esophageal strictures (abnormal narrowing of the esophageal lumen). She stated she has been trained to report changes in condition and she follows her chain of command which is letting the charge nurse know first. During an interview with CNA A on 5/3/2024 at 10:47am she stated, So I was confused as to who was in the room with me that day on 4/24/24. CMA A was in there with me because I didn't understand what the resident was trying to say. I asked the resident if she was going to throw up, and the resident said yea, yea so I gave her the trash can. CMA A asked the resident if she was choking, and the resident said yea. Resident #1 was not gasping for air, she wasn't purple, she wasn't' in distress and she was very calm. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I contacted LVN A, by calling her right away, and I told her Resident #1 was stating she was choking. LVN A went into the room right away, but I don't know what happened after that. I had a partner CNA B, who also helped me with the residents that day, so I don't know if Resident #1 told her anything more. The rest of the day on 4/24/24 I did not know of anything else regarding the resident. She stated she had thought this occurred the day Resident #1 went to the hospital, but she remembered this occurred when she was passing out lunch trays and Resident #1 went to the ER the morning of 4/25/2024 not during lunch on 4/24/24. She stated she was trained to report changes in resident status to the charge nurses, and she was trained to report right away. She stated if the charge nurse was not available, she would report the ADON or another charge nurse. During an interview with LVN A on 5/3/2024 at 11:05 am, she stated she does not recall anyone calling her on 4/24/2024 in regard to Resident #1's change in condition. She stated she did go see her on 4/24/24 and Resident #1 had refused her food but Resident #1 often refuses her food. She stated Resident #1 just said no to her tray. She stated CNA A did not notify her of Resident #1 having something stuck in her throat. She stated she did not notice any changes in Resident #1's behavior on 4/24/24. She stated she did not learn of Resident #1's change in condition until 4/25/24. She stated she was trained to report and reports to her chain of command. She stated if she had been notified on 4/24/24 she would have assessed the resident, notified the physician, the ADON and OP. She stated she was unaware of Resident #1 not feeling well the day prior and was not given any notification by any staff members. She stated when she saw the resident, she was her usual self. Record review of Facility policy titled Significant Change in Condition, Response with a revision date of 1/2022 revealed the following: .1. If at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the licensed nurse or nurse supervisor should be made aware. Examples would be the following (but not limited to): change in ability to or decline in physical function, change in ability to eat, or drink .change in medical condition . 2. The Nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with residents' provider.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 04033 Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 5 hallways (Hall 200) reviewed for safe environment, in that: The facility failed to ensure Hall 200 was free from pervasive foul odors. This failure could place residents at risk of a diminished quality of life and decline in self-worth. Findings include: Observation on 04/30/24 at 8:30 am, Hall 200 had a strong foul urine smell. Once past hall 200's double doors, there was a section of carpet that measured approximately 74 feet long by 23 feet wide. On the opposite end of this hall there was a section of carpet that measured approximately 68 feet long by 18 feet wide; and between these carpeted areas there was a dining area that was used by the residents for their meals, activities, therapy, or a place to sit throughout the day. Observation of Resident #2 on 04/30/24 at 8:30 am indicated she was sitting at a dining table receiving therapy with lingering foul odor. Resident #2 was asked questions specific to the foul odor in her hallway; however, she did not respond to questions asked of her. Observation of Resident #5 on 04/30/24 at 8:32 am indicated he was sitting in his wheelchair in the dining area with lingering foul odor. Resident #5 was asked questions specific to the foul odor in her hallway; however, he did not respond to questions asked of him. Observation and interview with Resident #3 on 04/30/24 at 8:40 am revealed she was sitting at a dining table eating her snack with lingering foul odor. Resident #3 was asked questions specific to the foul odor in her hallway; however, her responses to questions asked of her were unclear and inappropriate. Observation of Resident #4 on 04/30/24 at 8:45 am indicated he was sitting in his wheelchair in the dining area with lingering foul odor. Resident #4 was asked questions specific to the foul odor in her hallway; however, but his responses were not understood. During an interview on 04/30/24 at 8:27 am with LVN B, indicated there was a bad odor that smelled like urine on hall 200. During an interview on 04/30/24 at 8:27 am with LVN C, indicated there was a bad odor that smelled like urine on hall 200, and the smell linger throughout the day. During an interview on 04/30/24 at 11:43 am with LVN D, indicated she noticed the foul odor every time she entered hall 200. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/02/24 at 8:59 am upon entering past the double doors into hall 200 there was a foul odor, and there were residents in the hallway and dining area. During an interview on 05/02/24 at 9:00 am, with DON, she stated there was a foul odor in hall 200. During an interview on 05/02/24 at 11:00 am maintenance supervisor (MS A), stated there was a foul odor in hall 200. MS A said the carpet in hall 200 was the same one that was installed when the facility was built in 2001. During an interview on 05/02/24 at 1:15 pm the Operations Manager (OM A), indicated he was aware the carpet in hall 200 had a foul odor, and he had a discussion with corporate staff, and they said they were planning to replace it. During an interview on 05/02/24 at 1:37 am with housekeeping supervisor A, stated there was a foul odor in hall 200, and the odor contines even after it's cleaned. During an interview on 05/02/24 at 2:15 pm family member B, indicated hall 200 had a strong sour odor, which bothered her because a facility should smell clean. During an interview on 05/02/24 at 2:27 pm family member A, indicated hall 200 had a strong urine smell. During an interview on 05/02/24 at 4:14 pm family member C, indicated hall 200 had a strong urine smell. During an interview on 05/02/24 at 7:20 pm CC A's technician (CT A), indicated the last time he cleaned the carpet in hall 200 was 09/28/23. CT A informed the facility's staff the foul odor was between the carpet and the concrete and shampooing it would not eliminate this odor. Review of CC A's Invoice dated 09/28/23 indicated the facility's carpet was shampooed via a steam cleaning. Review of facility's policy and procedure specific to Resident Rights dated 2023, indicated residents Safe Environment included the right to a safe, clean, comfortable and homelike environment.