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	09/12/2024

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

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on Interviews and record review, the facility failed to implement their written policies and procedures to prohibit and prevent abuse and neglect for 2 (Resident #1 and Resident #2) of 7 residents reviewed for abuse and neglect. A. The facility failed to report and investigate the allegation of verbal abuse that was alleged by Family Member C on 08/31/24 involving Resident #1 and CNA A. B. LVN F failed to immediacy report an allegation of verbal abuse. C. The facility failed to report and investigate the allegation of exploitation that was alleged by CNA B on an unknown date in September 2024 involving Resident #2 and CNA A. This failure could place residents at risk of reoccurring abuse and exploitation. Findings Included: Resident #1 Record review of Resident #1's face sheet, dated 09/12/24, revealed an [AGE] year-old male was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit (language or speech deficit), depression (sadness), need for personal care and dementia (memory loss). Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: *Section C Brief Interview for Mental Status score revealed a score of 11, which indicated the resident's cognition was intact. *Section B. Ability to understand others revealed that she had clear speech, could make himself understood, and could understand others. Record review of Resident #1's progress note dated 09/01/24 at 06:35 AM written by LVN F documented: (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 called a staff member (CAN A) a CNA a derogative term while speaking to her and about her and stated she was lazy and does not help him or give him showers when in fact she always gives him a shower the same time each week. An incident occurred while in the shower the day prior to where this resident had a bowel movement on the floor and was cursing at the CNA (CNA A) and calling her names from what was reported by her, this nurse (LVN F) informed the CNA (CNA A) to make a statement on the resident as to what exactly happened. Resident #1 called Family Member C and informed her of the incident but gave her a different side of the story and Family Member C did not want to state exactly what was said but would speak to management about the situation this week. This nurse (LVN F) is informing the MD of the behaviors, and we are collecting a UA to rule out a possible UTI due to this not being his normal behavior pattern. Will continue to monitor his behaviors or any changes and incidents that may occur. During an interview on 09/11/24 at 1:35 PM, LVN F stated she was unsure of the exact date of the incident but that she documented the incident in Resident #1's progress notes. LVN F said she was on lunch the day of the incident when CNA A gave the resident a shower. She said CNA A pulled her to the side and reported Resident #1 was cursing at her because he had a bowel movement during the shower. She said CNA A reported that Resident #1 called her a bitch. LVN F said she instructed CNA A to write a statement. She said she did not follow up to see if CNA A wrote a statement. LVN F said did spoke to Resident #1 the day of the incident and checked to see if he was ok. LVN F said Resident #1 was upset and called CNA A a fat bitch and called her lazy. LVN F said CNA A worked her entire shift the day of the incident. LVN F stated later the same day that Family Member C pulled her to the side and reported to her that CNA A had called Resident #1 a name. LVN F said Family Member C never specified what names CNA A allegedly called Resident #1. LVN F said Family Member C stated she did not want to involve LVN F. LVN F said Family Member C was upset when she reported the incident, but she believed it was because Resident #1 was upset. LVN F said she did not report the incident to the ADM and DON because they were not present in the facility when it occurred on the weekend. She stated the following Monday after the incident she did report it in the morning standup meeting. LVN F stated the ADM and DON marked it down and made note of it. LVN F said she would consider Family Member C's report to her an allegation of abuse, and at the moment, Family Member C was listening to Resident #1's side. LVN F said she had been trained on the facility's ANE policy. She said if she suspected or witnessed abuse, she had been trained to report abuse to the ADON right away. LVN F said there was no reason why she did not report it immediately but thought they (she and Family Member C) were waiting on the urine sample as they thought Resident #1 was acting out of character. During an interview on 09/11/24 at 9:54 AM, Family Member C stated on a Friday night on 08/30/24, Resident #1 told her what happened between him, and CNA A. Family Member C said Resident #1 had diarrhea. On 08/31/24, CNA A showered Resident #1, and a verbal incident occurred. She stated Resident #1 told her that he had a bowel movement while in the shower, and CNA A said, Omg, this is nasty. I am not cleaning it up. She said Resident #1 said that CNA G started to clean up the feces, and eventually, CNA A began to help. Family Member C said Resident #1 stated this was the second time CNA A had humiliated him. Family Member C said she reported the concern to LVN F. She said she was told by LVN F that she would address CNA A but was unsure if she had spoken with CNA A or not. She said when she told LVN F about the incident, she was concerned and expressed that she had concerns about verbal abuse. She said no one ever followed up with her about the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/24 at 1:55 PM, Resident #1 stated that CNA A was mean to him. He said CNA A was slow and lazy and yelled at people. He said he had a bowel movement while in the shower, and CNA A stated she would not clean up the bowel movement. Resident #1 said CNA A was mean about it and could tell by how she said the statement. Resident #1 said he called and told Family Member C about it but never told anyone else about the incident. Resident #1 said he felt safe, and that the incident never happened again. Resident #2 Record review of Resident #2's face sheet, dated 09/12/24, revealed an [AGE] year-old male was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit (language or speech deficit) and Alzheimer's disease with an early onset (memory loss). Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: *Section C Brief Interview for Mental Status score revealed a score of 13, which indicated the resident's cognition was intact. *Section B. Ability to understand others did not reveal any data. Record review of Resident #2's progress notes dated from 07/11/23-09/12/24 did not reveal any information related to the exploitation allegation. During an interview on 09/11/24 at 2:36 PM, CNA B stated she had reported concerns to upper management, specifically ADON D and ADON E, regarding CNA A. She said a week ago (unknown specific date) she noticed Resident #2's coffee was being used faster than normal. CNA B stated that she reported her concern to both ADONs (D and E) and was told that they would look into the situation. CNA B said she had heard things about CNA A related to her resident care, specifically about not taking residents to the toilet like she was supposed to. She stated she did not report it to the DON or ADM because she did not see it firsthand. CNA B said she was unsure if CNA A was placed on leave or if the incident was investigated. During an interview on 09/11/24 at 3:44 PM, ADON D stated he had no concerns with CNA A regarding residents, but CNA B expressed concern. ADON D stated CNA B reported to him (date not specified) that she and CNA A had a verbal altercation concerning coffee that belonged to a resident. ADON D stated that he asked both staff what happened and deduced that it pertained more to professionalism and that he verbally counseled CNA A regarding the matter. ADON D stated he did not look further into the situation because there was no coffee around when he spoke with the staff. He stated he did not speak with Resident #2 about his coffee. He stated that he expected the abuse policy to be followed and that if staff witnessed or suspected abuse, they should report it immediately. During an interview on 09/11/24 at 4:03 PM, Resident #2 did not reveal any additional indications of deficient practice. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/24 at 4:42 PM, ADON E stated she had not received any complaints about CNA A outside of CNA preference for day-to-day activities. She said she had not received any allegations of ANE. She stated no one reported any ANE allegations in their morning meetings. She said she was unaware of an incident that involved CNA E and Resident #2's coffee. ADON E stated she was unaware of the incident that allegedly occurred between Resident #1 and CNA A. ADON E stated she had been trained on the facility abuse policy and that any suspicion of ANE should be reported to the ADM so that an investigation can be conducted. She stated if there were an allegation of ANE, the AP would be suspended until everything was cleared. ADON E stated she was unaware of any recent investigations regarding CNA A. She said she believed the reason the incidents was not investigated was because it was not reported. She said the purpose of following the abuse policy was to prevent abuse and injuries. ADON E stated that she could not think of a reason why staff would not report incidents of ANE. She stated all staff were responsible for following the ANE policies. She stated she could not name a potential negative outcome because it depends on what was reported. She said their system to monitor ANE was through in-services with staff. During an interview on 09/11/24 at 4:57 PM, the ADM stated that he was unaware that there were any allegations of abuse regarding Resident #1. He stated in a morning meeting (unsure of the date) that it was brought to their attention that Resident #1 had used racial slurs when talking to the staff. He stated his focus when it was brought to him was how the CNAs responded. He stated it was told to him that the CNAs did not respond to Resident #1. The ADM stated he did not speak to Resident #1 or any staff about the incident but knew shortly after the resident was diagnosed with a UTI. The ADM stated he was unaware that Family Member C had verbalized concern. The ADM stated he was unaware of an incident between CNA A and B over Resident #2's coffee. The ADM stated that ADON E and CNA B brought this to his attention on 09/11/24. The ADM stated that when it was brought to his attention on 09/11/24, he was only told about the verbal altercation between CNAs A and B, not about Resident #2's coffee potentially being used for other residents and staff. The ADM stated he was unaware of both allegations and expected all allegations of ANE to be reported to him as the abuse coordinator as soon as possible. He stated the potential negative outcome was abuse could happen without them knowing. The ADM stated he had been trained on the facility abuse policy. The ADM stated he had not observed CNA A being rude or mistreating residents. The ADM stated all staff were responsible for reporting allegations of abuse. During an interview on 09/11/24 at 5:06 PM, the DON stated she was unaware of the incident involving CNAs A and B over Resident #2's coffee. The DON also said she was unaware of the incident that involved Resident #1 and CNA A. The DON stated the only incident she was aware of was that Resident #1 became upset when CNA A took her breaks with another staff member. The DON stated the potential negative outcome of not following the abuse policy was that the allegation would not be investigated if the staff did not report it. The DON stated she did not feel these instances were not the case because these instances were rumors. She said even rumors of ANE should have been reported so that the allegations could be reported. The DON said she had been trained on the facility abuse policy. She said all staff are trained on the abuse policy upon hire, annually, and each time there was an allegation of abuse. She said she had not observed CNA A be rude to residents or staff. The DON said that it was her expectation that all allegations of abuse should be reported to the ADM and then to her if he was unavailable. She said everyone was responsible for following the abuse policies. She said if the incident had been reported, the AP would have been suspended until the allegation was investigated. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/24 at 5:21 PM, CNA A stated she was unsure of the date of the incident, but the incident with Resident #1 occurred on or about a week before her interview. CNA A stated she proceeded to give Resident #2 a shower after lunch. She stated Resident #1 had a bowel movement and explained that she needed to clean up the mess. She stated the resident then proceeded to call her a nigger and a bitch. CNA A stated Resident #1 said he had already taken too long to shower. She stated that Resident #1 was mad. She said that after this, she continued to shower Resident #1. She said that as soon as the incident happened, she reported it to LVN F. She stated that she had even asked therapy if they had any issues with Resident #1. She stated LVN F wanted her to write a statement. She said she did not write a statement. She reported the incident to ADON D. She said she believed LVN F wrote a statement but ultimately decided to check Resident #1 for a UTI. CNA A stated no one came to her and asked her any questions about the incident outside of her reporting the incident to LVN F and ADON D. She said LVN F told her that Family member C was upset about Resident #1 wanting his shower at a certain time. She stated she had never been suspended pending investigation. Still, she believed she did everything she was supposed to by letting the charge nurse and ADON D know. She stated that regarding Resident #2, CNA B assumed she was using Resident #2's coffee, but that was not true. She said she had never used Resident #2's coffee. She stated that ADON D talked to her about using the right coffee. During an interview on 09/11/24 at 5:36 PM, CNA G stated regarding the incident in the shower room involving Resident #1 and CNA, she did not know much about it as she walked in at the very end. She stated she heard Resident #1 calling CNA A a bitch while she was picking up his bowel movement off the floor. CNA G stated she had no concerns with ANE regarding CNA A. CNA G stated no one had talked to her about the incident in the shower room. She stated that regarding Resident #2's coffee, CNA B accused them of using Resident #2's coffee. She stated they never used them. She stated no one came to her and asked any questions about Resident #2's coffee. She said she had been trained on ANE and had no concerns regarding the facility. Record review of the facility policy, Abuse: Prevention of the and Prohibition Against, dated Dec. 2023 revealed: Policy It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. Prevention All personnel, residents, visitors, etc. are encouraged to report incidents and grievances without the fear of retribution. Identification Facility staff with knowledge of an actual or potential violation of this policy must report the violation (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to his or her supervisor or the Facility administrator immediately. The Facility will assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. This includes identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. Investigation All identified events are reported to the Administrator immediately. Reporting/Response All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.