

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675925	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER The Mildred & Shirley L Garrison Geriatric Educati		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36954</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal privacy was provided for 4 of 4 shower rooms reviewed dignity.</p> <p>1. The staff failed to provide privacy for Resident #1 and Resident #2 during showers by not having a shower curtain up or the shower curtain that was too small that it did not close all the way and exposing the resident.</p> <p>The failure could place residents at risk for diminished quality of life and loss of dignity and self-worth.</p> <p>The findings included:</p> <p>Resident #1:</p> <p>Record Review of Resident #1's face sheet revealed an [AGE] year-old female, who was admitted to the facility on [DATE] with a primary diagnoses of metabolic encephalopathy (an acute condition of global cerebral dysfunction in the absence of primary structural brain disease), acute cystitis (an infection of your bladder), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), type 2 diabetes (a condition in which the body has trouble controlling blood sugar and using it for energy), vitamin deficiency, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), depression, anxiety, high blood pressure, hypotension (low blood pressure), acid reflux, osteoarthritis (type of arthritis that occurs when flexible tissue at the end of bones wears down), muscle weakness, dysphagia (difficulty swallowing), cognitive communication deficit.</p> <p>Record Review of Resident #1's Admission MDS (Minimum Data Set) dated 11/22/2024 revealed Resident #1 listed with the BIMS of 2 meaning that Resident #1 had severe cognitive impairment.</p> <p>Resident #2:</p> <p>(continued on next page)</p>

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #2's face sheet revealed a [AGE] year-old female, who was originally admitted to the facility on [DATE] and currently admitted to the facility on [DATE], with a primary diagnoses of cellulitis (a common and potentially serious bacterial skin infection), dementia (a group of thinking and social symptoms that interferes with daily functioning), open wound on right lower leg, dysphagia (difficulty swallowing), anemia (a condition in which the blood does not have enough healthy red blood cells and hemoglobin), local infection, overactive bladder (a problem with bladder function that causes the sudden need to urinate), tinea unguium (a nail fungus causing thickened brittle, crumbly, ragged nails), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), vitamin deficiency, hypokalemia (low potassium), depression, heredity & idiopathic neuropathy (an illness where sensory and motor nerves of the peripheral nervous system are affected), polyneuropathy (a general term for a condition that affects multiple peripheral nerves throughout the body), high blood pressure, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), sick sinus syndrome (sinus node dysfunction, a group of heart rhythm abnormalities), pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), respiratory failure (when respiratory system cannot maintain normal levels of oxygen and carbon dioxide in the blood), xerosis cutis (dry skin), muscle weakness, difficulty in walking, repeated falls, cognitive communication deficit (a communication difficulty caused by a cognitive impairment), pain, need for assistance with personal care, presence of cardiac pacemaker.</p> <p>Record Review of Resident #2's Admission MDS (Minimum Data Set) dated 9/26/2024 revealed Resident #2 listed with the BIMS of 12 meaning that Resident #2 had mild cognitive impairment.</p> <p>During an interview with Resident #1 on 12/18/2024 at 1:27 PM. Revealed Resident #1 stated she does take showers on a regular basis. Resident #1 stated she had a broken leg and a knee replacement and must get help from the staff because she cannot do things like shower. Resident #1 stated she does not like to have to go to the shower room to get a shower because the curtain does not close all the way so when other people go in there, they see her naked. Resident #1 stated that full privacy was not provided. Resident #1 stated that the staff do not cover her with a towel, and the shower curtain does not completely close. Resident #1 stated that when she showers, people come in and out every time. Resident #1 stated that she had told staff that it makes her uncomfortable for the shower curtain not to close all the way. Resident #1 stated that staff tell her that they cannot do anything about the curtain not closing. Resident #1 stated that it makes her feel ashamed, embarrassed, and as though she does not get to say who saw her like that.</p> <p>During an observation of shower room on 500 hall on 12/18/2024 at 3:15 PM revealed the shower curtain on the left side with a blue shower curtain on a bar that would swivel back and forth. Observed the shower curtain did not fully close with approximately 5 inches left open. Observed the shower curtain was too small to cover the opening of the shower. Observed no shower curtain on the right side to cover the opening of the shower.</p> <p>During an observation of shower room on 400 hall on 12/18/2024 at 3:22 PM revealed the white shower curtain on the right side that did fully cover the opening of the shower. Observed no shower curtain on the left side. Observed screens on the left side that were lying against the wall.</p> <p>During an observation of shower room on 300 hall on 12/18/2024 at 3:31 PM revealed Observed the shower curtain on the right side was not big enough to cover the opening of the shower. Observed the shower curtain on the right side was not big enough to cover the opening of the shower.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of shower room on 200 hall on 12/18/2024 at 3:37 PM revealed CNA D came in the shower room and demonstrated how the shower curtain is usually used. CNA D swiveled the shower bar out straight with the shower curtain that was not big enough to cover the opening of the shower. Observed that half of the opening was visible to anyone that would open the shower door. Observed no curtain on the left side.</p> <p>During an interview with CNA D on 12/18/2024 at 3:40 PM. CNA D stated that he had been working in the facility since February 2024 and there had never been a shower curtain on one side and on the other side it had always been the same curtain that did not really fit. CNA D stated that he had worked other halls and it is the same way, so he assumed that it was supposed to be like that. CNA D stated that sometimes the staff will open the door, they will open the door and go into the shower room, or they will just state what they need and leave. CNA D stated that there is no lock on the door. CNA D stated that there is an in use door plate outside of the door and that is how other staff would know that someone is in the shower.</p> <p>During an interview with CNA B on 12/18/2024 at 3:49 PM. CNA B stated people are alerted that someone was in the shower room was the door plate indicated in use, and there were no locks on the door. CNA B stated that she did not use the shower screens because it was a fall hazard and could have caused someone to fall. CNA B stated that the shower curtains did not fit the entire time that she had worked there and that had been two years. CNA B stated that she had worked all the halls and it had always been that way, with either no shower curtain or a curtain that did not fit. CNA B stated that if someone opened the door the resident would be exposed. CNA B stated that staff have opened the door halfway and looked in the shower room to see if the shower room was being used. She stated if someone was in the shower room staff stated what they needed, but that did not always happen. CNA B stated that the resident could have felt embarrassed if they were exposed.</p> <p>During an interview with Resident #2 on 12/18/2024 at 5:42 PM. Resident #2 stated that she did not have issues currently with privacy in the showers, but she did a couple of months ago. Resident #2 stated when staff would help her shower the curtain would not close all the way. Resident #2 stated that when that happened it made her feel like she wanted to cover up.</p> <p>During an interview with CNA C on 12/18/2024 at 5:57 PM. CNA C stated that on some of the halls they did not have shower curtains at all and other halls the curtains were too short to stretch all the way across. CNA C stated this had been a problem since she had worked in the facility. CNA C stated that some of the residents refused a shower because they were not provided privacy. CNA C stated the residents that refused a shower would ask for a bed bath instead. CNA C stated that she had not reported this to anyone because she did not know who to report it to. CNA C stated that if she had thought about it the situation should have been reported to the maintenance by QR code. CNA C stated that when maintenance was called before the situation was usually not resolved. CNA C stated that she received training over privacy from the facility through in-services, every other week. CNA C stated if the shower room did not have a shower curtain, or the shower curtain did not close all the way to provide privacy the resident could become embarrassed.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON on 12/18/2024 at 7:15 PM the DON stated that she would have expected staff to provide privacy with closing the curtain and shutting the door. The DON stated that she would have expected the staff to report the missing and small sized shower curtains to herself or the Administrator. The DON stated that the staff had been trained with providing privacy through in-services, every other month. The DON stated that the negative potential outcome for not providing privacy for the residents would be that it may affect their self-esteem, dignity, and feeling embarrassed.</p> <p>Record review of facility provided policy, titled, Resident Rights, date amended 07/13/2017, revealed:</p> <p>As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States.</p> <p>Privacy and Confidentiality: You have the right to personal privacy and confidentiality of your personal and medical records. You have the right to</p> <p>personal privacy, including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>36954</p> <p>Based on observation, interview and record review, the facility failed to prepare food in a form to meet individual needs in 1 of 1 kitchen reviewed for dietary services in that:</p> <p>The facility failed to ensure puree meat was prepared to a smooth uniform texture.</p> <p>This failure could place residents at risk for choking.</p> <p>Finding include:</p> <p>During on observation on 12/18/2024 at 12:40 PM, the test tray sampled revealed the pureed meat had small pieces of meat in it and was not a smooth uniform texture.</p> <p>During an interview on 12/18/24 at 12:58 PM, the DM stated the pureed meat on the test tray look like mechanical altered meat. He stated the meat was not as smooth as it should be for a puree meal. He stated a resident that required a puree diet needed that type of diet so they could eat and not have food get stuck in their throat. He stated if a resident on a puree diet ate the meat from the test tray they could have choked. He stated [NAME] A was responsible for making the puree food because [NAME] A was certified in making puree food. He stated did not review the puree meal with [NAME] A before it was served due to [NAME] A being certified in puree food.</p> <p>During an interview on 12/18/2024 at 1:28 PM, [NAME] A stated residents placed on a puree diet could not swallow or chew. He stated the consistency of the puree food should be pudding like, smooth and not dry. [NAME] A stated that he did try the pureed food items before he served them to residents to ensure smoothness, no chunks, no bumps and flavor. [NAME] A stated the processor blade was not as sharp and was old, that he processed the meat for about 20 minutes before he served it. [NAME] A stated, There was always a nurse there with the resident when the residents ate the pureed food and if there was ever a problem, he would be more than willing to make them another plate, or if it were not up to their standards. [NAME] A stated there was always a risk for any resident as anyone could chock.</p> <p>Record review of facility policy Dietary Services dated only with a revised date 08/2007</p> <p>Subject: Food Sanitary Conditions for</p> <p>Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State and/or local authorities.</p> <p>Procedure:</p> <p>1. The facility will store, prepare, distribute, and serve food under sanitary conditions.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36954</p> <p>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 for residents who consumed food orally from 1 of 1 facility kitchen reviewed for dietary services in that:</p> <p>The facility failed to ensure [NAME] A used good hygienic practices while serving ready to eat food.</p> <p>Food contact equipment was not washed, rinsed, and sanitized in a sanitary manner.</p> <p>These failures could place residents at risk of foodborne illness.</p> <p>Finding include:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/18/24 at 11:30 AM, revealed [NAME] A walked away from the steam table and went to the back of the kitchen to the oven. He put an oven mitt on his right hand, over his disposable glove, and used his left hand to open the oven door with the disposable glove on his left hand. He removed a pan from the oven. He used his right hand with the oven mitt on it over the disposable glove. He used a food scoop to scoop food onto three plates, then returned the pan to the oven. He removed another pan from the oven and scooped pureed green beans on the plates and returned the pan to the oven. He placed the scoops on the three-compartment sink on a stack of dirty dishes, in a dirty pan needing to be washed. He returned to the oven and removed another pan from the oven and set it down on the prep table and walked over to get a foam container. He walked over to the three-compartment sink and removed the scoops from the dirty pan and used them to scoop food into the foam container. He returned the pan to the oven, closed the oven door. He returned to the steam line and continued to plate food. He did not change the gloves he had on, and he did not wash his hands. At 11:50 AM he stepped away from the steam table, walked to the back of the kitchen to the three-compartment sink, took a scoop out of the sink filled with liquid, shook the scoop off, and removed his gloves. He did not wash his hands and did not replace his gloves. He took three pans out of the oven and scooped pureed meat, mashed potatoes, and green beans on a plate, returned the pans to the oven, He left the plate on the prep table and walked away with the scoops in his hand and walked to the dish washing room and placed the scoops in the room. He returned to the back of the kitchen and took the plate from the prep table and carried it back to the steam table and scooped gravy over the meat on the plate. He walked away from the steam table and washed his hands, then reached in his left pant pocket and pulled out gloves and put them on. He returned to the steam table and continued serving food. At 11:59 AM he stepped away from the steam table and walked to the back of the kitchen. He opened the oven door, removed a plate from the oven, removed foil wrap from the plate, closed the oven door, returned to the steam table, scooped gravy over the meat and placed the plate on a tray for the food cart. He did not change gloves or wash his hands. At 12:07 PM he walked away from the steam table, over to a warmer, opened the warmer door, closed the warmer door, returned to the steam table, continued to serve food, and did not change gloves or wash his hands. At 12:15 PM he walked away from the steam table and got a bowl; then a container of a powder mixture, walked to the back of the kitchen to the sink area, placed his left hand with the glove on it under the running water, added water to the bowl, stirred the mixture, and walked to the microwave. He opened the microwave door and placed the bowl in the microwave. He closed the door and turned the microwave on. He opened the microwave door and removed the bowl. He placed the bowl on a prep table and covered the bowl with plastic wrap then carried the bowl to a tray for the food cart. [NAME] A removed his gloves, washed his hands, and returned to the steam table. [NAME] A did not put on gloves and served food on a plate. At 12:19 PM he walked to the dish washer room then walked to the back of the kitchen, opened the oven door, used the oven mitt, and removed pans. He scooped puree food onto a plate, he did not have gloves on, and returned to the steam table.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/18/24 at 12:58 PM, the DM stated The DM stated dietary staff should change gloves and wash their hands when they touched one food item and before touching the next food items. He stated staff that served food on the steam table should have washed their hands and changed gloves once staff leave the steam table or serving line and touched something else, then discard gloves and do it all over again (hand hygiene). He stated [NAME] A should not have returned to the steam table with the same gloves on. He stated that was not the facility procedure staff should have discarded gloves washed hands and started again. He stated [NAME] A shouldn't have served the cooked prepared food without gloves one. The DM stated once staff placed any items in the dirty sink or dirty area that staff should leave the items in the dirty area until washed. He stated [Cook A] did not handle or serve food the way the policy stated. He stated, Residents could get sick if dietary staff do not wash hands or practice hand hygiene.</p> <p>During an interview on 12/18/2024 at 1:28 PM, [NAME] A stated [NAME] A stated he was told by different state surveyors that dietary staff are not even supposed to wear gloves when serving food, but he would change gloves when he needed to. [NAME] A stated, He grabbed the food scoops from the dirty dish area because he felt the state surveyor was breathing down his neck and he didn't think about grabbing the scoops from the dirty area of the sink and that was a huge mistake on his part. [NAME] A stated there is a risk residents could get sick when he used a dirty food scoop from the dirty dish area. [NAME] A stated he was not sure of the facility policy as to when to wear gloves or wash hands but had heard nurses state staff are not supposed to wear gloves while they served food. [NAME] A stated he had not received in-service from the facility on when he should wash hands or change gloves.</p> <p>During an interview on 12/18/2024 at 2:25 PM, the DON stated she called the Dietitian for the facility, and the Dietitian stated she did in-service staff on hand hygiene a few months ago but was left with the previous dietary manager. She stated the dietary manager was conducting an in-service with the dietary staff on hand hygiene.</p> <p>During an interview on 12/18/2024 at 2:51 PM the ADON stated Once a year staff have to take yearly training and during that time [Cook A] took Infection Control - food service on 10/16/24 and passed the test 100%.</p> <p>Record Review of [NAME] A's yearly training transcript reflected he completed Infection Control - Food Services Focus on 10/16/2024 and competed the course with a grade of 100%. The course material titled Infection Control and Prevention in the Kitchen: Hand washing- hand sanitizers are not considered appropriate hand hygiene in the kitchen setting. Hand washing should occur, during these times but this list is not inclusive: when you enter the kitchen, each time after you touch your face, masks, hair nets, put your hands in your pockets, before handling any food, including food service, after handling food, including food preparation, before donning gloves to handle ready-to eat food, after any cleaning or trash removal activity.</p> <p>Record review of the facility policy Hand Hygiene dated 05/2007 with revision/review date(s) 6/2021; 1/2022; 10/2022; 12/2023</p> <p>Policy It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers preform hand hygiene, which is one of the most effective measures to prevent the spread of infection, based on the accepted standards. Residents, family, and visitors will be encouraged to practice hand hygiene.</p> <p>(continued on next page)</p>		

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