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	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Mildred & Shirley L. Garrison Geriatric Educat	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents were free of any significant medication errors for 1 (Resident #1) of 6 residents reviewed for medication administration. 1. The facility failed to ensure furosemide (Lasix) (used to treat conditions involving fluid retention) administered to Resident #1 as ordered from 5/9/2025-5/20/2025 (12 days). This failure could place residents at risk for not receiving medications as ordered by their physician. The findings include: Record review of Resident #1's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a readmission date of 5/09/2025. Resident #1 had a medical history of cellulitis (a common bacterial skin infection) of right lower limb, essential hypertension (high blood pressure), and infection and inflammatory reaction due to internal fixation (infection and inflammation from a surgical procedure used to stabilize and heal fractures by using metal implants). Record review of Resident #1's annual MDS dated [DATE] Section C- Cognitive Patterns revealed a BIMS score of 11, which indicated Resident #1 had moderate cognitive impairment. Record review of Resident #1's hospital Discharge summary dated [DATE] revealed Discharge medications . unchanged medications .furosemide 40mg tablet, Take 1 tablet by mouth daily aka Lasix. Document also revealed Resident #1 was admitted to the hospital on [DATE] and discharged back to the facility on 5/09/2025. Record review of Resident #1's physician orders revealed the following: Furosemide tablet 40mg, Give 1 tablet by mouth one time a day with an order date of 5/22/2025 and Furosemide 20mg Give 2 tablets my mouth one time a day with a start date 9/26/2024 and a discontinue date of 5/5/2025. Record review of Resident #1's medication administration record revealed Resident #1 received the following: Furosemide 40mg (two 20 mg tablets) from 5/1/25-5/4/25 and Furosemide 40mg tablet on 5/21/25-5/30/25 and 6/1/25-6/3/25. The administration record did not reveal Furosemide 40mg was administered to Resident #1 between 5/9/2025-5/20/2025. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #1's MD progress note dated 5/12/2025 revealed Daily subjective: She is awake, alert .Afebrile (no fever) vital signs stable .Lungs clear to auscultation (the action of listening to sounds from the heart, lungs, or other organs, typically with a stethoscope)/heart regular rate and rhythm . no clubbing (physical change in the shape and appearance of the fingertips), cyanosis (a bluish color in the skin, lips, and nail beds caused by a shortage of oxygen in the blood), or edema (swelling caused by an abnormal buildup of fluid in the body's tissues). Record Review of Resident #1's NP progress note dated 5/14/2025 revealed . Daily subjective: She is awake, alert . Denies any chest pain or shortness of breath upon exertion .Afebrile vital signs stable .Lungs clear to auscultation/heart regular rate and rhythm .no clubbing, cyanosis, or edema. Record Review of Resident #1's NP progress note dated 5/19/2025 revealed . Daily subjective: She is awake, alert and sitting up in recliner . She voices no complaints of any pain or discomfort.Afebrile vital signs stable .Lungs clear to auscultation/heart regular rate and rhythm .no clubbing, cyanosis, or edema. Record Review of Resident #1's NP progress note dated 5/21/2025 revealed . Daily subjective: Patient is awake and alert and is up in her wheelchair. She is dressed and ready to go to her doctor's appointment. She will be going to see her wound care doctor. No acute distress noted .Afebrile vital signs stable .Lungs clear to auscultation/heart regular rate and rhythm .no clubbing, cyanosis, or edema. Record Review of Resident #1's progress notes dated 5/21/2025 revealed The ADON spoke with resident Infectious Disease provider regarding residents' concerns with Lasix. Providers office states they show on their end that resident (Resident #1) should be on 40mg daily . Head to toe assessment completed by this ADON. Resident continues with post-surgical wound to right ankle. Slight edema noted to bilateral lower extremities however normal for resident baseline. No c/o pain voiced at this time by resident (Resident #1) . Resident (Resident #1) received initial dose of Lasix as ordered. During an interview with LVN A on 6/3/2025 at 12:12pm, she stated she was here when Resident #1 was re-admitted from the hospital on 5/9/2025. She stated she reviewed the discharge paperwork and checked off one by one the medications on the list as she input them into the computer. She stated she was not sure what happened, or if she may have gotten distracted and checked off the Lasix order without inputting it into the system. She stated, the ADON and DON spoke to me about the missed medication, and I still don't know why that specific medication was missed. She stated the potential negative outcome of the residents not receiving their ordered medication could be an exacerbation of their illnesses, and increased swelling. She stated they are trained to have a second nurse double check the orders before signing them off. She stated she did not know if a second nurse verified the orders after she input them into the system. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADON on 6/3/2025 at 12:35pm he stated Resident #1 had gone to the wound care specialist appointment on 5/21/2025 and the clinic brought to the facilities attention that Resident #1 did not have Lasix on the medication list that had been sent over. He stated the clinic had explained that she had been on Lasix at the hospital. He stated he checked the discharge orders and the order for furosemide (Lasix) was there. He stated he spoke to LVN A and she was unable to explain what had happened or why it had been missed. He stated he did a head-to-toe assessment on the resident, notified the physician and family, and initiated the order. He stated during the 12 days she was without it there had been no change in condition and the resident had been stable. He stated due to this incident the facility had revised the way admission orders are verified. He stated two nurses will be verifying the orders together and administration will be going through each medication individually on the discharge orders and verifying they are in the system accurately. During an interview with PT on 6/3/2025 at 1:13pm, she stated she worked with Resident #1 on her physical therapy daily and Resident #1 did have some mild edema to both her legs. She stated Resident #1 often lays in bed during the weekend and the swelling increases but throughout the week it will get better due to her walking or moving more. She stated during the week the swelling was not very noticeable to her legs. She stated she did not notice any changes in Resident #1's level of function and even knowing now that Resident #1 was back on her Lasix, there had not been a change in her leg swelling. During an interview with Resident #1 on 6/3/2025 at 1:34pm, she stated she thought there was an issue with her water pill (furosemide/Lasix) but did not remember what or when. She stated everything was fine now and she was happy that they give her the water pill in the morning because she does not have to get up at night. She stated the facility had it all figured out and she did not have any concerns. Resident #1 was unable to recall having conversations with the wound care clinic, the ADM or ADON on 5/21/2025. During an interview with the DON on 6/3/2025 at 2:40pm, she stated the nursing staff was responsible for ensuring any resident orders are placed into the system upon admission. She stated during their morning meetings as a team, they would review all admissions for accuracy. She stated she was not sure how the furosemide order was missed for Resident #1. She stated due to the incident they (administration) had now implemented going through each medication on the discharge forms and making sure they are in the system correctly. She stated the potential negative outcome of the orders not being placed into the system could be the residents not having their medication regimen or reaching their therapeutic effect. During an interview with the ADM on 6/3/2025 at 2:47pm, he stated the floor nurses are responsible for initiating the admission procedure. He stated they have to input the medications, skin assessments, initial notes and on their next clinical meeting the ADON and DON review the admission paperwork for verification. He stated the potential negative outcome of residents not being given their ordered medications could be missing medication and pertinent treatments. He stated he is not sure what had happened and why the medication was missed but they had implemented a new intervention for verifying the orders during their clinical meetings. He stated the DON and ADON would be reviewing the medication list and going through each order individually to ensure they are in the system. Record review of facility policy titled Admission, Transfer, and Discharge Rights last revised 10/2007 revealed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	POLICY: It is the policy of this facility to have written policies and procedures governing admissions to the facility that will be maintained on a current basis to ensure fair and impartial admission practices. PROCEDURES: . The primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility . 4. It shall be the responsibility of the administrator, through the admissions department, to assure that the established admission policies, as they may apply, are followed by the facility and resident. Record review of facility policy titled Pharmacy Services undated, revealed POLICY: It is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs.