

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 08/22/2025
NAME OF PROVIDER OR SUPPLIER The Mildred & Shirley L. Garrison Geriatric Educat		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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the residents physician and representative regarding a change in the resident's condition, for 1 of 6 residents (Resident #1) reviewed for changes in condition - The facility failed to immediately consult with Resident #1's physician when Resident #1 sustained a fall with complaints of pain to the knee on the evening of 08/07/2025 until the next morning 08/08/2025, because CNA C failed to inform nursing staff. An Immediate Jeopardy (IJ) was identified on 08/21/25 at 2:23 PM. The IJ template was provided to the facility on [DATE] at 2:51 PM. While the IJ was removed on 8/22/2025 at 2:51pm, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated, because all staff had not been trained on 08/22/2025. This failure could place residents at risk of not having their family and physicians notified of changes resulting in a delay in decision making for medical interventions. The Findings include: Record review of Resident #1's undated face sheet revealed an [AGE] year-old female admitted on [DATE]. Resident #1 had a medical history of periprosthetic fracture around internal prosthetic right knee joint (a bone break that occurs around a knee replacement implant), dementia (a general term for a decline in mental ability severe enough to interfere with daily life), gout (a painful form of inflammatory arthritis that happens when uric acid crystals build up in the joints), and age-related osteoporosis (a bone disease that makes bones weak and brittle, leading to an increased risk of fractures). Record review of Resident #1's quarterly MDS dated [DATE], Section C-Cognitive Patterns revealed Resident #1 had a BIMS of 4 which indicated Resident #1 had severe cognitive impairment. Record review of Section GG- Functional Abilities revealed Resident #1 required Supervision or touching assistance with chair/bed-to chair transfers and sit to stand. Record review of Resident #1's care plan revealed a focus initiated on 4/29/2025 [Resident#1] is at risk for acute/chronic pain r/t [related to] gout with an intervention to anticipate need for pain relief and respond immediately to any complaint. The care plan also revealed a focus initiated on 8/21/2025, [Resident #1] has a fracture of the right distal femur (the lower end of the thigh bone (femur), specifically the area just above the knee joint) related to hearing a pop during transfer and interventions initiated on 8/21/2025 revealed Anticipate and meet needs, be sure call light is within reach and respond promptly to all request for assistance, change surgical incision dressing as per order and PRN(as needed), follow weight bearing orders per MD order, reposition as necessary to prevent skin breakdown, therapy evaluation and treatment per orders. Record review of Resident #1's document titled Physical Therapy Treatment Encounter Note(s) dated 8/7/2025 at 4:00pm, revealed Pt (patient) STS (sit to stand) and stand pivot with CGA (Contact Guard Assist, describes a level of assistance where a therapist or caregiver has their hands on the patient to provide physical support and balance for tasks like walking or standing, even though the patient performs most of the activity) /[NAME] (minimum assistance) Record review of Resident #1's progress note dated 8/8/25 at 7:10AM revealed X ray to the Right Knee to R/O Dislocation. pt Stated she heard a loud pop when transferring to bed last HS, she c/o to this nurse this morning that she was in pain, and she couldn't move her leg. This nurse medicated pt for pain level 10 and notified NP. requested X ray to R/O Dislocation of the RT knee. STAT signed by RN H. Progress note dated 8/8/25 at 10:56 AM revealed Per [MD] sent pt to [hospital] to get tx and evaluate for the rt knee fx signed by RN H. Record review of Resident #1's radiology report dated 8/8/2025 10:02AM revealed Impressions: 1. Osteoporosis 2. The knee arthroplasty is aligned (the specific way the new knee joint components are positioned during surgery to restore function and balance) 3. The acute distal femoral metaphyseal [the wider portion of a bone] fracture is visualized with posterior displacement (distal femoral metaphyseal fracture with posterior displacement is a serious injury to the thigh bone, just above the knee. Posterior displacement means the broken end of the thigh bone has shifted backward towards the back of the knee). Record review of Resident #1's hospital records revealed Date of admission: [DATE]; History of present illness: presents to [hospital] ED (emergency department) via EMS (emergency medical services) with complaints of right knee pain. Patient states that she fell yesterday when trying to transfer to the shower with the assistance of nurse aide and lost balance causing her to fall and hit the right side of her body. Patient denies pain to her remaining extremities. Denies hitting her head. Denies blood thinner use. Denies blurry vision or headache. Denies numbness or tingling. States that her functional status prior to injury was ambulatory with assistive device and occasional wheelchair use. Diagnostic Studies: IX-ravl acute distal femoral fracture Date: 08/08/25 open reduction internal fixation of</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from neglect for 1 of 6 residents (Resident #1) reviewed for neglect in that: 1. CNA C neglected to notify LVN A or any licensed nurse of Resident #1's incident on 8/7/2025, that resulted in a broken distal femur. 2. The facility neglected to ensure Resident #1's pain was adequately assessed and treated for approximately 12 hours on 8/7/2025-8/8/2025, after Resident #1 reported having pain to her right knee following an incident with CNA C. An Immediate Jeopardy (IJ) was identified on 08/21/25 at 2:23 PM. The IJ template was provided to the facility on [DATE] at 2:51 PM. While the IJ was removed on 8/22/2025 at 2:51pm, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated, because all staff had not been trained on 08/22/2025. This failure placed residents at risk for neglect, mental anguish, pain and emotional distress. The Findings include: Record review of Resident #1's undated face sheet revealed an [AGE] year-old female admitted on [DATE]. Resident #1 had a medical history of periprosthetic fracture around internal prosthetic right knee joint (a bone break that occurs around a knee replacement implant), dementia (a general term for a decline in mental ability severe enough to interfere with daily life), gout (a painful form of inflammatory arthritis that happens when uric acid crystals build up in the joints), and age-related osteoporosis (a bone disease that makes bones weak and brittle, leading to an increased risk of fractures). Record review of Resident #1's quarterly MDS dated [DATE], Section C-Cognitive Patterns revealed Resident #1 had a BIMS of 4 which indicated Resident #1 had severe cognitive impairment. Section GG- Functional Abilities revealed Resident #1 required Supervision or touching assistance with chair/bed-to chair transfers and sit to stand. Record review of Resident #1's care plan revealed a focus initiated on 4/29/2025 [Resident#1] is at risk for acute/chronic pain r/t [related to] gout with an intervention to anticipate need for pain relief and respond immediately to any complaint. The care plan also revealed a focus initiated on 8/21/2025, [Resident #1] has a fracture of the right distal femur (the lower end of the thigh bone (femur), specifically the area just above the knee joint) related to hearing a pop during transfer and interventions initiated on 8/21/2025 revealed Anticipate and meet needs, be sure call light is within reach and respond promptly to all request for assistance, change surgical incision dressing as per order and PRN(as needed), follow weight bearing orders per MD order, reposition as necessary to prevent skin breakdown, therapy evaluation and treatment per orders. Record review of Resident #1's document titled Physical Therapy Treatment Encounter Note(s) dated 8/7/2025 at 4:00pm, revealed Pt (patient) STS (sit to stand) and stand pivot with CGA (Contact Guard Assist, describes a level of assistance where a therapist or caregiver has their hands on the patient to provide physical support and balance for tasks like walking or standing, even though the patient performs most of the activity) /([NAME]) (minimum assistance) Record review of Resident #1's progress note dated 8/8/25 at 7:10AM, revealed X ray to the Right Knee to R/O Dislocation. pt Stated she heard a loud pop when transferring to bed last HS, she c/o to this nurse this morning that she was in pain, and she couldn't move her leg. This nurse medicated pt for pain level 10 and notified NP. requested X ray to R/O Dislocation of the RT knee. STAT signed by RN H. Progress note dated 8/8/25 at 10:56 AM revealed Per [MD] sent pt to [hospital] to get tx and evaluate for the rt knee fx signed by RN H. Record review of Resident #1's radiology report dated 8/8/2025 at 10:02AM, revealed Impressions: 1. Osteoporosis 2. The knee arthroplasty is aligned (the specific way the new knee joint components are positioned during surgery to restore function and balance) 3. The acute distal femoral metaphyseal [the wider portion of a bone] fracture is visualized with posterior displacement (distal femoral metaphyseal fracture with posterior displacement is a serious injury to the thigh bone, just above the knee. Posterior displacement means the broken end of the thigh bone has shifted backward towards the back of the knee). Record review of Resident #1's physician orders revealed Tramadol 50mg. Give 50mg by mouth two times a day for pain 0800 and 1800 [8am and 6pm] with a start date of 4/28/2025 and end date of 8/8/2025. Resident #1's physician orders also revealed Gabapentin Capsule 100mg. Give 1 capsule by mouth two times a day related to pain. 7am and 15 [3pm] with a start date of 4/29/2025 and an end date of 8/8/2025. Physician order to monitor and assess level of pain using the 0-10 scale, 0=no pain, 1-2 mild pain, 4-6 moderate pain, 7-10- severe pain with start date of 4/28/2025 per shift. Record review of Resident #1's medication administration record revealed Gabapentin was administer[PH1] [CO2] on 8/7/2025 at approximately 1500 [3pm] and 8/8/2025 at approximately 7AM. The document also revealed Tramadol 50mg</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 6 residents (Resident #1) reviewed for neglect.1. The facility failed to ensure staff followed the abuse policy by not preventing neglect for Resident #1 on 8/7/2025 when CNA C failed to notify a licensed nurse of an incident that resulted in a broken distal femur for Resident #1. 2. The facility failed to ensure staff followed the abuse policy by not preventing neglect for Resident #1 on 8/7/2025 when staff failed to adequately assess and treat Resident #1's report of pain, for approximately 12 hours, to her right knee following an incident with CNA C. An Immediate Jeopardy (IJ) was identified on 08/21/25 at 2:23 PM. The IJ template was provided to the facility on [DATE] at 2:51 PM. While the IJ was removed on 8/22/2025 at 2:51pm, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated, because all staff had not been trained on 08/22/2025. These failures could place residents at risk for injury and neglect. The Findings include:Record review of facility policy title Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment original date: 11/2017 revealed: 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.Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers. Neglect is the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.Record review of facility policy titled Change in Condition, last revised 4/2025 revealed .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. 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 the resident's provider using telephone or similar process to obtain new orders or interventions. Record review of facility policy titled Rounds undated, revealed; It is the policy of this facility to ensure the safety ad comfort of the resident and to assist in continuity of care and to identify potential change in condition. 1. Resident will be checked by the certified nursing assistants during rounds. 2. Observe resident for privacy, dignity and safety. 3. Note positioning of the resident and comfort level. Record review of Resident #1's undated face sheet revealed an [AGE] year-old female admitted on [DATE]. Resident #1 had a medical history of periprosthetic fracture around internal prosthetic right knee joint (a bone break that occurs around a knee replacement implant), dementia (a general term for a decline in mental ability severe enough to interfere with daily life), gout (a painful form of inflammatory arthritis that happens when uric acid crystals build up in the joints), and age-related osteoporosis (a bone disease that makes bones weak and brittle, leading to an increased risk of fractures). 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