

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 03/01/2026
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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personnel provide basic life support, including CPR, to a resident requiring such care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 (Resident #1) of 5 residents reviewed for full code status. The facility failed to ensure staff were able to perform CPR, according to standard protocol, when RN J and LVN S were unable to provide timely rescue breaths to Resident #1 during a code, due to the Ambu bag (a device used to provide manual ventilation) not being readily available on the crash cart. Resident #1 was pronounced deceased at the facility. An Immediate Jeopardy was identified on [DATE] at 5:05 PM. The IJ template was provided to the facility Administrator on [DATE] at 5:07 PM. While the immediate jeopardy was removed on [DATE] at 6:00 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated, due to the facility's need to evaluate the effectiveness of their plan of correction to prevent future concerns. This failure could place residents at risk of hospitalization, brain damage, and untimely death. Record review of Resident #1's face sheet dated [DATE] revealed an [AGE] year-old female admitted the facility on [DATE]. Resident #1 had medical diagnoses to include: displaced intertrochanteric fracture of left femur (hip fracture), chronic kidney disease (irreversible loss of kidney function), Type II Diabetes Mellitus (condition characterized by the body's inability to use insulin properly), dementia, and anemia. Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 01, which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's Comprehensive Care Plan dated initiated on [DATE] revealed Resident #1 elected Full Code status (a formal choice to receive all possible medical interventions and life-saving measures to revive a person, including CPR, if their breathing or heart stops) with the following intervention: Initiate full code measures in case of cardiac arrest, to include CPR and AED use. Record review of Resident #1's Physicians orders, dated [DATE] revealed an order for Full Code status with a start date of [DATE]. Record review of Resident #1's progress report dated [DATE] had the following entry dated [DATE] at 06:21 (6:21 AM) Upon giving report to oncoming nurse, charge nurse was alerted that resident was not breathing and appeared to be unresponsive. Upon entering room resident was unresponsive and did not respond to verbal commands, or physical stimuli at this time resident was moved from bed to floor and CPR began, EMS was called. CPR was continued by staff until EMS arrived and took over Code. Nephew was called, did not answer, left voicemail for him to return call. ADON and Nurse Practitioner notified as well.Author: [Name] LVN S [e-SIGNED] During an interview on [DATE] at 10:41 AM, SP stated she went to Resident #1's room on [DATE] at approximately 6:15 AM to get her for therapy and the resident was observed to be breathing but unresponsive. She stated she went to the station to notify the nurses, LVN S and RN J, who were at the station for change-of-shift report. SP stated she returned to the room and Resident #1 was no longer breathing and she again notified the nurses. SP stated LVN S and RN J both responded to the room with the crash cart that was designated for Magnolia and Sage halls, while another day-shift nurse [name not given] called EMS. SP stated CNA (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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>U and CNA T also came to the room to assist. She stated Resident #1 was assessed by both nurses and determined to have no pulse or respirations and was lowered to the floor. SP stated the AED pads were applied to Resident #1 and chest compressions were started at 6:31 AM. She stated she did not recall which nurse started compressions. She stated one of the CNAs who responded to the room was asked to retrieve the Ambu bag from the cart, but she did not recall which CNA it was. SP stated the Ambu bag could not be located on the cart by the CNA who then ran to retrieve an Ambu bag from the facility's supply room. SP stated she was holding Resident #1's head while LVN S and RN J rotated with performing chest compressions. SP stated the resident began foaming at the mouth and had greenish-brown secretions coming from her mouth during compressions and RN J began suctioning the resident. She stated the CNA returned from the supply room with an Ambu bag after approximately 4-5 minutes. SP stated staff were unable to use the Ambu bag at that point, due to the amount of secretions and emesis (vomit) coming from Resident #1's mouth. She stated RN J and LVN S continued compressions and suctioning until EMS arrived. SP stated EMS took over CPR upon arrival to the facility and pronounced Resident #1 deceased at 7:06 AM. During an interview on [DATE] at 11:08 AM, RN J stated she worked the previous day on [DATE] and was involved in the resuscitative efforts for Resident #1, along with LVN S who was also on duty at the time of the emergency. RN J stated she and LVN S were in morning report on [DATE] at approximately 6:15 AM when the SP notified them that Resident #1 did not look good and was unresponsive. RN J stated she grabbed the crash cart for Magnolia and Sage halls and ran to Resident #1's room with LVN S. She stated the AED was connected and chest compressions were initiated but the Ambu bag could not be immediately located on the cart and one of the CNA's ran to grab an Ambu bag from the supply room, which took several minutes. RN J stated the AED did not advise a shock and mouth-to-mouth breathing was not given. She stated the resident had to be suctioned due to the amount of stomach contents that was coming from her mouth. She stated EMS arrived approximately 8-10 minutes later and compressions were still being done and care was turned over to EMS. She stated the resident was pronounced deceased a short time later. RN J stated notifications were made to the family and physician. During an interview on [DATE] at 1:38 PM, CNA U stated she was on duty on the 6 AM-6 PM shift on [DATE], when Resident #1 was found unresponsive and she responded to the room to provide assistance. CNA U stated she looked for an Ambu bag on the cart but did not find one and she ran to the supply room to retrieve another bag. She stated she thought she was gone maybe 2 minutes and returned with another Ambu bag. She stated RN J and LVN S were alternating performing chest compressions. She stated she did not recall whether the Ambu bag was used but she did recall the resident being suctioned. CNA U stated EMS arrived approximately 10 minutes after CPR was initiated and she realized the Ambu bag was on the cart. CNA U stated she was unsure why she did not initially locate the Ambu bag on the crash cart. During an interview on [DATE] at 3:37 PM, CNA T stated she was on duty on the 6 AM-6 PM shift on [DATE], when Resident #1 coded. She stated she was in and out of the room while other staff performed chest compressions. She stated RN J, LVN S and CNA U alternated performing chest compressions. She stated LVN S asked CNA U for the Ambu bag from the crash cart, but it could not be located so CNA U was sent to retrieve a bag from the supply room. CNA T stated during the time CNA U was gone to get a bag, she looked through the drawers of the cart and found an Ambu bag. She stated once the Ambu bag was made available to the nurses, a few rounds of CPR had already been performed and staff had switched out a time or two on chest compressions. CNA T stated she believed staff would have utilized the Ambu bag sooner if it had been available. During a follow-up interview on [DATE] at 6:01 PM, RN J stated she was notified of Resident #1 being unresponsive by the SP and she immediately responded to the room with the crash cart and assisted LVN S to lower Resident #1 to the floor. She stated she put AED pads on the resident then immediately began chest compressions. She stated she asked for the Ambu bag at that point, but it was not immediately available. RN J stated she had been trained in CPR, and the steps included the following: 1st - check pulse and determine the resident is unresponsive. 2nd- open the airway and (continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>deliver 2 rescue breaths with the Ambu bag. 3rd - begin chest compressions with a ratio 30 compressions to 2 breaths. RN J stated she began with compressions because the Ambu bag was not available. She stated the Resident #1 started having emesis (vomit) after compressions were performed and required suctioning. RN J stated she would have delivered rescue breaths according to the 30:2 ratio, if the Ambu bag had been available because that's just the standard. She stated she did not know the facility policy for CPR, but she assumed it was the same as current CPR protocol. RN J stated not having rescue equipment readily available on the cart could prolong the time it takes to be resuscitated and could result in resident death. During an interview on [DATE] at 11:07 AM, LVN S stated she had worked the night shift and at approximately 6:15 AM she was giving report to the oncoming nurse, RN J, when the SP notified the nurses that Resident #1 was breathing but not responding. SP then notified the nurses that Resident #1 was no longer breathing. LVN S stated she ran to Resident #1's room and RN J got the crash cart. She stated CNA U and CNA T were also present. LVN S stated Resident #1 was assessed and had no pulse and no respirations and was lowered to the floor and chest compressions were initiated and staff rotated performing compressions for a few rounds. She stated the Ambu bag could not be located initially but she believed she was still doing the first round of compressions when the bag was found. LVN S stated Resident #1 started having emesis and suctioning was performed by RN J. She stated EMS arrived and took over the care of the resident, but the resident expired and was pronounced at 7:06 AM. LVN S stated it was the responsibility of the charge nurses to make sure the crash cart was ready for use and not having essential equipment readily available on the cart during an emergency could result in a poor outcome for the resident. During an interview on [DATE] at approximately 12:45 PM, the ADM stated he was notified of Resident #1's passing at the facility. He stated he was not aware that there was any difficulty locating resuscitative equipment from the crash cart for Magnolia and Sage halls. The ADM stated his expectation was that residents wishing to receive CPR be provided with proper CPR, including rescue breathing, according to policy. During an interview on [DATE] at approximately 12:51 PM, the DON stated he was notified of Resident #1's passing at the facility. He stated he was not aware that any resuscitative items had not been readily available during CPR. He stated residents should receive CPR, to include rescue breaths, per protocol and standard of care when a full code status is elected. Record review of the facility policy titled Policy/Procedure - Nursing Clinical, revised 10/2018 revealed: Section: Emergency ProceduresSubject: Cardiopulmonary Resuscitation (CPR)Procedures:1. Check for responsiveness, quality of breathing and pulse simultaneously.2. If unresponsive, not breathing (occasional gasps are not breathing) and no pulse, activate EMS system:Page or yell loudly for Code Blue to the areaCall 9113. Position the resident face-up, on firm, flat surface, supporting the head, neck and back in a straight line.4. Start chest compressions.Perform 30 chest compressions at a rate at least 100- 120/ minuteCompression depth of at least 2 inches (5 cm) for an average adult, while avoiding excessive chest compression depths (greater than 2.4 inches [6 cm]) 5. Open airway (tilt the head back and lift the chin up), give 2 rescue breaths.May use a bag valve mask (BVM) or Ambu bag to give rescue breathsBlow in for about 1 second to make the chest clearly rise. If chest does not risewith rescue breaths, retilt head, look for and remove object if seen and give another rescue breath.6. Continue cycles of CPR, 30 chest compressions : 2 rescue breaths. Do not stop CPR except in one of these situations:Sign of breathing and pulse activityAn Automated External Defibrillator AED is ready to use (if available)Another trained responder or EMS personnel take over . This was determined to be an IJ on [DATE] at 5:05 PM. The administrator and DON were notified on [DATE] at 5:08 PM an IJ situation was identified due to the above failure and the IJ Template was provided. The following Plan of Removal submitted by the facility was accepted on [DATE] at 7:06 PM. Record review of the facility Plan of Removal reflected the following: [Facility Name]F-678Plan of Removal [DATE]Per the information provided in the IJ template given on [DATE] at 5:07 PM, the facilityfailed to provide goods and services related to life saving measures and available equipment/suppliesThe Medical Director was notified of IJ on [DATE] (continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>by the Executive Director. Crash cart for Magnolia/Sage hall was cleaned, replenished, and verified by ADON- 1, ADON-2, and Clinical Resource on [DATE] at approximately 1:43 PM. Education completed on [DATE] with licensed nurses, certified medication aides and certified nursing assistants on:Emergency code names (i.e. code blue) Policies and Procedures for crash carts Regular auditing of crash carts [Facility Name] CPR Policy requirements This training was completed on [DATE] with current nursing staff (licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) on shift. A member of management will be at the facility at each shift change to ensure remaining nursing staff (licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) complete training prior to starting their work on the floor. Staff will not be allowed to work unless they have completed the training. This training will also be included in the new hire orientation with new nursing staff (licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) hires not being allowed to work the floor until training is completed.An ad hoc QAPI meeting regarding items in the 1J template was completed on [DATE] with complete policy review. CPR policy and crash cart auditing policy with required contents were specifically reviewed. Attendees included the Medical Director, Executive Director-[Facility], DON-[Facility], ADON x2-[Facility], and Clinical Resource.The DON, ADON, or designee will verify nursing staff {licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) competency weekly via quiz.Crash carts will be reviewed daily by licensed nurse floor staff and verified by DON, ADON or designee daily and after each usage. Once a day audit and after each use audit by licensed nurse floor staff is required indefinitely. DON, ADON, or designee daily auditing is required for 90 days.Summary of IJ and corrective action to be reviewed by QAPI Committee weekly for 4 weeks or until substantial compliance is established and continue monthly for 90 days to ensure ongoing compliance On [DATE] the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During an interview on [DATE] at 10:55 AM, the ADM stated all staff from the previous night shift on [DATE] and all staff who were working today, [DATE] had been in-serviced according to the POR topics prior to going on duty today. He stated ADM and nursing administration were calling staff members who were not assigned to work today to give an in-service over the phone. He stated all crash carts were clean, stocked and audited with verification of auditing by nursing administration. Observation on [DATE] at 11:12 AM of crash cart #1 revealed the cart was clean and stocked, and the audit logbook had been signed for the daily audit. Observation on [DATE] at 11:17 AM of crash cart #2 revealed the cart was clean and stocked, and the audit logbook had been signed for the daily audit. Observation on [DATE] at 11:19 AM of crash cart #3 revealed the cart was clean and stocked, and the audit logbook had been signed for the daily audit. Record review of an in-service training for clinical staff dated [DATE] revealed, Topic: Facility Codes, Code Blue, CPR Policy, Crash Cart Expectations (Crash cart audit items).Facility Emergency Preparedness Codes - red, gray, orange, green, yellow, white; with emphasis on - Code Blue=a life-threatening medical emergency involving a patient who is unresponsive, not breathing, or without a pulse. Current CPR policy was reviewed with staff. Crash carts should be audited daily for the listed supplies on the crash cart log and initialed.Signed by 76 staff members. During an interview on [DATE] at 1:49 PM, LVN L stated she was assigned to verify that licensed staff were auditing crash carts daily. LVN L stated she had been in-serviced on the location and daily auditing of all crash carts in the facility, emergency preparedness codes and reviewed on the proper steps of CPR, according to current facility policy. During an interview on [DATE] at 1:51 PM, RN M stated she was assigned to verify that licensed staff were auditing crash carts daily. RN M stated she had been in-serviced on the location and daily auditing of all crash carts in the facility, emergency preparedness codes and reviewed on the proper steps of CPR, according to current facility policy. During a phone interview on [DATE] at 3:39 PM, the Medical Director stated he was informed by the ADM of the delay in rescue breathing during CPR for Resident #1 due to the Ambu bag not being located timely from the crash cart. He stated he spoke with the ADM a little yesterday but mainly today. He stated he and the ADM reviewed the crash cart (continued on next page)</p>		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<p>policy and CPR policy. The Medical Director stated that he agreed with the facility training that a delay in any component of CPR, even seconds, could adversely affect the outcome of a resident. Record review of ad hoc QAPI meeting summary sheet. Meeting was held on [DATE] with discussion of CPR policy and crash cart policy and weekly competencies for licensed staff. In attendance were - ADM, DON, ADONs, MD On [DATE] between 1:31 PM and 5:15 PM interviews were conducted with the following staff members: CNAs A, C, D, E, G, K, N, O, Q; LVNs B, F, H, I, L P, R, S; RNs J, M; Housekeeper, OT, DS, MDS Coordinator, and COTA. All staff members stated they were in-serviced on [DATE] or [DATE] on Facility Emergency Preparedness Codes - red, gray, orange, green, yellow, white; with emphasis on - Code Blue=a life-threatening medical emergency involving a patient who is unresponsive, not breathing, or without a pulse. If witness to a resident who is unresponsive, notify the charge nurse immediately; CPR policy - Basic Life Support is to be provided to any resident who has elected full code status, prior to EMS arrival. Crash cart expectations: cart will be clean and fully stocked (according to the audit log) at all times and immediately following the use in an emergency situation. The 3 crash carts are located at each of the 3 nurses stations. The carts are to be audited by the charge nurse daily and initialed on the daily log. If any item is missing from the cart or is not able to be located in the facility supply, notify the ADM immediately. LVNs and CNAs were also given competency quizzes with the following questions: 1. What is the code for a medical emergency at [Facility Name]? 2. Where are the crash carts located at the facility? 3. How often should the crash cart be audited? 4. After use, how soon should the crash cart be cleaned and replenished? 5. If crash cart items are missing or need to be replaced, when and who should you inform? On [DATE] at 6:00PM, the ADM was informed the IJ was removed however the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #1) of 27 residents reviewed for quality of care. 1. The facility failed to ensure that the crash cart shared for Magnolia hall, housing Resident #1, and Sage Hall (which housed a total of twenty-seven residents who had elected Full Code status) was audited daily, sanitized, and had all resuscitative equipment readily available and easily located to deliver life-saving measures in the event of a medical emergency. 2. During a medical emergency on [DATE] at approximately 6:30 AM for Resident #1, RN J and LVN S were unable to timely locate an Ambu bag (a device used to provide manual ventilation) from the crash cart for Magnolia and Sage halls, resulting in delayed ventilation during resuscitative efforts. Resident #1 was pronounced deceased at the facility. 3. The crash cart for Magnolia and Sage halls was utilized on [DATE] at approximately 6:30 AM for Resident #1. RN J and LVN S failed to clean and replenish the cart after use for Resident #1. An Immediate Jeopardy was identified on [DATE] at 5:05 PM. The IJ template was provided to the facility Administrator on [DATE] at 5:08 PM. While the immediate jeopardy was removed on [DATE] at 6:00 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of pattern, due to the facility's need to evaluate the effectiveness of their plan of correction to prevent future concerns. This failure could place residents who have elected Full Code status (a formal choice to receive all possible medical interventions and life-saving measures to revive a person, including CPR, if their breathing or heart stops) at risk of death by not being provided CPR in a timely manner. Record review of Resident #1's face sheet dated [DATE] revealed an [AGE] year-old female admitted the facility on [DATE]. Resident #1 had medical diagnoses to include: displaced intertrochanteric fracture of left femur (hip fracture), chronic kidney disease (irreversible loss of kidney function), Type II Diabetes Mellitus (condition characterized by the body's inability to use insulin properly), dementia, and anemia. Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 01, which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's Comprehensive Care Plan dated initiated on [DATE] revealed Resident #1 elected Full Code status (a formal choice to receive all possible medical interventions and life-saving measures to revive a person, including CPR, if their breathing or heart stops) with the following intervention: Initiate full code measures in case of cardiac arrest, to include CPR and AED use. Record review of Resident #1's Physicians orders, dated [DATE] revealed an order for Full Code status with a start date of [DATE]. During an observation and interview on [DATE] at 10:55 AM, the crash cart for 2 of 5 resident halls (Magnolia and Sage halls) was observed to be in unusable condition with dirty/contaminated suction tubing, suction canister and Yankauer suction device (a rigid, bulb-tipped instrument used to clear secretions from the mouth to maintain a clear airway during emergency care), which were observed to contain green colored fluid. The AED pads had been used and remained connected to the AED device. RN J conducted an audit with state surveyor of the contents of the crash cart for Magnolia and Sage halls, according to the facility's crash cart inventory log. The following items were missing from the cart upon inspection: O2 mask, suction canister, suction tubing, Yankauer suction device, and AED pads. RN J stated it was the responsibility of the charge nurses to audit the cart daily for supplies. She stated the audits were usually conducted by the night shift nurses. RN J stated the cart had not been cleaned since a code (resuscitation efforts including chest compressions and suctioning) was initiated on [DATE] at 6:30 AM on Resident #1. She stated during the code for Resident #1, all the necessary equipment was on the cart, with the exception of an Ambu bag which was not readily located on the cart for Magnolia and Sage halls, resulting in a delay in providing rescue breaths for the resident. She stated the cart could not be used in the current condition due to contamination from (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>previous use during the code for Resident #1. RN J stated the cart was missing multiple vital pieces of equipment such as the O2 mask, suction equipment and AED pads that would be necessary to initiate a code. RN J stated she and LVN S should have cleaned and replenished the cart following the use of single-use equipment during the previous code for Resident #1 on [DATE]. She stated there were multiple Full Code residents on Magnolia and Sage Halls and the crash cart, in its current condition, would not be able to be used timely in the event of a life-threatening emergency. During an interview on [DATE] at 11:07 AM, LVN S stated she was on duty during code for Resident #1 on [DATE] and she participated in CPR efforts. She stated there was a delay in locating an Ambu bag from the cart for Magnolia and Sage halls, but all other necessary equipment was in place on the cart. She stated immediately following the code for Resident #1, the contaminants on the cart should have been emptied and the cart should have been cleaned and restocked. She stated she did not know whose responsibility it was to get the cart back in order when it was shift change but she had to leave to pick up her kids. She stated she did not know offhand how many residents were Full Code status on Magnolia and Sage Halls. She stated the cart would not have been usable in the condition it was left in following the code for Resident #1 on [DATE]. She stated the cart is to be audited daily by the charge nurses and it could be done by either shift. Record review of the [DATE] and February 2026 Crash Cart Checklist for the crash cart for Magnolia and Sage Halls revealed the following items to be checked daily and initialed: O2 tank level O2 tubing-mask Suction machine-working order Suction Canister Suction Yankauer Ambu bag Stethoscope BP cuff Pen light-working Y/N? Backboard Gloves AED pads in date- Y/N? AED battery in date- Y/N? AED working? The following dates were blank, indicating a staff member did not sign for an audit being conducted, on the [DATE] checklist: 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/16, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30 and 1/31. The following dates were blank, indicating a staff member did not sign for an audit being conducted, on the February 2026 checklist: 2/1, 2/5, 2/8, 2/9, 2/12, 2/13, 2/15, 2/24, 2/26, and 2/27. Record review of the Full Code Order Listing Report for Magnolia Hall, dated [DATE] revealed sixteen residents had elected Full Code status. Record review of the Full Code Order Listing Report for Sage Hall, dated [DATE] revealed eleven residents had elected Full Code status. During an interview on [DATE] at approximately 12:45 PM, the ADM stated he was not aware that the crash cart for Magnolia and Sage halls was missing any resuscitative items, and his expectation was that the cart was audited for readiness in an emergency situation. He stated nursing administration was responsible to ensure crash carts were audited regularly, according to policy. During an interview on [DATE] at approximately 12:51 PM, the DON stated he was not aware that the crash cart for Magnolia and Sage halls was missing any resuscitative items and nurses on night shift were assigned to audit the crash cart for proper supplies every shift, then initial the log. He stated the logbook contained on each cart had a list of each item the cart should have at all times and a check-off for the items to be in working order, such as the suction machine, and AED machine. The DON stated all disposable items needed for the crash carts were kept in the central storage. Record review of the facility policy titled Policy/Procedure - Nursing Clinical, revised 05/2007 revealed: Section: Emergency Subject: Crash Cart, Modified Policy: It is the policy of this facility that a modified crash cart will be maintained at each nurse's station for use during emergency situations. Procedures: 1. The modified crash cart will routinely be stored at each nurse's station. 2. Person or Persons identified by each facility will check the crash cart every day and restock as necessary. 3. After each use, supplies will be re-stocked as needed. This was determined to be an IJ on [DATE] at 5:05 PM. The administrator and DON were notified on [DATE] at 5:08 PM and the IJ Template was provided. The following Plan of Removal submitted by the facility was accepted on [DATE] at 7:06 PM. Record review of the facility Plan of Removal reflected the following: [Facility Name] F-684 Plan of Removal [DATE] Per the information provided in the IJ template given on [DATE] at 5:07 PM, the facility failed to provide goods and services related to life saving measures and available equipment/supplies. The Medical Director was notified of IJ on [DATE] by the Executive Director. (continued on next page)</p>		

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 03/01/2026
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Crash cart for Magnolia/Sage hall was cleaned, replenished, and verified by ADON- 1, ADON-2, and Clinical Resource on [DATE] at approximately 1:43 PM. Education completed on [DATE] with licensed nurses, certified medication aides and certified nursing assistants on: Emergency code names (i.e. code blue) Policies and Procedures for crash carts Regular auditing of crash carts [Facility Name] CPR Policy requirements This training was completed on [DATE] with current nursing staff (licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) on shift. A member of management will be at the facility at each shift change to ensure remaining nursing staff (licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) complete training prior to starting their work on the floor. Staff will not be allowed to work unless they have completed the training. This training will also be included in the new hire orientation with new nursing staff (licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) hires not being allowed to work the floor until training is completed. An ad hoc QAPI meeting regarding items in the 1J template was completed on [DATE] with complete policy review. CPR policy and crash cart auditing policy with required contents were specifically reviewed. Attendees included the Medical Director, Executive Director-[Facility], DON-[Facility], ADON x2-[Facility], and Clinical Resource. The DON, ADON, or designee will verify nursing staff (licensed nurses, certified medication aides-CMA, certified nursing assistants-CNA) competency weekly via quiz. Crash carts will be reviewed daily by licensed nurse floor staff and verified by DON, ADON or designee daily and after each usage. Once a day audit and after each use audit by licensed nurse floor staff is required indefinitely. DON, ADON, or designee daily auditing is required for 90 days. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly for 4 weeks or until substantial compliance is established and continue monthly for 90 days to ensure ongoing compliance On [DATE] the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During an interview on [DATE] at 10:55 AM, the ADM stated all staff from the previous night shift on [DATE] and all staff who were working today, [DATE] had been in-serviced according to the POR topics prior to going on duty today. He stated ADM and nursing administration were calling staff members who were not assigned to work today to give an in-service over the phone. He stated all crash carts were clean, stocked and audited with verification of auditing by nursing administration. Observation on [DATE] at 11:12 AM of crash cart #1 revealed the cart was clean and stocked, and the audit logbook had been signed for the daily audit. Observation on [DATE] at 11:17 AM of crash cart #2 revealed the cart was clean and stocked, and the audit logbook had been signed for the daily audit. Observation on [DATE] at 11:19 AM of crash cart #3 revealed the cart was clean and stocked, and the audit logbook had been signed for the daily audit. Record review of an in-service training for clinical staff dated [DATE] revealed, Topic: Facility Codes, Code Blue, CPR Policy, Crash Cart Expectations (Crash cart audit items). Facility Emergency Preparedness Codes - red, gray, orange, green, yellow, white; with emphasis on - Code Blue=a life-threatening medical emergency involving a patient who is unresponsive, not breathing, or without a pulse. Current CPR policy was reviewed with staff. Crash carts should be audited daily for the listed supplies on the crash cart log and initialed. Signed by 76 staff members. During an interview on [DATE] at 1:49 PM, LVN L stated she was assigned to verify that licensed staff were auditing crash carts daily. LVN L stated she had been in-serviced on the location and daily auditing of all crash carts in the facility, emergency preparedness codes and reviewed on the proper steps of CPR, according to current facility policy. During an interview on [DATE] at 1:51 PM, RN M stated she was assigned to verify that licensed staff were auditing crash carts daily. RN M stated she had been in-serviced on the location and daily auditing of all crash carts in the facility, emergency preparedness codes and reviewed on the proper steps of CPR, according to current facility policy. Record review of ad hoc QAPI meeting summary sheet. Meeting was held on [DATE] with discussion of CPR policy and crash cart policy and weekly competencies for licensed staff. In attendance were - ADM, DON, ADONs, MD On [DATE] between 1:31 PM and 5:15 PM interviews were conducted with the following staff members: CNAs A, C, D, E, (continued on next page)</p>		

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 03/01/2026
NAME OF PROVIDER OR SUPPLIER The Mildred & Shirley L. Garrison Geriatric Educat		STREET ADDRESS, CITY, STATE, ZIP CODE 3710 4th St Lubbock, TX 79415	

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