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	06/16/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to treat residents with respect, dignity, and care in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality for 1 of 7 residents (Resident #1) reviewed for dignity in that: The facility failed to ensure Resident #1's call light was answered in a timely manner. This could place residents at risk for falls, diminished quality of life and loss of dignity and self-worth.Findings include: Record review of the admission record for Resident #1, dated 06/16/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: encounter for attention to colostomy (alternate route for bowel movements), viral pneumonia (lung infection), and depression (mood disorder). Record review of the comprehensive MDS assessment for Resident #1, dated 06/05/26 revealed Resident #1's BIMS score was 12, indicating his cognition was intact. During an interview with a confidential family member on an undisclosed date at an undisclosed time, the family member stated they were unhappy with the care received at the facility. The family member stated it took the staff a long time to answer the call lights, sometimes over 15 minutes. The family member stated sometimes staff were seen sitting around the nurse's station while call lights were ringing. During an observation on 06/16/26 at 10:53 AM, Resident #1's call light was observed ringing and a light was observed over room [ROOM NUMBER] and at the nurse's station. RN A was observed sitting at the nurse's station on the computer. During an observation and interview on 06/16/26 at 11:03 AM revealed RN A continued sitting at the nurse's station and stated she did not know why room [ROOM NUMBER]'s call light had not been answered. RN A stated she was trained to answer the call lights as soon as possible. RN A stated she was last trained to answer the call lights during her orientation to the facility when she was hired. RN A stated she did not answer the call light for room [ROOM NUMBER] because she wanted to finish a note. RN A stated a potential negative outcome to the residents was there could be something really wrong. During an observation on 06/16/26 at 11:05 AM, RN A answered the call light for Resident #1. During an interview on 06/16/26 at 1:25 PM, Resident #1 stated sometimes it took the staff 20 minutes to answer his call light. Resident #1 stated he had a colostomy bag that needed frequent changing and sometimes the bag would bust before staff answered his call light. Resident #1 stated his bag needed to be burped but did not bust earlier when his call light was ringing. Resident #1 stated ever since he was admitted to the facility, the call light wait times have been long. During an interview on 06/16/26 at 2:37 PM, the DON stated he expected any of the staff members to answer the call lights. The DON stated he did not know why RN A did not answer the call light for room [ROOM NUMBER] in a timely manner and stated she was probably depending on the CNAs to answer the call light. The DON stated part of the training he did monthly with the staff was related to answering the call lights in a timely manner. The DON stated if a staff member was sitting at the nurse's station, then the call light should have been answered right then and there. The DON stated a potential negative outcome for the residents was they were at risk for falls or an overall delay in care. During an interview on 06/16/26 at 2:55 PM, the ADM stated he expected the staff to answer the call lights in a timely manner. The (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADM stated if a staff member was not doing anything else and they did not answer the call light in a timely manner, that's wrong. The ADM stated the staff were provided training regarding call lights during orientation on hire and then as needed. The ADM stated he thought the DON went over answering call lights in his monthly meeting with the nursing staff. The ADM stated a potential negative outcome to the residents was not meeting their needs. Record review of the facility document titled, Resident Advisory Council Agenda and Minutes, dated 05/27/26 reflected the following: .Nursing ReviewNews/Announcements: Call lights response time is too long. Record review of the facility document titled, Education/Training Record, dated 04/10/26 reflected the following: .Topics: Abuse and Neglect, Resident Rounds, Call light safety.In-Service: Call Light Safety & ResponsibilityPurpose: To ensure resident safety, timely assistance, and dignity by maintaining proper access to call lights and responding promptly to resident needs.Who This Applies To:All Staff: Nursing, CNAs, therapy, housekeeping, dietary, and ancillary departments.Answering Call lights is everyone's responsibility.Staff must make every effort to answer call lights as quickly as possible.Call lights should never be allowed to ring for an extended period of time. Record review of the facility policy titled Resident Rights, undated reflected the following: 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 of the United States.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 2 of 7 residents (Resident #2 and Resident #3) reviewed for care plans. The facility failed to develop a care plan for Resident #2's and Resident #3's enhanced barrier precautions (EBP). These failures could place residents at risk of not receiving the care required to meet their individual needs. Findings included: Resident #2 Record review of the face sheet for Resident #2, dated 06/16/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: unspecified protein-calorie malnutrition (poor nutrition), gastroenteritis and colitis (bowel disorder), and pain. Record review of Resident #2's quarterly MDS assessment, dated 04/28/26, revealed Resident #2 had a BIMS score of 12, indicating his cognition was moderately impaired. The MDS further revealed Resident #2 had a feeding tube while a resident. Record review of Resident #2's physician's orders, dated 06/16/26, revealed an order: Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: Implanted feeding device every shift with a start date of 06/16/26. Record review of the current comprehensive care plan for Resident #2, undated, revealed there was no specific care plan regarding when EBP would be required for the resident. Resident #3 Record review of the face sheet for Resident #3, dated 06/16/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: metabolic encephalopathy (brain dysfunction), urinary tract infection (bladder infection), and anxiety (mood disorder). Record review of the significant change MDS assessment for Resident #3, dated 05/21/26, revealed Resident #3 had a BIMS score of 07 indicating his cognition was severely impaired. The MDS further revealed Resident #3 had an unhealed Stage 4 pressure ulcer (the most severe and deepest type of skin injury) and an indwelling catheter. Record review of Resident #3's physician orders, dated 06/16/26, revealed an order: ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: wounds, foley [catheter] every shift with a start date of 05/22/26. Record review of the current comprehensive care plan for Resident #3, undated, revealed there was no specific care plan regarding when EBP would be required for the resident. During an interview on 06/16/26 at 2:37 PM, the DON stated the Interdisciplinary Team was responsible for ensuring a resident's care plan was completed. The DON stated the MDS Nurses, ADONs and himself were a part of the Interdisciplinary Team. The DON stated some things could have been missed when Resident #2 went in and out of the hospital. The DON stated Resident #3 had not always been on EBP but was now due to him having a Foley catheter, so it should have been caught. The DON stated training for care plans was as needed at the facility. The DON stated a potential negative outcome to the residents was that the care plan was not comprehensive to them. During an interview on 06/16/26 at 2:55 PM, the ADM stated the nursing managers were responsible for ensuring a resident's care plan was completed. The ADM stated the nursing managers were provided care plan training as they went and things came up. The ADM stated he did not know why Resident #2 and Resident #3 were missing a care plan for EBP. The ADM stated the residents were at risk for [staff] potentially not doing EBP. Record review of the facility's policy titled, Comprehensive Person-Centered Care Planning, with a revised date of 04/25, reflected the following: Policy: It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 7 residents (Resident #2) reviewed for infection control. The facility failed to ensure PTA B followed EBP by wearing a gown while assisting Resident #2 in his room. This failure could place residents at risk for cross contamination and infection. The findings included: Record review of the face sheet for Resident #2, dated 06/16/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: unspecified protein-calorie malnutrition (poor nutrition), gastroenteritis and colitis (bowel disorder), and pain. Record review of Resident #2's quarterly MDS assessment, dated 04/28/26, revealed Resident #2 had a BIMS score of 12, indicating his cognition was moderately impaired. The MDS further revealed Resident #2 had a feeding tube while a resident. Record review of Resident #2's physician orders, dated 06/16/26, revealed an order: Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: Implanted feeding device every shift with a start date of 06/16/26. Record review of the current comprehensive care plan for Resident #2, undated, revealed there was no specific care plan regarding when EBP would be required for the resident. During an observation on 06/16/26 at 10:54 AM, PTA B was observed from the hallway assisting Resident #2 with putting the blankets over Resident #2's feet and pushing the bed back against the wall. PTA B was not wearing a gown when she was assisting Resident #2. An EBP sign was noted on the door to Resident #2's room with indications for wearing PPE to include transferring a resident and changing linens. A PPE box was observed sitting outside of Resident #2's room and no gowns were observed in the box. During an interview on 06/16/26 at 10:57 AM, PTA B stated she did not think about putting on a gown to assist Resident #2. PTA B stated the reason she did not wear a gown for Resident #2 was because he asked for help getting into bed and she thought he was going to fall out of his chair. PTA B stated she knew she was supposed to wear a gown. PTA B stated she was last trained sometime last week regarding EBP. PTA B stated a potential negative outcome to the resident was he was at risk for infection. During an interview on 06/16/26 at 2:37 PM, the DON stated the therapy staff receive training for EBP annually and as needed if anything changes. The DON stated he expected the staff to follow the EBP protocol and if they had questions, they asked for clarification. The DON stated he was not sure if putting covers on a resident required EBP and that may be why she did not wear a gown. The DON stated the staff should ask for more gowns if none were available in the PPE box. The DON stated the residents had a risk for infection without wearing the proper PPE for a resident on EBP. During an interview on 06/16/26 at 2:55 PM, the ADM stated he expected the staff to follow the policies and procedures for EBP. The ADM stated he did not know the last time PTA B had been trained on EBP. The ADM stated he did not know why PTA B was not wearing a gown when assisting Resident #2. The ADM stated the resident had a risk for possible infection. Record review of the facility's policy titled, IPCP Standard and Transmission-Based Precautions with a revised date of 04/25 reflected the following: Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable disease and conditions.Procedure:.3. Enhanced Barrier Precautions (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (.residents with.indwelling medical devices are especially high risk of both acquisition of colonization with MDROs) .c. Examples of high-contact resident care activities requiring gown and gloves use for Enhanced Barrier Precautions include:.iii. Transferring.v. Changing linens6. Implementation:.b Make PPE, including gowns and gloves, available immediately outside of the resident room.