Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675997	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carillon Inc	1717 A Norfolk Ave Lubbock, TX 79416

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 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** 49305 Based on interviews, 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 included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Residents #1) reviewed for care plans. The facility failed to develop an accurate, consistent, and completed care plan for Resident #1's activities of daily living and nutritional needs, specific to assistance needed during meals. This failure could place residents at risk of not receiving the care required to meet their individualized needs. Findings included: Resident #1 Record review of the face sheet, dated 10/25/2024, revealed Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with the following diagnoses: heart failure (condition in which the heart does not pump blood adequately), psychotic disorder with delusions (condition affecting brain function with altered perception of reality), cognitive communication deficit (communication difficulty caused by cognitive impairment), hypertension (high blood pressure), anemia (low levels of healthy red blood cells that carry oxygen), and hypokalemia (low potassium level). Record review of Resident #1's admission MDS assessment, dated 09/08/2024, revealed Resident #1 had a BIMS score of 00, which indicated severely impaired cognition. The MDS revealed Resident #1 usually required set up or clean up assistance for eating. The MDS revealed Resident #1 was on a mechanically altered diet. Record review of Resident #1's Nutritional Assessment, dated 09/11/2024, revealed under H. Oral Status, 2. Eating, Supervision and touching assistance is marked. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675997	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carillon Inc	1717 A Norfolk Ave Lubbock, TX 79416

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the current care plan for Resident #1, date initiated 9/11/2024 and revised on 9/20/2024, revealed a focus area indicating the resident required assistance with daily adl's due to end of life care, with a goal stating the resident will have all needs met through the next target date of 12/31/2024, and the intervention and tasks included assess resident current functional level with gg scores eating 5. The care plan also revealed a focus area indicating the resident was at risk for nutritional deficits related to end of life care. The plan stated the resident was on a regular diet, minced and moist Level 5 (dysphagia mesh altrd/grind) texture and regular/thin liquids (level 0) consistency with a spill cup to be used for liquids. The focus area stated the resident required cuing assistance with meals. The goal for this focus area stated the resident will have optimum nutrition level as evidence by not losing or gaining significant weight through the next review date of 12/31/2025. The interventions and tasks for this focus area stated the resident should have a diet per physician's order, food preferences should be discussed with the resident and her requests should be honored, and the resident's weight should be checked weekly. The care plan stated Resident #1 required assistance with ADL's due to end of life care. The interventions included: identify resident's level of assistance needed and complete resident Kardex, resident summary or nursing assistant assignment sheet for delivery of care. The care plan for ADL assistance contained coding information from the MDS for all ADL's and stated gg scores eating 5 under interventions. The care plan did not define the score. During an observation of the noon meal on 10/25/24 at 11:51 AM, Resident #1 was seated at the assistive feeding table wearing a clothing protector and holding a beverage. CNA A stated Resident #1's food had been cut up for her at the beginning of the meal. Resident #1 had consumed approximately fifty percent of her meal and was being encouraged by CNA A to continue eating. Resident #1 was observed to require frequent staff cueing to eat her meal. During an interview on 10/26/2024 at 1:02 PM, the ADM stated care plans were developed by the MDS nurse after the IDT team met to discuss the resident's needs. The ADM stated the DON was responsible for ensuring the care plan was completed and accurate. The ADM stated the IDT was responsible for monitoring the accuracy of the care plan, and all staff were responsible for reporting any changes and/or updates that were needed. The ADM stated the DON or designee was responsible for ensuring staff were trained on the resident's care plan. The ADM stated the expectation was for the care plan to be accurate. The ADM stated, if a care plan was not accurate or current, the resident was at risk for not receiving the care they need to obtain an optimal quality of life. During an interview on 10/26/2024 at 1:16 PM, the DON stated care plans were developed by the MDS nurse and the DON was responsible for ensuring they were completed and accurate. The DON stated care planning would have started on the day of admission and included the floor nurse who assessed the resident as well. The DON stated care plans were then completed within 7 days of admission and were usually completed by the MDS nurse. The DON stated changes were required to be updated on a resident's care plan as soon as the change was noticed. The DON stated she was not aware Resident #1's care plan was not accurate and consistent with her nutritional and adl needs. The DON stated staff were usually trained by the MDS nurse on care plans and they should have been updated with any changes to a resident's care plan immediately. The DON stated there was a stand-down meeting every day at 4 pm with all departments to go over any needs for residents and to update staff on what was completed for care planning. The DON stated assessments were also made at admission for care planning. The DON stated a resident was at risk of receiving unsatisfactory care if their care plan was not completed or accurate, and their care may not be to the fullest potential. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675997	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carillon Inc	1717 A Norfolk Ave Lubbock, TX 79416

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/26/2024 at 1:30 PM, the MDS coordinator stated she was responsible for completing and updating care plans for residents, and the DON was responsible for ensuring she completed and updated all care plans. The MDS coordinator stated a baseline care plan was developed within 48 hours of admission, and a comprehensive care plan was completed within 7 days of admission. The MDS coordinator stated care plans were updated frequently for any acute changes, and changes were updated immediately, as seen, or as reported. The MDS coordinator stated she trained staff on resident's care plans. The MDS coordinator stated she completed Resident #1's care plan, and the care plan should have reflected Resident #1's nutritional assessment. The MDS coordinator stated she was made aware, within a week of admission, that Resident #1 needed more assistance with meals and required cuing and supervision while eating. The MDS coordinator verified this was on Resident #1's nutritional assessment. The MDS coordinator stated, a resident's care plan not being accurate or consistent could result in the nursing staff not being aware of the resident's functional status, and Resident #1's inaccurate care plan could have resulted in Resident #1 experiencing weight loss. Record review of the facility's undated policy titled, Resident Care Plan Policy - Comprehensive, Person-Centered with a reviewed date of October 2024, reflected the following: Policy Statement: A comprehensive, person-centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy and Procedures: Care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Care plan interventions are chosen only after a proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessment of residents is ongoing, and care plans are revised as information about the resident and resident conditions change. The interdisciplinary team reviews and updates the care plan: When the desired outcome is not met;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675997	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Carillon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 A Norfolk Ave Lubbock, TX 79416	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observations, interviews, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition for 1 of 5 residents (Resident #1) reviewed for quality of life. The facility failed to ensure Resident #1 was provided assistance with eating during the lunch meal and dinner meal on 10/12/2024, while the resident was on in-room isolation. This failure could place residents at risk for decreased food intake, weight loss, decline in health, and a decreased quality of life. The findings included: Record review of the face sheet, dated 10/25/2024, revealed Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with the following diagnoses: heart failure (condition in which the heart does not pump blood adequately), psychotic disorder with delusions (condition affecting brain function with altered perception of reality), cognitive communication deficit (communication difficulty caused by cognitive impairment), hypertension (high blood pressure), anemia (low levels of healthy red blood cells that carry oxygen), and hypokalemia (low potassium level). Record review of Resident #1's admission MDS assessment, dated 09/08/2024, revealed Resident #1 had a BIMS score of 00, which indicated severely impaired cognition. The MDS revealed Resident #1 usually required set up or clean up assistance for eating. The MDS revealed Resident #1 was on a mechanically altered diet. Record review of the current care plan for Resident #1, date initiated 9/11/2024 and revised on 9/20/2024, revealed a focus area indicating the resident required assistance with daily adl's due to end of life care, with a goal stating the resident will have all needs met through the next target date of 12/31/2024, and the intervention and tasks included assess resident current functional level with gg scores eating 5. The care plan also revealed a focus area indicating the resident was at risk for nutritional deficits related to end of life care. The plan stated the resident was on a regular diet, minced and moist Level 5 (dysphagia mesh altrd/grind) texture and regular/thin liquids (level 0) consistency with a spill cup to be used for liquids. The focus area stated the resident required cuing assistance with meals. The goal for this focus area stated the resident will have optimum nutrition level as evidence by not losing or gaining significant weight through the next review date of 12/31/2025. The interventions and tasks for this focus area stated the resident should have a diet per physician's order, food preferences should be discussed with the resident and her requests should be honored, and the resident's weight should be checked weekly. The care plan stated Resident #1 required assistance with ADL's due to end of life care. The interventions included: identify resident's level of assistance needed and complete resident Kardex, resident summary or nursing assistant assignment sheet for delivery of care. The care plan for ADL assistance contained coding information from the MDS for all ADL's and stated gg scores eating 5 under interventions. The care plan did not define the score. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675997	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Carillon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 A Norfolk Ave Lubbock, TX 79416	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the order summary report, dated 10/24/2024, revealed Resident #1 had an order for regular diet with mechanically altered texture, thin liquids consistency, and spill cup to be used for liquids. Record review of Resident #1's Dietary/Nutrition Profile, dated 9/11/24, revealed the resident required supervision and touching assistance for eating. During an observation of the noon meal on 10/25/24 at 11:51 AM, Resident #1 was seated at the assistive feeding table wearing a clothing protector and holding a beverage. CNA A stated Resident #1's food had been cut up for her at the beginning of the meal. Resident #1 had consumed approximately fifty percent of her meal and was being encouraged by CNA A to continue eating. Resident #1 was observed to require frequent staff cueing to eat her meal. During an interview on 10/25/24 at 12:08 PM with CNA A, she stated she had been caring for Resident #1 since the resident was admitted a couple of months ago. CNA A stated Resident #1 always required assistance with cutting her food and required frequent cueing throughout the meal to stay on task to eat. She stated, at times, Resident #1 would require assistance from staff to begin eating her meal by feeding her a few bites to get her started. During an interview on 10/25/24 at 12:11 PM with LVN A, she stated Resident #1 was initially placed at an independent feeding table but had to be moved to an assistive feeding table within a couple of weeks after admission due to not eating well on her own. LVN A stated Resident #1 required verbal cueing throughout the meal to eat. During an interview on 10/25/24 at 3:11 PM with CNA B, she stated she worked PRN in the facility. She stated she was assigned to Resident #1 on 10/12/24, which was her first full shift working in the memory care unit. She stated Resident #1 was on isolation on the day she was assigned to her, and she brought Resident #1 her lunch tray and dinner tray during her shift. CNA B stated Resident #1 was sitting up in her chair when she brought her lunch to her room. She stated meals were being served in Styrofoam boxes at that time due to isolation precautions. She stated she opened the box for Resident #1 and showed her where her silverware was and left the room. CNA B stated she was not the one who picked up Resident #1's lunch tray and did not know how much food Resident #1 had consumed at lunch. CNA B stated she brought Resident #1 her dinner tray but did not provide eating assistance to the resident. She stated she picked up Resident #1's dinner tray and stated she did not eat much-maybe a bite or two of the meal. CNA B stated she was not aware that Resident #1 required assistance with meals. She stated she had been trained to obtain information about the resident's ADL needs by asking other staff members, but it was not reported to her that Resident #1 required assistance during meals. During an interview on 10/25/24 at 1:03 PM with the ADM, he stated the procedure to ensure dependent residents are provided adequate care, according to their needs was to train staff on proper ADL care and provide staff with accurate information for the level of care each resident required. He stated the DON, MDS nurse and nurse managers were responsible to ensure dependent residents needs were met and information was accurate for each resident's required level of assistance. The ADM stated his expectation of staff was to provide care as planned for each resident. He stated a potential negative outcome for failure to provide adequate care to a dependent resident was that the resident would not receive proper care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675997	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Carillon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 A Norfolk Ave Lubbock, TX 79416	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 1:19 PM with the DON, she stated charge nurses, the nursing team and the DON were responsible to assure that dependent residents needs are being met, according to their plan of care. She stated the system for monitoring that dependent residents' needs were being met was for nurse management to conduct rounds twice per week and perform random audits of the health care record. She stated staff were trained to use their preceptors as the primary information source for obtaining current information about a dependent resident's needs. The DON stated since the incident with Resident #1, staff had been retrained to use the Kardex system to obtain information regarding needs of dependent residents. She stated new staff were now being trained to use the Kardex system. The DON stated her expectation from staff for providing ADL care for dependent residents was to perform accurate care every two hours and as needed. She stated a potential negative outcome for failure to provide adequate care to a dependent resident was a decline in the resident's health status and potential harm, which is what we try to prevent. Record review of the facility provided policy titled Assistance with Meals, revised March 2022, revealed: Policy Statement Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation Dining Room Residents: . 2. Facility staff will serve resident trays and will help residents who require assistance with eating. 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity .