

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/24/2025
NAME OF PROVIDER OR SUPPLIER  Southern Specialty Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  4320 W 19th Street Lubbock, TX 79407	

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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to develop and implement a comprehensive care plan to meet the highest practicable physical, mental, and psychosocial needs for 1 of 3 residents (Resident #1) reviewed for care plans as follows: The facility failed to ensure to document Resident #1 was required to wear a fire-resistant apron and receive direct supervision from staff while smoking in the care plan, which resulted in staff not being trained or made aware of how to provide the resident with proper care. Resident #1's smoking assessment reflected she required direct supervision when smoking due shaking while smoking, falling asleep while smoking, past accidents/incidents with smoking materials, having visible burn marks on her clothing and she had finger dexterity problems. An Immediate Jeopardy was identified on 8/23/25 at 4:15 PM. The IJ template was provided to the facility Administrator on 6/12/24 at 4:18 PM. While the immediate jeopardy was lifted on 8/24/24 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 not receiving the care required to meet their physical, mental, and psychosocial needs which could result in serious harm and injuries. Findings included: Record Review of Resident #1's face sheet dated 8/22/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had a medical history of type 2 diabetes mellitus with diabetic chronic kidney disease (damage to the kidneys caused by high blood sugar and blood pressure), unspecified visual loss (loss of eye sight), hyperlipidemia unspecified (high levels of fats in the blood), schizophrenia unspecified (mental illness that causes hallucinations, delusions, and disorganized thinking), unspecified convulsions (sudden, violent, irregular movement of a limb or the body), dorsalgia unspecified (back pain), and essential (primary) hypertension (high blood pressure). Record review of Resident #1's MDS dated [DATE] revealed, Section C - Cognitive patterns revealed a BIMS score of 7 which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's care plan dated 7/14/25 revealed focus: Resident #1 was caught smoking in her room was at risk for injury while smoking and required supervised smoking, date initiated 8/14/25, Goals: Resident #1 will be able to smoke without causing injury through the next review date, date initiated 7/14/25, revision date 8/4/25, target date 10/14/25. Interventions: Resident #1 always check to make sure she does not have her cigarettes and lighter on her, remove if found, ensure smoking in designated smoking areas, ensure that no oxygen is located in the smoking area while the resident is smoking, ensure the resident is made aware of the facility smoking policy, no smoking materials or igniters will be stored in resident's rooms, safe smoking assessment every month, date initiated 7/14/25 and 8/14/25. Record review of Resident #1's safe smoking assessment dated [DATE], revealed under Section A Evaluation answered yes to the following questions, 7 resident shakes/has tremors while smoking, 8 resident falls asleep while smoking, 9 had past accidents/incidents with smoking materials, 10 are there any visible burn marks on the resident's clothing or coat, 11 does the resident have finger dexterity problems; and under Section B Summary the following options are checked, 2 This resident requires direct supervision while smoking, 3 this resident requires a fire-resistant smoking apron while smoking, 6 the evaluation has been discussed with the resident. Record review of Resident #2's care plan dated 7/17/25 revealed focus: Resident #2 vapes, date initiated 2/14/25, Goals: Resident #2 will be able to vape without causing injury, date initiated 2/14/2, revision date 2/14/24, target date 10/15/25. Interventions: Ensure smoking occurs in smoking areas, ensure that ensure that no oxygen is located in the smoking area while the resident is smoking, ensure the resident is made aware of the facility smoking policy, no smoking materials or igniters will be stored in resident's rooms, safe smoking assessment every month, date initiated 7/14/25 and 8/14/25, the resident will be supervised by a visitor or facility staff member at all times, date initiated 2/14/25. Record review of Resident #2's safe smoking assessment dated [DATE] revealed under Section A Evaluation answered no to the following questions: 3. Can the resident independently light smoking materials safely, 4. Can the resident extinguish smoking material completely in an appropriate receptacle, 5. Can the resident dispose of ashes or other tobacco-related residue appropriately, 6. Explanation: poor coordination; and under Section B Summary the following option was checked, 2. This resident requires direct supervision while smoking. Record review of Resident #3's care plan dated 6/19/25 revealed focus: Resident #3 had oxygen via a trach collar (surgical opening in the neck to provide an airway into the trachea) secondary to respiratory failure, date initiated</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 3 of 3 residents (Resident #1, Resident #2, and Resident #3) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #1 wore a fire-resistant apron and received direct supervision from staff on while smoking on 8/22/2025 and 8/23/25. Resident #1's smoking assessment reflected she required direct supervision when smoking due shaking while smoking, falling asleep while smoking, past accidents/incidents with smoking materials, having visible burn marks on her clothing and she had finger dexterity problems. 2. The facility failed to ensure Resident #2 received direct supervision per his smoking assessment from staff while smoking a vape on 8/23/25. 3. The facility failed to ensure Resident #3 did not have his oxygen tank with him while smoking on 8/22/25 and 8/23/25. An Immediate Jeopardy was identified on 8/23/25 at 4:15 PM. The IJ template was provided to the facility Administrator on 8/23/24 at 4:18 PM. While the immediate jeopardy was removed on 8/24/24 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. The failures could place residents at risk for serious injury, serious harm, burns, and death. Findings included: Resident #1 Record Review of Resident #1's face sheet dated 8/22/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had a medical history of type 2 diabetes mellitus with diabetic chronic kidney disease (damage to the kidneys caused by high blood sugar and blood pressure), unspecified visual loss (loss of eye sight), hyperlipidemia unspecified (high levels of fats in the blood), schizophrenia unspecified (mental illness that causes hallucinations, delusions, and disorganized thinking), unspecified convulsions (sudden, violent, irregular movement of a limb or the body), dorsalgia unspecified (back pain), and essential (primary) hypertension (high blood pressure). Record review of Resident #1's MDS dated [DATE] revealed, Section C - Cognitive patterns revealed a BIMS score of 7 which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's care plan dated 7/14/25 revealed focus: Resident #1 was caught smoking in her room, was at risk for injury while smoking and required supervised smoking, date initiated 8/14/25, Goals: Resident #1 will be able to smoke without causing injury through the next review date, date initiated 7/14/25, revision date 8/4/25, target date 10/14/25. Interventions: Resident #1 always check to make sure she does not have her cigarettes and lighter on her, remove if found, ensure smoking in designated smoking areas, ensure that no oxygen is located in the smoking area while the resident is smoking, ensure the resident is made aware of the facility smoking policy, no smoking materials or igniters will be stored in resident's rooms, safe smoking assessment every month, date initiated 7/14/25 and 8/14/25. Record review of Resident #1's safe smoking assessments dated 8/1/25, revealed under Section A Evaluation answered yes to the following questions, 7. resident shakes/has tremors while smoking, 8. resident falls asleep while smoking, 9. had past accidents/incidents with smoking materials, 10. are there any visible burn marks on the resident's clothing or coat, 11. does the resident have finger dexterity problems; and under Section B Summary the following options were checked, 2. This resident requires direct supervision while smoking, 3. This resident requires a fire-resistant smoking apron while smoking, and 6. The evaluation has been discussed with the resident. Record review of progress notes written by SW for Resident #1 dated 7/28/25, revealed staff spoke with the resident regarding the smoking policy and smoking in the hallways. Resident #1 stated she was confused and believed the CNA wheeled her into the smoking room. Reminded her that it was unsafe for her and the other residents to smoke inside. She understood and stated it won't happen again. Nurse and I (SW) asked her if we could hold the cigarettes and lighter at the nurses' station. Resident #1 said no, I'm not a child. Spoke with family member in person. Updated her and asked her if she would be willing to speak with the resident about the situation. The family member said yes and was understandable of situation. Record review of nursing progress notes, author unknown, for Resident # 1 dated 8/14/25, revealed Resident #1 was noted to be found smoking in the room. The resident stated she did not know she was in the building and said she thought she was in the smoking area. The resident was educated about fire hazards and a no smoking tolerance in the building. The family member was notified about the incident. Resident #2 Record Review of Resident #2's face sheet dated 8/23/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had a medical history of paraneoplasia</p>		