

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  11/04/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, observation, and record review, the facility failed to ensure that residents were free of significant medication errors for 6 of 10 residents (Resident #1, 2, 3, 5, 6, and 7) reviewed for pharmacy services. The facility failed to administer: Resident #1's order for Hydralazine and Amlodipine for blood pressure. Resident #2's order for Lamotrigine and Levetiracetam for seizures. Resident #3's order for Carvedilol for blood pressure, Entresto for heart failure, Torsemide for edema, and screen her blood pressure. Resident #5 order for Ziprasidone for Schizophrenia, Resident #6's order for Carvedilol for atrial fibrillation and congestive heart failure, Eliquis for heart failure, Levetiracetam for seizures, Lisinopril for high blood pressure, Vimpat for epilepsy, and screened for blood pressure. Resident #7's order for Midodrine for her blood pressure, Levetiracetam for convulsions, and screened for blood pressure. This failure could place residents at risk of complications, as well as jeopardizing their health and safety. Findings included:-Record review of Resident #1's admission Record dated 11/04/25 indicated her initial admission was 03/21/25 and was readmitted [DATE]. Record review of Resident #1's Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Brief Interview for Mental Status score (BIMS) was not filled out because resident rarely or never understood. Record review of Resident #1's Care Plan dated 09/05/25 included a focus area for hypertension, initiated 03/24/25 and revised 04/07/25, with interventions to educate the caregiver on the importance of medication, administer hypertensive (blood pressure consistently remains above normal levels) medications as order, monitor side effects such as orthostatic hypotension (a condition where blood pressure drops significantly upon standing up from a sitting or lying position), monitor tachycardia (increased heart rate exceeding 100 beats per minute), monitor the medications effectiveness, monitor/document/report to physician (MD) as needed any signs/symptoms (s/sx) of malignant hypertension to include headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, and difficulty breathing. Record review of Resident #1's Order Summary Report dated 11/04/25 with active orders as of 10/01/25, revealed a [AGE] year-old female with diagnoses that included essential-primary hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying medical cause). The order was to administer: *Hydralazine HCl (hydrochloride) oral tablet, 25 milligrams (mg. ), start date 03/07/25, give via G-tube (gastrostomy tube) every 6 hours as needed for elevated blood pressure (BP) related to hypertension, and systolic blood pressure ((SBP) indicates a significantly elevated risk for heart disease, stroke, and other cardiovascular issues) more than 160. *Amlodipine Besylate oral tablet 10 mg., start dated 03/08/25, give 10 mg. via G-Tube one time a day related to essential (primary) hypertension hold for SBP less than 110 or HR less than 60 Record review of Resident #1's Treatment Administration Record (TAR) dated 11/04/25 that covered the dates 10/01/25 through 10/31/25 revealed the A.M. (morning or ante meridiem before midday) 10/29/25, entries were blank, indicating her blood pressure was not taken and recorded. And further review of the TAR indicated her Amlodipine Besylate and Hydralazine HCl were not administered on 10/29/25. Observation and an attempted interview on 11/03/25 at 4:50 P.M. revealed Resident #1, who was lying in her bed, had a trachea (a cartilaginous tube that connects the larynx to the lung's bronchi, enabling air passage) and a tube feeding (delivers liquid nutrition through a flexi tube that goes in through your nose or directly into your stomach or small intestine) attachments. Resident #1 nodded her head up and down to all the questions asked of her, she was unable to respond appropriately. During an interview on 10/31/25 at 6:40 P.M with Licensed Vocation Nurse (LVN D) indicated she worked on 10/29/25 and left shift at approximately 7:30 A.M after the Administrator directed her to leave at 7:49 A.M. because he was taking over her residents, that included Resident #1. During an interview on 11/03/25 at 9:54 A.M. with LVN B indicated the morning medications are administered between 6 A.M. and 8 A.M. LVN B said on 10/29/25 at 7 A.M. she witnessed the Administrator and ADON at the facility. Then at approximately 10:45 A.M. she received red alerts on her electronic medication administration record, revealing resident #1, had not received her morning medications. LVN B said she was approached by the DON at 11 A.M. and she informed him Resident #1 had not received her morning medications. Afterwards, LVN B said she witnessed ADON asking LVN C to administer Residents #1's medication; however, she explained that she could not administer her morning medications because it was too close to the next medication pass. LVN B said the nurse assigned to Hall 100, which included Residents #1, failed to show up to work at 6 A.M. and a replacement was not assigned to resident #1. During an interview on 11/04/25 at</p>		