STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676028	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Specialty Rehab & Nursing	4320 W 19th Street Lubbock, TX 79407

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(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 - Some	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 observations , 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. The facility failed to protect and promote the rights of 12 confidential residents and 1 of 4 residents (Resident #7) reviewed for dignity in that: The facility failed to ensure staff were not utilizing their personal cell phones while providing care, which included assisting residents with their showers and performing peri-care. The facility failed to ensure LVN D provided privacy and dignity during wound care for Resident #7. This could place residents at risk for diminished quality of life and loss of dignity and self-worth.Findings include: At an undisclosed date and time twelve confidential residents stated the use of cell phones by CNAs while performing care made them feel embarrassed, concerned about the quality of the care being provided, and their privacy was violated. The twelve confidential residents stated the use of cell phones by CNAs occurred on every shift. Confidential residents stated staff utilize their cell phones while performing showers, when performing care in resident rooms, and while performing peri-care. The confidential residents stated the staff text and talk on their phones while walking down hallways, at the nurses' stations, and while in the dining area during meals. The twelve residents stated they did not know the names of the CNAs who utilized their cell phones while performing care. The confidential residents stated cell phone usage of the CNAs while performing care happened in the facility often, they said every CNA in the facility utilized their cell phone while performing care. During an interview on 06/11/26 at 12:35pm, the DON stated staff should not be on their cell phones in resident care areas. He stated residents should be provided care with no outside distractions; the residents should always be the staff's priority. He stated all staff were trained in privacy, resident rights, dignity, and cell phone usage during orientation and through continuous education by department heads and the DON. He stated staff were monitored by sporadic rounds completed by the DON and the ADON. The DON stated Resident Rights and cell phone usage are discussed at quarterly training and more often if there is a complaint. He stated the potential negative outcome would be a violation of privacy and a lack of attention to the care being provided to the residents. During an interview on 6/11/2026 at 1:25pm, the ADM stated staff should not have cell phones or earbuds on their person while performing care. He stated cell phones should be kept in breakroom lockers. Staff should provide undivided attention to residents while performing care. The ADM stated all staff are trained in resident rights, dignity, and cell phone usage during the on boarding process, continuous online training, and in-services. Staff are monitored for cell phone use by rounding completed by the ADON and the DON. The ADM stated the potential negative outcome for residents is a violation of their privacy and a lack of attention to the resident. Record review of the admission record for Resident #7, dated 06/09/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarctions affecting the left non-dominant side (paralysis of the left side) and urinary tract infection (bladder infection). Record review of the comprehensive MDS (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment for Resident #7, dated 12/20/25 revealed Resident #7's cognitive skills for daily decision making were severely impaired. During an observation on 06/10/26 at 3:30 PM, LVN D provided wound care to Resident #7's wounds and did not close the door or pull the privacy curtain around Resident #7 during care. Two female residents were observed passing by Resident #7's room and looked into his room while care was being provided. Resident #7 was able to be viewed from the doorway. During an interview on 06/10/26 at 4:42 PM, LVN D stated she had been trained to close the door and pull the privacy curtain for privacy during resident care. LVN D stated she did not close the door because she was waiting for the CNA and thought the CNA would close the door. LVN D stated she was trained about once a month regarding dignity for a resident. LVN D stated the residents could have self-image risks. During an interview on 06/11/26 at 1:32 PM, the DON stated he expected the staff to pull the curtain all the way around the resident and close the door when providing resident care. The DON stated the staff was recently trained on dignity, but he would have to look for the date. The DON stated he did not know why the door was left open and the curtain not pulled around Resident #7 during resident care. The DON stated residents could be at risk for getting embarrassed. During an interview on 06/11/26 at 2:07 PM, the ADM stated he expected the staff to close the door and pull the privacy curtain during resident care to maintain privacy. The ADM stated maybe LVN D was nervous and that was why she did not close the door or pull the privacy curtain. The ADM stated he would have to look for the last time the staff was trained on dignity. The ADM stated the residents were at risk of being embarrassed or having a dignity issue. Record review of the undated facility policy titled Resident Rights revealed the following: Policy: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. Policy Interpretation and ImplementationThe facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. The facility will provide the Resident Rights to each newly admitted resident and upon any revision to the Resident Rights to each resident and/or representative.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 3 of 3 Residents (Resident #7, #20, and #46) reviewed for incontinent care. The facility failed to ensure Resident #7's, #20's, and #46's catheter strap was in place and holding. The facility failed to ensure CNA E cleansed Resident #7's catheter with the correct technique to prevent infections. The facility failed to ensure Resident #20 catheter drainage bag was placed below the bladder. These failures placed the residents at risk of their Foley catheters getting dislodged, unwanted pain, trauma, infections, and decreasing their quality of life. Findings include:Resident #20Record review of Resident #20's face sheet dated 06/11/2026 revealed a [AGE] year-old-female admitted on [DATE] with the following diagnoses: respiratory failure, anoxic brain damage (no oxygen to brain), overactive bladder and retention of urine. Record review of Resident #20's quarterly MDS dated [DATE] revealed Resident #20 had a BIMS score of 00 which indicated severe cognitive impairment. The MDS further revealed Resident #20 was dependent (helper does all the effort) for ADLS. Bladder and Bowel section revealed Resident #20 had an indwelling catheter. Record review of Resident #20's care plan dated 03/24/2026 revealed a focus area of Resident #20 had a foley catheter related to neurogenic bladder (nerve damage disrupts communication between bladder and brain) with interventions to assure the drainage bag was below the level of the bladder at all times. Record review of the Order Summary Report dated 06/11/2026 for Resident #20 revealed an order dated 03/08/2021 to ensure catheter strap in place and holding every shift.During an observation on 06/10/2026 at 11:30 a.m. RN B observed catheter drainage bag for Resident #20 was lying in bed with catheter bag lying on foot of bed. Resident #20's catheter tubing was under her right leg and curled up on the bed. Observation revealed no catheter strap. He stated, the catheter drainage bag is not in the right place.Resident #46Record review of Resident #46's face sheet dated 06/11/2026 revealed a [AGE] year-old-male admitted on [DATE] with the following diagnoses: respiratory failure, quadriplegia (paralysis of all four extremities), epileptic seizure (abnormal electrical activity in the brain), and dysphagia (difficulty swallowing).Record review of Resident #46's quarterly MDS dated [DATE] revealed Resident #46 had a BIMS score of 00 which indicated severe cognitive impairment. The MDS further revealed Resident #46 was dependent (helper does all the effort) for ADLS. Bladder and Bowel section revealed Resident #46 had an indwelling catheter. Record review of Resident #46's care plan dated 01/08/2024 revealed a focus area of Resident #46 was on enhanced barrier precautions with interventions catheter care. Record review of the Order Summary Report dated 06/11/2026 for Resident #46 revealed an order dated 03/27/2026 to ensure catheter strap in place and holding every shift.During an observation on 06/10/2026 at 11:12 a.m. Resident #46 lying in bed with catheter tubing under his right leg with no catheter strap in place. LVN A stated he had a shower today and may have come off in the shower. He stated he was not aware Resident #46 did not have a catheter strap. LVN A verified the physician order stating Resident # 46 did have an order for a catheter strap to be in place.Record review of the face sheet for Resident #7, dated 06/09/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarctions affecting the left non-dominant side (paralysis of the left side) and urinary tract infection (bladder infection).Record review of the comprehensive MDS assessment for Resident #7, dated 12/20/25 revealed Resident #7's cognitive skills for daily decision making were severely impaired.Record review of the care plan for Resident #7, last review completed on 04/02/26 revealed: Focus: [Resident #7] has an indwelling catheter r/t neurogenic bladder. Interventions/Tasks: Ensure tubing is anchored to the residents leg or linens so that tubing is not (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pulling on the urethra with an initiation date of 04/24/26.During an observation on 06/10/26 at 2:50 PM, CNA E provided catheter care and incontinence care to Resident #7. Resident #7 was observed without a leg strap for the catheter tubing on either leg. CNA E cleansed the catheter with a wipe and grabbed the catheter where it meets the penis and rubbed the catheter in a back-and-forth motion, going away from the penis and towards the penis several times. CNA E then grabbed a clean wipe and wiped the catheter once going away from the penis and then wiped the catheter again going away from the penis with the same side of the wipe that was used prior.During an interview on 06/11/2026 at 10:56 a.m., CNA C stated the catheter drainage bag was to catch urine. She stated the purpose of the catheter strap was to keep the catheter from pulling. She stated she had been trained in foley catheter straps and drainage bags. She stated she checks on residents every two hours. She stated nursing staff was responsible for monitoring catheter drainage bags and straps. She stated the potential negative outcome of having a drainage bag on the bed could be urine going back into the resident and UTIs. She stated the potential negative outcome of not having a catheter strap could be pulling the foley catheter out.During an interview on 06/11/2026 at 10:20 a.m., DON stated the purpose of a catheter drainage bag was to catch urine. He stated the purpose of the catheter leg strap was to keep the catheter tubing secure. He stated he was not aware that the catheter drainage bag was on Resident #20's bed and was not aware Residents #20 and #46 did not have a catheter leg strap. He stated the nursing staff was responsible for monitoring catheter drainage bag placement and catheter leg straps every 2 hours during rounds. He stated all nursing staff had been trained in foley catheters. He stated the potential negative outcome of placing the catheter drainage bag on the bed could be lack of dignity and draining urine back into the bladder causing a UTI. He stated the potential negative outcome of not having a catheter leg strap could be pulling causing pain or pulling catheter out causing trauma.During an interview on 06/11/2026 at 10:38 a.m., ADM stated the purpose of a catheter drainage bag was to catch urine. He stated the purpose of the catheter leg strap was to keep the catheter tubing secure and prevent pulling. He stated he was not aware that the catheter drainage bag was on Resident #20's bed and was not aware Residents #20 and #46 did not have a catheter leg strap. He stated the nursing staff was responsible for monitoring catheter drainage bag placement and catheter leg straps during rounds and foley care. He stated all nursing staff had been trained in foley catheters. He stated that the potential negative outcome of placing the catheter drainage bag on the bed could be UTI and urine will not drain causing urine to sit in the bladder. He stated the potential negative outcome of not having a catheter leg strap could be pulling catheter out causing pain.During an interview on 06/11/26 at 11:28 AM, CNA E stated she was trained to clean the catheter from the point where it goes in the penis and then wipe 4 inches away from the penis. CNA E stated something was stuck on the catheter and that was why she used a back-and-forth motion. CNA E stated she did not know the last time she was trained on catheter care and stated she had several in-services since then. CNA E stated the residents had a risk for infection.During an interview on 06/11/26 at 1:32 PM, the DON stated during catheter care he expected the staff to always clean away from the penis. The DON stated he expected the staff to use one single swipe to cleanse away from the penis in one fluid motion. The DON stated the staff had been trained not to go back with the same soiled cloth or wipe. The DON stated he did not know why CNA E did not cleanse the catheter going away from the penis. The DON stated the residents had a risk for infection or skin breakdown.During an interview on 06/11/26 at 2:07 PM, the ADM stated staff were to follow the policies for catheter care. The ADM stated he expected the staff to use one wipe and then throw it away and get a new one. The ADM stated the risk to the residents was UTI or infection.During an interview on 06/11/2026 at 02:08 p.m. RN B stated the catheter drainage bags should be below the resident's bladder. RN B stated Resident #20 did not have a catheter strap. He stated the purpose of the catheter drainage bag was to catch the urine. He stated the purpose of the catheter leg strap was to keep the tubing from pulling and secure. He stated he was not aware the catheter drainage bag was placed on the bed and the resident did not have a catheter strap. He stated he had been trained on foley catheter care related to catheter (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drainage bags and catheter leg straps. He stated the nursing staff was responsible for monitoring catheter bag placement and leg straps. He stated the potential negative outcome could be urine flowing back up and UTIs. He stated the potential negative outcome of not having a catheter leg strap could be pulling the catheter out and causing pressure ulcers.Record review of the facility policy titled, Catheter Care, undated reflected the following: General Guidelines: .5. Check the residents frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site.Procedure: .15. Keep the drainage bag below level of bladder when cleaning the urethral area.17. Then wash the catheter from the meatus down the tube about 3 inches. On 06/11/2026 at 10:00 a.m. requested policy of following physician orders. During an interview on 06/11/2026 at 03:00 p.m. corporate nurse stated she could not find a policy on following physician orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: On 06/10/2026 DA failed to properly wear hair net while serving food.On 06/11/2026 DM failed to properly wear hair net while preparing food. This failure could place residents at risk for food contamination. Findings included: During an observation on 06/10/2026 at 12:00 p.m. DA was wearing a black beanie covering the top of head leaving hair braids uncovered while assisting with serving the noon meal. During an observation on 06/11/2026 at 10:45 a.m. DM was wearing a black headband with hair uncovered while preparing noon meal. During an interview on 06/11/2026 at 10:48 a.m., the DA stated the purpose of a hair net was to keep hair from getting in the food. He stated he did not need to cover his braids, only his beard and top of head. He stated he had been trained in hair restraints while in the kitchen. He stated the potential negative outcome of not wearing hair restraint could be hair falling into food. During an interview on 06/11/2026 at 10:51 a.m., the DM stated all staff in the kitchen were to wear hair restraints covering all hair including braids. She stated she was aware DA was not properly wearing his hair restraint and did an in-service with DA on proper hair restraints on 06/10/2026. She stated she wore a hair net over her head band but forgot to put it on. She stated the purpose of the hair restraint was to keep hair from falling into food. She stated all staff had been trained on proper hair restraints. She stated she was responsible for monitoring kitchen staff for proper hair restraints. She stated the potential negative outcome could be the food being contaminated with hair. During an interview on 06/11/2026 at 11:20 a.m., the ADM stated he was not aware the kitchen staff were not properly wearing hair restraints. He stated the purpose of the hair restraint was to keep hair out of the food. He stated all staff have been in-serviced on wearing proper hair restraints while in the kitchen. He stated the DM and ADM were responsible for monitoring compliance with hair restraints. He stated the potential negative outcome could be infection control and someone could get sick from hair falling into food. Record review of the facility's policy, titled Infection Control, dated revised April 9, 2025, reflected the following: We will ensure that all employees practice infection control in the Food and Nutrition Services Department and maintain sanitary food preparation.Procedure.9. Restricted access to kitchen and dining areasa. Only authorized employees necessary for the operation of the food service establishment, or as part of an organized educational event, shall be allowed in the food preparation or utensil washing areas, and all shall wear a hairnet or hair covering.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to offer sufficient fluid intake to maintain proper hydration and health for 1 of 3 Residents (Resident #6) reviewed for sufficient hydration.The facility failed to follow Resident #6 physician orders for hydration. This failures could affect residents receiving enteral hydration and place them at risk of health complications and decline in health. Findings included: Resident #6 Record review of Resident #6's face sheet dated 06/11/2026 revealed a [AGE] year-old-male admitted on [DATE] with the following diagnoses: acute and chronic respiratory failure, quadriplegia (paralysis of all four extremities), and persistent vegetative state. Record review of Resident #6's quarterly MDS dated [DATE] revealed Resident #6 had a BIMS score of 00 which indicated severe cognitive impairment. The MDS further revealed Resident #6 had a feeding tube. Record review of Resident #6's care plan dated 01/08/2024 revealed a focus area of Resident #6 had potential fluid deficit related to depends on all staff for h2o via g-tube with intervention to administer fluids per g-tube as ordered. Record review of the Order Summary Report dated 06/11/2026 for Resident #6 revealed an order dated 03/27/2026 for 45 ml/H20 for 22 hours with 2hr gut rest. Observation on 06/09/2026 at 07:00 a.m. revealed Resident #6 was in room and receiving g-tube feeding. Feeding pump rate displayed on pump screen was H2O 30ml/hr. Observation on 06/10/2026 at 10:10 a.m. revealed Resident #6 was in room and receiving g-tube feeding. Feeding pump rate displayed on pump screen was H2O 30ml/hr. During an interview and observation on 06/10/2026 at 03:43 p.m. observed LVN A confirmed Resident #6's pump rate was set at 30ml/hr for H2O. He stated Resident #6's physician order was H2O 45ml/hr for 22 hours with 2 hours of gut rest. He stated he was not sure why the rate on the pump was set at 30ml/hr unless the order had been changed. He stated he was not aware of any order changes. During an interview on 06/11/2026 at 10:03 a.m., LVN A stated the purpose of a resident receiving water with tube feeding was to keep the resident hydrated. He stated he was not aware the rate was wrong for Resident #6. He stated he monitors feeding tube pump rates at the beginning of his shift and 3 to 4 times during his shift. He stated he had been trained in feeding tube pumps and how to set the rate. He stated the LVN was responsible for setting the right rate when the H2O was started and any changes throughout the shift. He stated the potential negative outcome could be dehydration. During an interview on 06/11/2026 at 10:20 a.m., DON stated the purpose of a resident receiving water with tube feeding was to provide hydration above the formula. He stated he was not aware the water rate for Resident #6 was wrong. He stated the nurse should monitor the water rate at least once a shift during the initial assessment. He stated all staff have been trained on feeding pumps and pump rates. He stated he expects the nurses to check the orders and rates and make sure they match every shift and when they hang a new bag. He stated the primary nurses were responsible for the feeding tube pump and setting the rate. He stated the potential negative outcome could be dehydration, receiving too much or not enough liquids, and tube clogging up. During an interview on 06/11/2026 at 10:38 a.m., ADM stated the purpose of a resident receiving water was to provide hydration. He stated he was not aware Resident #6 were not receiving the proper water rate. He stated the nurse was to monitor the feeding pump rate daily and when they hang new bags. He stated all nurses have been trained in feeding pump rates. He stated the clinical staff (DON, ADON and CN) were responsible for feeding tube rates. He stated the potential negative outcome could be the residents receiving too much or not enough fluids, fluid overload and dehydration. Record review of the facility policy, titled Enteral Nutrition, undated, revealed the following: We will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth.Procedure:1. The nursing services department is responsible for all feeding equipment and the administration of tube feedings.3. If the physician and family opt for a feeding tube orders are written to include the following: .2. The volume to be given in 24-hours and the number of milliliters per feeding if not (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuous drip.5. Problems with the administration of the tube feeding are monitored and corrected by nursing. The dietitian is responsible for evaluating nutritional adequacy and fluid requirements. On 06/11/2026 at 10:00 a.m. requested policy of following physician orders. During an interview on 06/11/2026 at 03:00 p.m. corporate nurse stated she could not find a policy on following physician orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means receives the appropriate treatment to prevent complications of enteral feeding for 1 of 3 residents (Resident #6) reviewed for enteral nutrition, in that: The facility failed to follow Resident #6's physician orders for enteral feeding. These failures could affect residents receiving enteral nutrition and place them at risk of health complications and decline in health. The findings include: Record review of Resident #6's face sheet dated 06/11/2026 revealed a [AGE] year-old-male admitted on [DATE] with the following diagnoses: acute and chronic respiratory failure, quadriplegia (paralysis of all four extremities), and persistent vegetative state. Record review of Resident #6's quarterly MDS dated [DATE] revealed Resident #6 had a BIMS score of 00 which indicated severe cognitive impairment. The MDS further revealed Resident #6 had a feeding tube and received 51% or more of total calories through tube feeding. Record review of Resident #6's care plan dated 01/08/2024 revealed a focus area of Resident #6 had a potential risk for malnutrition related to BMI with interventions to administer enteral feedings as ordered. Record review of the Order Summary Report dated 06/11/2026 for Resident #6 revealed an order dated 03/27/2026 for enteral feed every shift Isosource 1.5 85ml/hr for 22 hours. Observation on 06/09/2026 at 07:00 a.m. revealed Resident #6 was in room and receiving g-tube feeding. Feeding pump rate displayed on pump screen was 55ml/hr. Observation on 06/10/2026 at 10:10 a.m. revealed Resident #6 was in room and receiving g-tube feeding. Feeding pump rate displayed on pump screen was 55ml/hr. During an interview and observation on 06/10/2026 at 03:43 p.m. observed LVN A confirmed resident pump rate was set at 55ml/hr. He stated Resident #6's physician order was Isosource 1.5 - 85ml/hr for 22 hours with 2 hours of rest. He stated he was not sure why the rate on the pump was set at 55ml/hr unless the order had been changed. He stated he was not aware of any order changes. During an interview on 06/11/2026 at 10:03 a.m., LVN A stated the purpose of a resident having a feeding tube was to receive nutrition. He stated he monitors feeding tube pump rates at the beginning of his shift and 3 to 4 times during his shift. He stated he had been trained in feeding tube pumps and how to set the rate. He stated the LVN was responsible for setting the right rate when the feeding was started and any changes throughout the shift. He stated the potential negative outcome could be malnutrition and weight loss. During an interview on 06/11/2026 at 10:20 a.m., DON stated the purpose of a feeding tube was to provide proper nutrition to the residents. He stated he was not aware the feeding rate for Resident #6 was wrong. He stated the nurse should monitor the feeding pump rate at least once a shift during the initial assessment. He stated all staff have been trained on feeding pumps and pump rates. He stated he expects the nurses to check the orders and rates and make sure they match every shift and when they hang a new bag. He stated the primary nurses were responsible for the feeding tube pump and setting the rate. He stated the potential negative outcome could be not enough nutrition, poor wound healing, weight loss, stomach distention, bowel distention, reflux and aspiration. During an interview on 06/11/2026 at 10:38 a.m., ADM stated the purpose of a feeding tube was to provide calorie intake and weight management. He stated he was not aware Resident #6 was not receiving the proper feeding rate. He stated the nurse was to monitor the feeding pump rate daily and when they hang new formula. He stated all nurses have been trained in feeding pump rates. He stated the clinical staff (DON, ADON and CN) were responsible for feeding tube rates. He stated the potential negative outcome could be the residents receiving too much or not enough calories and protein. Record review of the facility policy, titled Enteral Nutrition, undated, revealed the following: We will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth.Procedure:1. The nursing services department is responsible for all feeding equipment and the administration of tube feedings.3. If the (continued on next page)

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	676028	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Specialty Rehab & Nursing	4320 W 19th Street Lubbock, TX 79407

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician and family opt for a feeding tube orders are written to include the following: .2. The volume to be given in 24-hours and the number of milliliters per feeding if not continuous drip.5. Problems with the administration of the tube feeding are monitored and corrected by nursing. The dietitian is responsible for evaluating nutritional adequacy and fluid requirements. On 06/11/2026 at 10:00 a.m. requested policy of following physician orders. During an interview on 06/11/2026 at 03:00 p.m. corporate nurse stated she could not find a policy on following physician orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 5% based on 2 out of 40 opportunities, for 2 of 4 Residents (Residents #47 and #56) reviewed for medication administration, in that:-The facility failed to ensure MA G provided the correct dose of the medication guaifenesin 600mg to Resident #56.-The facility failed to ensure MA G provided the correct dose of the medication cranberry 500mg to Resident #47.These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.Findings included:Resident #56Record review of Resident #56's admission record, dated 06/11/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: acute respiratory failure (lungs do not function properly), protein-calorie malnutrition (bad nutrition), and quadriplegia (paralysis from the neck down).Record review of Resident #56's physician orders, dated 06/10/26, revealed an order for Mucinex Oral Tablet Extended Release 12 Hour 600 mg (Guaifenesin) Give 1 tablet by mouth one time a day for cough with a start date of 08/17/25.During a medication administration observation on 06/10/26 at 8:14 AM, MA G was observed dispensing guaifenesin 400mg 1 tablet by mouth to Resident #56. Resident #47Record review of Resident #47's admission record, dated 06/11/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: acute respiratory failure (lungs do not function properly), immunodeficiency (the body's defense system is weakened), and neuromuscular dysfunction of bladder (bladder muscles do not work properly).Record review of Resident #47's physician orders, dated 06/10/26, revealed an order for Cranberry Soft Oral Tablet Chewable 500 mg Give 1 tablet by mouth two times a day related to neuromuscular dysfunction of bladder, with a start date of 09/08/24.During a medication administration observation on 06/10/26 at 8:23 AM, MA G was observed dispensing Cranberry 450 mg 1 tablet by mouth to Resident #47. During an interview on 06/10/26 at 10:11 AM, MA G stated she had caught the error for Resident #56 and one of the other nurses went to get the correct dose of Mucinex. MA G stated she did not have the correct dose in her medication cart. MA G stated she did not see that the Cranberry tablet for Resident #47 was the wrong dose. MA G stated it was her fault.During an interview on 06/11/26 at 11:32 AM, MA G stated she had been trained on the 5 rights for medication administration, but it had been a while. MA G stated a potential negative outcome for the residents was they could not be getting the right dose that they would need and it was not good.During an interview on 06/11/26 at 1:32 PM, the DON stated he was unsure of when the last time the staff was trained on medication administration and stated he would have to ask the ADM. The DON stated he was not aware of medication administration training being provided with him working as DON at the facility. The DON stated he expected the 5 rights of medication administration to be followed, the correct medication/dose, the correct time, the correct route and the reason for the medication. The DON stated he did not know why the wrong doses of medications were given. The DON stated it was easy to get lazy, especially if it was the same people and it could have been nerves as well. The DON stated a potential negative outcome for the resident was no outcome or not enough outcome from the medication.During an interview on 06/11/26 at 2:07 PM, the ADM stated he expected the staff to look at orders and medications and ensure the correct dose before giving. The ADM stated the staff knew to let someone know if an over the counter medication was the wrong dose. The ADM stated he did not know why MA G gave the wrong doses for the medications. The ADM stated that depending on the medication, the medication could be harmful or cause adverse side effects to the residents.Record review of facility policy titled, Medication Administration and General Guidelines dated 2025 reflected the following: Policy: Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	so.Procedure:.2. Medications are administered in accordance with written orders of the attending physician.Checklist for completing proper steps in administration of medications.Adheres to the 6 rights of Medication AdministrationRight Dose.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 2 RT carts (RT Cart A) reviewed for medication storage. The facility failed to ensure RT Cart A was locked when not in use or unattended. This failure could place residents at risk of medication errors or adverse effects. The findings included:During an observation on 06/11/26 at 8:44 AM, RT Medication/Treatment Cart A was observed in the 200 Hall unlocked and unattended with the keys hanging from the opened lock. No staff or residents were observed within eyesight of the cart.During an observation and interview on 06/11/26 at 8:46 AM, RT F stated she had gone in a resident's room quickly to see what he needed. RT F stated she should have locked her cart when she stepped away from it. RT F opened the top drawer, and medications and supplies were observed in the cart. RT F stated she did not know the last time she was trained to keep her cart locked when she stepped away from it. RT F stated she did not know of a potential negative outcome to the residents.During an interview on 06/11/26 at 1:32 PM, the DON stated he expected the staff to keep their carts locked when not near them and their keys to be kept in their pocket or on their person. The DON stated the staff were trained on medication storage within the last couple of months, but he did not have an exact date. The DON stated he did not know why RT F did not lock her cart when she walked away from it. The DON stated a potential negative outcome to the residents was that they could get a medication they do not need or a possible allergy to the medication. During an interview on 06/11/26 at 2:07 PM, the ADM stated he expected the staff to lock their carts when they were not with them. The ADM stated the facility had done in-services regarding medication storage but did not have an exact date. The ADM stated he did not know why RT F did not lock her cart before she walked away. The ADM stated a potential negative outcome to the residents was that the resident could get in there and grab or take the medications.Record review of the facility policy titled, Medication Storage in the facility dated 2025 reflected the following: Policy: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Procedure:.2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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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 4 residents (Resident #7) reviewed for infection control. The facility failed to ensure CNA E changed her gloves and performed hand hygiene before going from dirty to clean during incontinence care for Resident #7. This failure could place residents at risk for cross contamination and infection. The findings included: Record review of the admission record for Resident #7, dated 06/09/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarctions affecting the left non-dominant side (paralysis of the left side) and urinary tract infection (bladder infection). Record review of the comprehensive MDS assessment for Resident #7, dated 12/20/25 revealed Resident #7's cognitive skills for daily decision making were severely impaired. During an observation of catheter care and incontinence care on 06/10/26 at 2:50 PM, CNA E provided catheter care and incontinence care to Resident #7. CNA E wiped Resident #7's buttocks, removed the dirty brief and then placed a clean brief and a clean draw sheet under Resident #7. CNA E did not change her gloves or perform hand hygiene after removing the dirty brief and before placing the clean brief and draw sheet under Resident #7. During an interview on 06/11/26 at 11:28 AM, CNA E stated she caught her mistake during incontinence care for Resident #7 after the fact. CNA E stated she was supposed to change her gloves after cleaning the resident and before putting on a new drawsheet and brief. CNA E stated she did not remember the last time she was trained on infection control. CNA E stated the risk to the resident was infection. During an interview on 06/11/26 at 1:32 PM, the DON stated he expected the staff to have clean gloves and clean hands when putting on a clean brief on a resident. The DON stated he did not know the last time CNA E was trained on infection control and stated he would look for it. The DON stated he did not know why CNA E did not change her gloves and perform hand hygiene between dirty and clean procedures. The DON stated the residents had a risk for infection. During an interview on 06/11/26 at 2:07 PM, the ADM stated he expected the staff to take their gloves off, wash their hands and put on clean gloves between dirty and clean to prevent the spread of infection. The ADM stated CNA E was recently trained for infection control but did not know exactly when. The ADM stated a potential negative outcome to the residents was that it could cause a UTI or infection. Record review of the facility's policy titled, Fundamentals of Infection Control Precautions undated reflected the following: A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions.1. Hand HygieneHand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:.after contact with a resident's mucous membranes and body fluids or excretions.GlovingGloves are worn for three important reasons1. To provide a protective barrier and prevent cross contamination of the hands when touching .body fluids.2. To reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident-care procedures that involve touching a resident's mucous membranes or non-intact skin.3. To reduce the likelihood that hands of personnel contaminated with microorganisms from a resident.can transmit these microorganisms to another resident.Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use.