

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER The Plaza at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Emory 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854</p> <p>Based on interviews, and record reviews the facility failed to ensure residents the right to be free from abuse and/or neglect for 3 (Resident #1, Resident #2, and Resident #3) of 10 residents reviewed for abuse and/or neglect.</p> <ol style="list-style-type: none"> The facility failed to keep RN A made inappropriate sexual comments to Resident #1 resulting in Resident #1 feeling ashamed and embarrassed. The facility failed to ensure that CNA B did not refuse to change Resident #2 when Resident #2's brief was saturated. The facility failed to ensure that CNA B did not make verbally abusive comments to Resident #2 when Resident #2 was talking to CNA B The facility failed to ensure that CNA B was not excessively rough when transferring Resident #3 from wheelchair to the commode. <p>These failures could affect residents resulting in physical or emotional harm resulting in in deterioration in their health condition, need for medical treatment, physical impairment, exacerbation of their condition, serious bodily harm, emotional distress, and feelings of isolation.</p> <p>Findings included:</p> <p>Resident #1:</p> <p>Record Review of Resident #1 face sheet, dated 10/17/2024, revealed that Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE] with, but not limited to the following diagnoses: Spinal stenosis (a chronic condition that occurs when the spinal canal narrows, putting pressure on the spinal cord and nerves), lumbar region with neurogenic claudication (a condition that occurs when the spinal canal narrows in the lower back, compressing the spinal nerves), Injury of peroneal nerve(a major nerve in the lower leg that controls movement and sensation in the foot, toes, and lower leg) at lower leg level, right leg, acute kidney failure, unspecified, low back pain, unspecified, other abnormalities of gait and mobility, muscle weakness (generalized), Pain, unspecified, cognitive communication deficit, urinary tract infection, site not specified.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #1's MDS, dated [DATE], revealed Resident #1 had a BIMS score of 15 and a functional capacity of being independent.</p> <p>Interview on 10/17/2024 at 6:39am LVN D stated that Resident #1 confided in her about things RN A had said to her. LVN D stated that RN A said, If you feel a warm body in bed with you, it is me crawling in next to you. LVN D could not give a date on which this was said. LVN D stated that Resident #1 told her that she did not feel comfortable around RN A and did not allow RN A to perform wound care on a wound that was located in between Resident #1's thighs. RN A then confronted Resident #1 and asked why she allowed another male nurse to perform wound care for that particular wound. LVN D stated she was unsure what was Resident #1's response to RN A. LVN D immediately reported this to the abuse coordinator for the facility.</p> <p>Interview on 10/17/2024 at 7:49am with Resident #1 stated that she was in the facility for just a few days when RN A came into her room and stated Wow, you are beautiful. Resident #1 stated that she thought that was weird, that some random man came into my room and gave me a compliment. Resident #1 stated that she did not learn RN A's name for quite some time and every time he would leave Resident #1's room RN A would I love you. Resident #1 stated, It was just too much, so I just blocked it out. Resident #1 stated that one day RN A came to perform wound care for my legs and feet. I apologized for my legs being swollen and RN A said Well, I would still lick and kiss them. I do have a wound in between my legs close to my groin area, I would not allow him to change the bandage. The next day RN A came into my room and said to me I thought you didn't want your bandage changed? I told RN A well I did, RN A stated, Well LVN D did it! I said to him yes he did. Resident #1 stated that there was one night she was up, and RN A came into her room. Resident #1 stated that she should have gotten in bed before the start of his shift and then maybe he wouldn't have come in. Resident #1 stated that she told RN A that she was getting ready for bed and that she didn't need anything. RN A then stated to Resident #1 Well if you feel a hot body behind you in bed, it is me getting in. Resident #1 stated she didn't know how to respond to him, and severe nervousness took over. On a different occasion RN A came into my room stating that there were 2 sisters that lived in the facility and that they fought over him every time that he went into their room. RN A stated that the sisters will say things like He is mine!. Resident #1 stated one day when LVN D came into perform wound care I told her that I was happy that she could get to my wound care because I didn't want RN A to have to do it. LVN D stated that RN A no longer worked here. Once LVN D said that to me I knew I could tell her everything, so I opened up to her, before that I felt so ashamed and embarrassed, I just didn't want any problems.</p> <p>Interview on 10/17/2024 at 8:59am with ADM revealed that during the facilities full book survey RN A was being interviewed by SS and an inappropriate comment was said to SS about being a red head. SS felt uncomfortable enough to report it to the ADM of the facility and stated that the comment was just a little off.</p> <p>Interview on 10/17/2024 at 10:11am with ADM revealed that the in-service that was performed for staff regarding the abuse allegation by RN A was a review of the Abuse policy along with interviews of the residents. ADM stated that there no concerns from residents.</p> <p>Interview on 10/17/2024 at 11:58am-when a call was attempted to reach RN A to interview him, however his phone has been disconnected.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/17/2024 at 12:30pm with DON stated that when she went to go and speak to Resident #1 about the allegation of abuse by RN A. Resident #1 stated to DON that it was safe to say something because RN A was no longer employed in the facility. DON was asked what a negative outcome was for having staff that were verbally abuse towards residents. DON responded with Residents will feel like they cannot talk to anyone, and it can take a huge toll on their overall health.</p> <p>Interview on 10/17/2024 at 3:55pm with ADM stated that a negative outcome of having staff who are abusive towards residents could lead to residents isolating, not wanting to come out of their rooms, this could lead to an increase in depression and weight loss.</p> <p>Resident #2:</p> <p>Record review of Resident #2's face sheet, dated 10/17/2024 revealed that Resident #2 is a [AGE] year-old male who was admitted to the facility on [DATE] with, but not limited to the following diagnoses: Parkinsonism, unspecified, chronic systolic (congestive) heart failure, unspecified atrial fibrillation, unspecified kidney failure, transient cerebral ischemic attack, unspecified, malignant neoplasm of prostate, obstructive sleep apnea (adult) (pediatric), muscle weakness (generalized), other lack of coordination, cognitive communication deficit.</p> <p>Record Review of Resident #2's MDS, dated [DATE], revealed that Resident #2 had a BIMS score of 15 and functional capacity of maximal assistance.</p> <p>Record review of Resident #2's care plan dated, 10/11/2024, revealed nothing related to deficiency.</p> <p>Interview on 10/17/2024 at 7:14am with Resident #2 revealed that CNA B had yelled at Resident #2 after I accidentally called her 'sir'. She then got angry with me yelled at me I am not a sir! My name is [CNA B]! Resident #2 stated This was not the only time she has snapped at me. I said 'Hi, how are you?', CNA B responded by saying, 'My name is [CNA B]!'. On a different occasion, unsure of when exactly it happened, I pushed my call light because my brief was wet and needed to be changed. My call light was going off, CNA B came into the room very flamboyantly walked over to the call light and turned it off. CNA B then looked at me and said, What do you want?!. I let her know that I was wet and that my sweats were even wet now. CNA B told me that she was going to go and get someone, I never saw her again, and I had to call again.</p> <p>Interview on 10/17/2024 at 11:02am with CNA B revealed that the CNA B could not recall any instances of abuse or neglect towards residents. CNA B stated, I could never jeopardize myself after investing 2 years of energy into getting my CNA. It is very difficult to stay positive and have a good attitude when so many residents on that hall have a flirtations attitude. I have very thick skin when it comes to things like this, however it is a very difficult environment to work in. The residents are being very needy, I tried to get to the lights as soon as I could.</p> <p>Resident #3:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #3's face sheet, dated 10/17/2024, revealed that Resident #3 is a 70+ year-old male who was admitted to the facility on [DATE] with, but not limited to the following diagnoses: Heart failure, unspecified, muscle wasting and atrophy, not elsewhere classified, unspecified site, muscle weakness (generalized), Pain, unspecified, other reduced mobility, other lack of coordination, nasal congestion, other hemorrhoids, edema, unspecified, iron deficiency anemia, unspecified.</p> <p>Record review of Resident #3's MDS, dated [DATE], revealed that Resident #2 has a BIMS score of 14 and a functional capacity of limited assistance.</p> <p>Interview on 10/17/2024 at 3:52am with Resident #3 stated that there was one CNA who was very rough with me when she transferred me to the commode from my wheelchair. Resident #3 stated that he did not know the CNA's name. She was just a tall black girl who worked in the afternoon during the daytime.</p> <p>Interview on 10/17/2024 at 6:08am with LVN C stated that there was a CNA that matched the description given by Resident #3. LVN C stated that it would be CNA B. LVN C did state that CNA B can be very rough with residents and loud. LVN C was asked if this type of behavior was reported, LVN C stated that it had been.</p> <p>Interview on 10/17/2024 At 6:17am with ADON stated that there was a CNA that matched the description given by Resident #3. ADON stated that there was a CNA that worked in the afternoon that matched that description and named CNA B. ADON stated that CNA B did not have the best personality for this type of work but was not aware of any abuse or neglect by CNA B towards residents.</p> <p>Record review of facility provided policy titled, ABUSE, NEGLECT AND EXPLOITATION AND MISAPPROPRIATION OF RESIDENT PROPERTY, reviewed on February 12, 2020, revealed the following:</p> <p>Purpose</p> <p>The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect,</p> <p>.Verbal abuse: the use of oral, written or gestured language that willfully includes disparaging terms to residents or their families, or within their hearing distance, regardless of their age, inability to comprehend, or disability.</p> <p>Sexual abuse: includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.</p> <p>.Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854</p> <p>Based on observation, interviews and record reviews the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of (Resident #4) 10 residents reviewed for misappropriation of property.</p> <p>The facility did not prevent CNA F from taking a bag of chips from Resident #4.</p> <p>This failure could place residents at risk of continued misappropriation of property.</p> <p>Findings included:</p> <p>Record review of face sheet, dated 10/17/2024 revealed that Resident #4 was a [AGE] year-old female who was admitted to the facility on [DATE] with, but not limited to the following diagnoses: chronic kidney disease, unspecified, primary osteoarthritis, unspecified site, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, depression, unspecified, gastro-esophageal reflux disease without esophagitis, essential (primary) hypertension, cognitive communication deficit, other lack of coordination, difficulty in walking, not elsewhere classified, muscle weakness (generalized)</p> <p>Record review of Resident #4's MDS, dated [DATE], revealed Resident #4 had a BIMS score of 00 and a functional capacity of supervision.</p> <p>Observation on 10/17/2024 at 4:41am revealed Resident #4's room where there was basket of food products on a small table next to Resident #4's dresser. Resident was sleeping at this time and investigator did not disturb her for an interview.</p> <p>Observation on 10/17/2024 at 5:36am of a text message, dated 10/17/2024 at 5:36am from ADM with the video evidence revealing CNA F taking a bag of chips from the snack basket in Resident #4's room.</p> <p>Observation on 10/17/2024 at 7:14am revealed Resident #4 up and dressed and ready for breakfast. Interview was attempted, Resident #4 was unable to answer questions and only mumbled answers.</p> <p>Interview on 10/17/2024 at 10:11am ADM stated that an in-service was being completed regarding the allegations of misappropriation of property for Resident #4. ADM stated that CNA F was suspended until the investigation was completed.</p> <p>Interview 10/17/2024 at 12:10pm CNA F stated A lot of residents give me stuff and I didn't know that food was considered a gift. Resident #4 pointed over to the bag of chips and pointed and said, 'Here Momma'. I didn't have time to get them at that time and so I just went and got them later. I was then pulled into the office and the ADM said, 'I caught you on camera'. I really wasn't sure what she was even talking about. I honest to God didn't know that taking a snack from a resident was something that I didn't know I could do. CNA F was asked what misappropriation of property was, CNA F stated, taking a resident's belongings.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/17/2024 at 12:10pm DON stated that a negative outcome for having a staff member take a resident's personal belongings. DON stated, That snack could be the only thing that the resident eats all day, because she has dementia so badly that maybe she takes a couple of bites of her food and then gets up to leave the dining room.</p> <p>Interview on 10/17/2024 at 3:55pm ADM stated that a negative outcome for having a staff member take a resident's personal belongings. ADM stated, the resident could be without something they purchased and could lead to them not leaving their rooms for fear of having something else taken.</p> <p>Record review of facility provided section of employee handbook, titled Gratuities and Other Gifts, dated 06/01/2023, revealed the following:</p> <p>accepting gifts or gratuities for services rendered to residents or patients, or for the granting of business contracts to vendors or contractors is unethical, unprofessional, and strictly prohibited by the Compliance Program. Soliciting or accepting gratuities, tips or gifts of any kind from residents, clients, family members, vendors or contractors may result in corrective action up to and including discharge from employment.</p> <p>Record review of facility provided policy titled, ABUSE, NEGLECT AND EXPLOITATION AND MISAPPROPRIATION OF RESIDENT PROPERTY, reviewed on February 12, 2020, revealed the following:</p> <p>Purpose</p> <p>The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation, and misappropriation of resident property</p> <p>.Misappropriation: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p>		