

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 10/11/2024
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal privacy was provided for 1 of 1 residents reviewed for dignity. (Resident #257)</p> <p>1. CNA D and LVN A failed to pull the privacy curtain while providing wound care for Resident #257.</p> <p>These failures could place residents at risk for diminished quality of life and loss of dignity and self-worth.</p> <p>The findings included:</p> <p>Resident #257:</p> <p>Record Review of Resident #257's face sheet revealed a [AGE] year-old female, who was admitted to the facility on [DATE] with a primary diagnoses of spinal stenosis lumbar region (narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), urinary tract infection, type 2 diabetes mellitus with diabetic nephropathy, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), major depressive disorder, and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone).</p> <p>Record Review of Resident #257's Admission MDS dated [DATE] revealed Resident #257 with the BIMS left blank and incomplete.</p> <p>Record Review of Resident #257's Physician Orders dated 10/02/2024 revealed: Cleanse wound every am shift (6am-2pm). Cleanse right groin wound with wound cleanser or NS, pack with iodoform 1/2 inches packing strip, and cover with a silicone foam dressing.</p> <p>An observation was done of LVN A providing wound care with assistance from CNA D for Resident #257 on 10/10/2024 at 1:43 PM. LVN A and CNA B entered Resident #257's room to provide wound care on the right groin area. LVN A and CNA D closed Resident #257's door but failed to close the privacy curtain. Resident #257's pants had to be removed in order to provide wound care. Resident #257 had a brief on while LVN A cleaned the wound on the groin area.</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN A on 10/10/2024 at 2:22 PM LVN A stated that she should have pulled the curtain to provide privacy for the resident but did not think of it because she was nervous. LVN A stated that by not providing a secondary form of privacy it could be a dignity issue especially where the wounds were located. LVN A stated that she had been trained in privacy and dignity upon hire in March.</p> <p>During an interview with CNA D on 10/10/2024 at 2:37 PM CNA D stated that she did not realize that she should had closed the curtain to provide a second form of privacy for the resident. CNA D stated that she had thought as long as the door was closed then it would of be fine to provide care. CNA D stated that she had not known that if someone walked in the door then the resident would be exposed. CNA D stated that she had been trained in privacy and resident rights by in-services, approximately monthly. CNA D stated that the negative outcome was that someone could walk in, making the resident feel embarrassed.</p> <p>During an interview with the DON on 10/10/2024 at 2:54 PM revealed that the DON expected staff to provide a second form of privacy when providing care to the residents. The DON stated that staff should have closed the door and pull the curtain to make sure to provide as much privacy as possible. The DON stated that staff had been trained in dignity and privacy at least once a month through in-services. The DON stated that the negative potential outcome for not providing a second form of privacy during resident care was that the resident could be exposed causing them emotional distress and embarrassment. The DON stated that privacy and dignity was a big deal.</p> <p>During an interview with the Administrator on 10/11/2024 at 2:37 PM revealed that the Administrator expected staff to close the door and pull the curtain completely closed when providing care for the resident, to keep the resident from being exposed. The Administrator stated that the staff had been trained through in-services, annually, and upon hire. The Administrator stated that the negative potential outcome for not providing complete privacy when providing care would be emotional distress and embarrassment if someone other than the nurse had seen them.</p> <p>During an Interview with the Administrator on 10/11/2024 at 2:41 PM. The Administrator stated that the facility did not have a policy on pulling privacy curtain during care.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>46425</p> <p>Based on observations, interviews, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 7 of 18 confidential residents.</p> <p>The facility failed to ensure 7 of 18 confidential residents were provided, through postings in prominent locations, the Grievance Procedure, were provided access to the Grievance form, were provided information who the facility grievance official was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance.</p> <p>This failure could place the residents at risk of unresolved grievances and decreased quality of life.</p> <p>Findings included:</p> <p>Interviews during confidential interviews on, 10/10/2024 at 2:00pm, attendees 7 of 18 confidential residents, stated they did not know the grievance process, they did not know where to obtain or submit a grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in confidential interviews, and they had not observed a posting of the Grievance procedure in prominent locations. The Residents attending the confidential interview did not know how to file a grievance. The Residents did not know where to acquire a grievance form, who to turn the form into, and what happened once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Seven Residents attended the meeting, the seven Residents in attendance had all been Residents of the facility for 6 plus months.</p> <p>Record Review of the facility Grievance policy on 10/11/2024 at 10:05am revealed a copy of the Grievance/complaint procedure should be posted on the resident bulletin board.</p> <p>Observed prominent postings on 10/11/2024 at 10:30am; the facility did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available to Residents and there was no access to submit a Grievance anonymously.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the ADM on 10/11/2024 at 11:05am; the ADM stated she was the Grievance Officer for the facility. The ADM stated the Grievance form was kept in the facilities' electronic record system. The ADM stated there was not a written Grievance form accessible to the residents. The ADM stated she completed all Grievances as there was not currently a Social Worker on her team. The Grievances were completed when a Resident came to her or another staff member with a complaint, and/or if complaints were voiced in the Resident Council meeting. The ADM stated the Grievance Procedure was not posted for Residents. The ADM stated the Residents cannot file a Grievance anonymously due to the Residents not having access to the Grievance form and having no means of submitting a Grievance form anonymously. The ADM stated she was responsible for assigning a Grievance to a staff member to address. She stated her expectation was Grievances were to be resolved in 24 hours. The ADM stated Residents who voice a complaint were interviewed by the staff member assigned to resolve the Grievance; she stated this was the first step in resolving the Grievance. These interviews were documented on the electronic Grievance form. The ADM stated the resolutions to the Grievances were documented on the electronic Grievance form. The ADM stated the resolutions to Grievances were discussed with Residents face to face. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance. The ADM stated she would meet with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. The ADM stated she was not aware the Grievance procedure was not being discussed in the Resident Council meetings . The ADM stated the potential negative outcome to residents could be increased depression, increased behaviors and isolation.</p> <p>Grievance Policy</p> <p>Record Review of the Grievance Policy last updated in 2020.</p> <p>Policy Statement:</p> <p>Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or their representative. Residents have the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. The resident has the right to file a complaint/concern and the facility must make prompt efforts to resolve grievances the resident may have.</p> <p>Policy Interpretation and Implementation:</p> <ol style="list-style-type: none"> 1. Any resident, family member, or representative may file a grievance or complaint. 2. Residents, family, and representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. 3. All grievances from resident or family concerning issues of residents' care in the facility will be considered. Actions will be responded to in writing. 4. Upon admission residents are provided with written information on how to file a grievance. <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Grievances may be submitted orally or in writing and may be filed anonymously.</p> <p>6. The contact information for the individual with whom a grievance may be filed is provided to the resident or representative upon admission .</p> <p>12. The resident or person filing the grievance on behalf of the resident, will be informed (verbally or in writing) of the findings of the investigation and actions will be taken to correct any identified problems. A written summary of the investigation will be provided to the resident and a copy will be filed in the business office.</p> <p>13. If the grievance is filed anonymously the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance and report the findings.</p> <p>14. The results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision.</p> <p>15. This policy will be provided to the resident or the resident's representative upon request.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>46425</p> <p>Provide activities to meet all resident's needs.</p> <p>Based on observations, interviews, and record review, the facility failed to provide an ongoing program to support residents in their choice of activities, both facility-sponsored group, individual activities, and independent activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of 7 of 18 residents (confidential residents) reviewed for quality of life.</p> <p>The facility:</p> <ol style="list-style-type: none"> Failed to engage in activities at scheduled times. Failed to offer engaging activity replacement for scheduled activities that were cancelled or not completed. <p>This failure could affect Residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome.</p> <p>The findings included:</p> <p>Observation and an interview of the dining room and the common area on 10/09/24 beginning at 10:10am, revealed the scheduled activity at 10:00am was Washer Toss. There were four confidential residents sitting in the common area and three confidential residents sitting in the dining area, the AD was not present. The residents in the common area informed the state surveyor they were waiting for Washer Toss to start; two of the confidential residents stated the activities never start on time. The residents in the dining room also stated they were waiting for Washer Toss to start; all seven residents informed the state surveyor they had not seen the AD. Continued observation of the dining room and common area at 10:23am revealed the four residents in the dining room remained in the dining room. The three residents in the common area remained in the common area and stated they assumed the activity was not going to happen, they had not seen the AD.</p> <p>Observation and an interview of the dining room and the common area on 10/09/24 at 3:10pm, revealed the scheduled activity was an Outdoor Lemonade Social, there were five confidential residents in the dining room who informed this state surveyor they were waiting for the activity. The residents informed the state surveyor they had not seen the AD; however, the AD told them after lunch to wait in the dining room for the outdoor activity. Continued observation of the dining room and the courtyard at 3:25pm revealed the same five residents waiting for the activity. The residents informed this state surveyor they had not seen the AD and nothing was set up for the activity. Last observation completed at 3:55pm, the residents stated the activity did not occur.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and an interview of the dining room on 10/10/24 at 3:35pm, revealed the scheduled activity was Music Works, Name that Tune, there was nothing set up for the activity, there were five confidential residents who stated they were waiting for the activity. Continued observation of the dining room at 3:45pm revealed the same residents waiting for the activity. One confidential resident stated the activities rarely happened as scheduled; therefore, they choose to stay in the dining room together and socialize. Observation at 4:05pm revealed the same five residents in the dining room, one of the confidential residents stated they had not seen the AD and the activity did not occur.</p> <p>Observation and an interview of the dining room and the common area on 10/11/2024 at 10:10am revealed the scheduled activity of Bible Study with was not occurring in either area. Observation of the dining room revealed the dining room displayed a sign stating it was closed for cleaning. Interview with six confidential residents waiting in the common area stated they were waiting for the 10:00am activity. Observation of the AD's office revealed the AD sitting in her office at her desk. Observation at 10:25am revealed a confidential resident asking the AD where he could join the Bible activity; the AD informed the resident the activity would not begin until the dining room was clean. The AD told the resident he would need to check back because she did not know what time the dining room would be clean. Observation of the dining room at 10:45am revealed 8 confidential residents sitting at a table; one of the residents stated they were waiting for the Bible Study activity. Observation of the same eight residents at 10:50am revealed the AD was at the table with the residents beginning the activity.</p> <p>Interview on 10/11/2024 at 10:51am, ADM stated her expectation was for the AD to follow the activities on the calendar as scheduled, ask for resident preferences for activities, for activities to begin on time, and to inform residents of any changes to the calendar. The ADM stated if the AD was not able to attend a scheduled activity the AD has an AD assistant and other department heads can assist with activities as needed. The ADM stated her expectation if no residents were present for an activity was for the AD to go to the rooms of the residents and invite them to the activity. In addition, the ADM stated if there was no interest in the activity the ADM expected the AD to change the activity to activity of interest to the residents. The ADM stated if an activity was scheduled in the dining room, however, the dining room was closed, her expectation was for the activity to be held in another location. The ADM stated the activity should not be cancelled or started late due to the dining room being closed. The ADM stated the potential negative outcome of residents not having activities was increased depression, social isolation, and residents' needs were not being met.</p> <p>Interview on 10/11/2024 at 11:20am with the AD, the AD stated she has been employed by the facility for 3 years. The AD stated she walked to every resident's rooms if an activity was cancelled or was going to begin later than scheduled. The AD stated she has fell ow employees and volunteers she can lean on if she was unable to lead an activity. The AD stated if no residents attend an activity, she goes room to room to invite residents. The AD stated she asked residents for their choices regarding activities in resident council monthly. The AD stated the scheduled activities this state surveyor observed that did not occur or began late were all due to the dining room not being available. The AD stated she could have moved the activity to another area in the facility, however, she chose not to move the activity. The AD stated residents do not have any emotions when activities do not occur because all the scheduled activities were occurring as scheduled; she had no concerns with activities not occurring as scheduled. The AD stated the potential negative outcome for residents if activities' calendar was not followed was increased depression, boredom, increased behaviors, falls, and possible issue with hydration.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of facility's undated activity policy reflected the following:</p> <p>The facility provides an ongoing program providing a variety of activity functions through the Resident Wellness and Activities Program. The program is designed to include attractions to meet the interests and physical, mental, and psychological well-being of each resident in accordance with the resident's comprehensive assessment. The facility provides group and individual opportunities for all residents who are able to participate. Resident Council meetings are encouraged if desired. All residents, particularly bedfast and those residents unable to participate in group functions will be visited by the Wellness and Life Enrichment Director and/or a volunteer. A monthly calendar of events is posted at the beginning of each month in an area that is accessible and frequented by the residents. A balance of recreational functions including physical, social, religious, arts and crafts, diversional, and intellectual, will be scheduled.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new pressure ulcers from developing for 2 of 2 residents (Residents #87 and Resident #257) reviewed for pressure ulcer care.</p> <p>1. LVN A failed to use the correct wound techniques during wound care for Resident #87 and #257.</p> <p>These failures could place residents with wounds at an increased and unnecessary risk of complications such as pain, acquiring new pressure ulcers, worsening of existing pressure ulcers, and infection.</p> <p>Findings included:</p> <p>Resident #87:</p> <p>Record Review of Resident #87's face sheet revealed a [AGE] year-old male, who was admitted to the facility on [DATE] with primary diagnoses of fracture of unspecified part of neck of right femur, senile degeneration of the brain (loss of intellectual ability), Guillain-Barre syndrome (condition in which the immune system attacks the nerves), acute cerebrovascular insufficiency (a number of rare conditions that result in obstruction of one or more arteries that supply blood to the brain), pain in right hip, muscle weakness, and dependence on wheelchair.</p> <p>Record Review of Resident #87's Admission MDS dated [DATE] revealed Resident #87 had a BIMS score of 12 indicating that Resident #87 was cognitively moderately impaired. The MDS indicated under skin conditions that Resident #87 had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, under risk of pressure ulcer indicated that Resident #87 was at risk for pressure ulcers, under unhealed pressure ulcers/injuries were left blank and incomplete, under current number of unhealed pressure ulcers/injuries at each stage listed as 1, under current number of unhealed pressure ulcers/injuries at each stage were listed at 0 and 2 listed as a stage 4, under number of venous & arterial ulcers were listed as 0, under other ulcers, wounds, and skin conditions were listed as none, under skin and ulcer/injury treatments were listed as pressure ulcer/injury care and pressure reducing device for bed.</p> <p>Record Review of Resident #87's Care Plan dated 10/02/2024 revealed Resident #87 had a skin tear on the left hand dated 04/23/24, stage 4 pressure ulcer dated 06/07/2024, history of bruising and skin tears dated 11/08/2023, and history of pressure injury dated 06/20/2024.</p> <p>Record Review of Resident #87's Physician Orders dated 09/02/2024 revealed: pressure relieving mattress every shift.</p> <p>Record Review of Resident #87's Physician Orders dated 09/03/2024 revealed: non weight bearing to right lower extremity until seen by ortho.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #87's Physician Orders dated 09/13/2024 revealed: Enhanced barrier precautions every shift due to current wounds needing treatment.</p> <p>Record Review of Resident #87's Physician Orders dated 09/19/2024 revealed: cleanse pressure wound every am shift (6am-2pm), cleanse right heel with wound cleanser or normal saline, pat dry, apply calcium alginate cut to wound size and cover with silicone foam dressing.</p> <p>During an observation of LVN A providing wound care for Resident #87 on 10/10/2024 at 10:53 AM, LVN A provided hand washing and put on clean gloves. CNA D provided hand washing and put on clean gloves. CNA D removed residents sock on right foot and held Resident #87's foot up for LVN A to provide wound care to pressure ulcer on right foot. LVN A removed the old bandage dated 10/07/2024 and discarded in the trash. LVN A put on hand sanitizer and put on clean gloves. LVN A put wound cleanser on one gauze pad and placed in center wound, consistently using circular motion three times. LVN A lifted the gauze pad off of the skin and used the same gauze pad using circular motion in the center of the wound, another three times. LVN A discarded gauze in the trash. LVN A used a dry gauze to pat dry in the center wound by touching the wound with the gauze, lifting, and touching the wound with the same side of the gauze five times. LVN A covered wound with bandage with initial and date. LVN A removed gloves and discarded. CNA D replaced Resident #87's sock on the right foot.</p> <p>Resident #257:</p> <p>Record Review of Resident #257's face sheet revealed a [AGE] year-old female, who was admitted to the facility on [DATE] with a primary diagnoses of spinal stenosis lumbar region (narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), urinary tract infection, type 2 diabetes mellitus with diabetic nephropathy, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), major depressive disorder, and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone).</p> <p>Record Review of Resident #257's Admission MDS dated [DATE] revealed Resident #257 with the BIMS left blank and incomplete. MDS indicated under skin conditions were left blank and incomplete, under risk of pressure ulcer were left blank and incomplete, under unhealed pressure ulcers/injuries were left blank and incomplete, under current number of unhealed pressure ulcers/injuries at each stage were left blank and incomplete, under current number of unhealed pressure ulcers/injuries at each stage were left blank and incomplete, under number of venous & arterial ulcers were left blank and incomplete.</p> <p>Record Review of Resident #257's Care Plan dated 10/02/2024 revealed Resident #257 had Skin Breakdown: Pressure Ulcer, cleanse wound every am shift (6am-2pm), wound (pressure, diabetic, or stasis). Interventions of dietitian referral, inspect skin complete body head to toe every week and document, inspect skin daily with care and bathing, and report any changes to charge nurse, monitor nutritional intake, weight, lab values, report significant changes to MD, off load heels, position resident properly, use pressure-reducing or pressure-relieving devices, treatments, and dressings as ordered per physician.</p> <p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm). Cleanse right groin wound with wound cleanser or NS, pack with iodoform 1/2 inches acking strip, and cover with a silicone foam dressing.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Plaza at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Emory Lubbock, TX 79416	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm), cleanse right foot wound with wound cleanser or normal saline, pat dry, apply calcium alginate, cover with a border gauze.</p> <p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm), cleanse right calf wound with wound cleanser or normal saline, pat dry, apply calcium alginate, cover with a border gauze.</p> <p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm), cleanse left foot wound with wound cleanser or normal saline, pat dry, apply calcium alginate, cover with a border gauze.</p> <p>During an observation of LVN A providing wound care for Resident #257 on 10/10/2024 at 1:43 PM, LVN A provided hand washing and put on clean gloves. LVN A checked Resident #257's wounds on right groin area. LVN A removed gloves and discarded in trash. LVN A used hand sanitizer and put on clean gloves. LVN A used a gauze pad with wound wash on it to blot the center of wound, picking up gauze off the skin, and placing it back on the skin on same gauze, seven times. LVN A place calcium alginate in the wound. LVN A removed dirty gloves and discarded in the trash. LVN A used hand sanitizer and put on clean gloves. LVN A used a clean gauze pad to pad dry the wound on right groin area by blotting with the same gauze five times. LVN A removed gloves and discarded in the trash. LVN A used hand sanitizer and put on clean gloves. LVN A used wound cleanser on a gauze pad to clean the wound on Resident #257's right foot using the blotting method, four times, using the same gauze pad. LVN A used a clean gauze pad and pat dry six times using the same gauze pad. LVN A removed gloves and discarded in the trash. LVN A used hand sanitizer and put on clean gloves. LVN A used wound was on a clean gauze pad to clean wound on right calf by going in horizontal direction back and forth over the wound without lifting the gauze pad, nine times. LVN A used a dry clean gauze to pat dry, five times, using the same gauze pad. LVN A applied calcium alginate to the top of the foot and covered it with bandage with date and initials. LVN A placed calcium alginate on wound on right calf and covered it with bandage with date and initials. LVN A removed gloves and discarded in the trash. LVN A used hand sanitizer and put on clean gloves. LVN A used clean gauze pad with wound wash to clean closed wound on bottom of right foot, going in a horizontal direction, back and forth, six times using the same gauze. LVN A discarded the gauze pad in the trash. LVN A used a dry clean gauze pad to pat dry the right bottom foot by blotting, five times. LVN A discarded the used gauze in the trash. LVN A covered wound on bottom foot with a bandage with date and initials. LVN A discarded gloves in the trash.</p> <p>During an interview with LVN A on 10/10/2024 at 2:18 PM. LVN A stated that it was best that once you lifted off the skin with the gauze to not retouch the skin. LVN A stated that she should have cleaned the skin with one gauze and once she lifted off the skin to discard of the gauze and get a new one. LVN A stated that she should have cleaned in a circular motion from inside the wound to outward. LVN A stated that she was nervous and was not used to being watched. LVN A stated that she had been trained by the wound care education center that the facility used, and she was trained in April 2024. LVN A stated that it was a hands-on training, and it was provided once a year. LVN A stated that the negative potential outcome for not cleaning wounds with correct technique would be dispersing bacteria from inside wound to another area of the skin.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 10/11/2024 at 2:55 PM she stated that she expected wound care to be done per policy. The DON stated that LVN A had been trained by the wound care education that came to the facility to teach techniques as well as competency skills checks, annually. The DON stated that the negative potential outcome of not using the correct techniques for wound care would be getting the wound infected.</p> <p>During an interview with the Administrator on 10/11/2024 at 2:37 PM she stated that she expected staff that were cleaning wounds to use a clean gauze and not the same one. The Administrator stated that LVN A should have followed policy for technique. The Administrator stated that LVN A had been trained by a wound care education center for wound care techniques, upon hire and annually. The Administrator stated that the negative potential outcome was spread of infection and poor wound healing.</p> <p>Record Review of facility provided policy, labeled, An Overview of Wound Care, dated July 2018, revealed:</p> <p>Record review of facility policy for wounds did not address the cleaning technique to be used.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480</p> <p>Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1of 2 treatment carts observed for pharmacy services.</p> <p>The facility failed to ensure 1 tube of Medih [NAME] Gel and 1 tube of zinc oxide ointment were dated when opened.</p> <p>The facility failed to ensure that all medical supplies in the treatment cart were not past their expiration date.</p> <p>The facility failed to ensure single use open collagen packets were not stored in the treatment cart after being opened.</p> <p>This failure could result in harm due to resident received expired medical supplies, such as wound dressings, as well as those supplies not being maintained at their best therapeutic level.</p> <p>The findings were:</p> <p>During an observation on [DATE] at 11:00 AM during treatment cart inspection observed 1 tube of Med Honey gel and 1 tube of zinc oxide ointment with no open date. Observed 1 package of single use collagen powder packet open with no date or resident information. Observed 1 package of hydrofera blue wound dressing with expiration date [DATE].</p> <p>During an interview on [DATE] at 11:10 AM with LVN A, she stated med honey gel and zinc oxide ointment should have been dated when opened. She stated the open packet of collagen powder was a onetime use and should have been discarded. She stated the collagen powder was no longer sterile because it was opened. She stated hydrofera blue should have been thrown away because it had expired on [DATE]. She stated using an expired dressing was not as effective and could loss sterility. She stated the collagen package was meant to be single use as it could become contaminated with bacteria since it was no longer sealed. She stated all nurses were responsible for checking treatment carts for expired and undated supplies. She stated treatment carts were checked weekly. She stated the undated zinc oxide ointment and med honey gel not being dated, the open collagen packet, and expired hydrofera blue was an over site. She stated the potential negative outcome of not dating open multiuse supplies was it can become contaminated with bacteria and multiuse supplies should be discarded 30 days after opening.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 12:20 PM with the DON, she stated the med honey gel and zinc oxide ointment should have been dated when opened. She stated the collagen packets were single use and should have been discarded. She stated the supply coordinator, wound care nurse, the ADON, and the DON were responsible for checking the treatment carts. She stated the treatment carts were checked every ,d+[DATE] weeks. She stated the potential negative outcome could be the supplies not having the same effectiveness as it would if not expired. She stated expired supplies could make wounds worse. She stated reusing single use collagen packets could cross contaminate. She stated all staff have been trained on checking the treatment carts.</p> <p>During an interview on [DATE] at 01:02 PM with the ADM, she stated the expired dressing, and the single use collagen powder should have been discarded. She stated the med honey gel and zinc oxide ointment should have been dated when opened. The stated the expired hydrofera blue dressing should have been discarded. She stated the potential negative outcome could be a decrease in effectiveness of the dressing and decrease the healing of the wound. She stated supplies undated staff would not be able to know when to discard supplies. She stated the nurses and nurse manager were responsible for checking treatment carts. She stated all staff have been trained. She stated all staff should check all supplies and medications before use.</p> <p>Record review of facility policy titled Medication Ordering and Receiving from Pharmacy Provider - Medications and Medication Labels dated ,d+[DATE] reflected the following:</p> <p>Policy: The pharmacy will use sound professional judgement and acceptable industry practices for establishing pharmacy's formulary. Medications were labeled in accordance with currently accepted professional principles including appropriate auxiliary and cautionary instructions to promote safe medication use following state and federal laws. Only the dispensing pharmacy can modify or change prescription labels</p> <p>5. Non-prescription medications not labeled by the pharmacy were kept in the manufacturer's original container. Nursing care center personnel may write the resident's name on the container or label as long as the required information is not covered, if applicable by state regulations.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49927</p> <p>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.</p> <p>The facility failed to ensure food was accurately dated and labeled.</p> <p>These failures could place residents at risk for food contamination and foodborne illness.</p> <p>The findings included:</p> <p>The following observations were made during a kitchen tour on 10/9/24 that began at 10:00 AM and concluded at 11:40 AM:</p> <p>Observation on 10/9/2024 at 10:12 AM revealed the following unlabeled and undated items: Ziplock bag of 2 ounce mayonnaise and mustard cups, tray of approximately 15 sandwich halves, glass of white substance that was later identified by the KMGR as milk, stainless steel container of yellow substance that was later identified by the KMGR as egg salad, four 2 ounce cups of a red substance that was later identified as salsa, 8 serving flutes of juice, and a Ziplock bag of 2 ounce cups of a white substance later identified by the KMGR as tartar sauce.</p> <p>The following observations were made during a kitchen tour on 10/10/2024 that began at 11:50 AM and concluded at 12:05 PM:</p> <p>Observation on 10/10/2024 at 11:55 AM revealed the following: a Ziplock bag of mayonnaise and mustard containers were dated 10/8; a Ziplock bag of tartar sauce contained a date of 10/8; juice flutes were dated dates from 10/8-10/10, the milk glass, salsa, sandwiches, and egg salad were no longer observed in the refrigerator.</p> <p>The following observations were made during a kitchen tour on 10/11/24 that began at 10:55 AM and concluded at 11:05 AM:</p> <p>Observation on 10/11/2024 at 10:57 AM revealed the following: approximately 11 juice flutes were undated and unlabeled and approximately 6 pitchers of liquids were unlabeled and undated.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/11/2024 at 1:30 PM an interview was conducted with the KMGR regarding concerns observed in the kitchen and dining areas. The KMGR stated she was aware of the unlabeled and undated items observed in the kitchen refrigerator and stated she also saw these items. The KMGR stated dates were placed on the items after they were observed, based on her knowledge of when the items were prepared. The KMGR stated it was the facility's policy to label and date all items in the kitchen as they were opened. The KMGR stated it was the facility's policy to throw items in the refrigerator, that were opened, away within 3 days. The KMGR stated all kitchen staff were responsible for ensuring items were labeled and dated when stored in the refrigerator. The KMGR stated she was responsible for double checking to ensure this was done by staff. The KMGR stated it was important for items in the refrigerator to be labeled and dated so residents did not get sick from food poisoning and to make sure food didn't spoil. The KMGR stated she was trained in food service and had a food handler's certification, and she referred to the copy hanging on her office wall. The KMGR stated all kitchen staff received training on food safety and had a food handler's certification. The KMGR stated all staff that serve food should have washed or sanitized their hands before serving each resident's plate and as necessary when they touched anything contaminated. The KMGR stated all staff were trained on hand hygiene. The KMGR stated the potential negative outcome for the residents when food was not stored properly was the potential for residents getting sick or getting food poisoning. The KMGR stated the potential negative outcome for residents when staff did not wash or sanitize their hands properly could be passing germs to residents and residents and/or staff could get sick.</p> <p>On 10/11/2024 at 1:47 PM an interview was conducted with the ADM regarding concerns observed in the kitchen and dining areas. The ADM stated the facility's policy on storing items in the refrigerator stated all items in the refrigerator should be dated when they were made. The ADM stated sauces and other items opened should have been dated when they were opened. The ADM stated items should never be backdated and if staff were not sure of the date of the items, they should have been thrown away to ensure resident's safety. The ADM stated the person who prepared the food or opened the item was responsible for dating and labeling the items stored in the refrigerator. The ADM stated the kitchen manager should have checked to ensure items were dated and labeled properly in the refrigerator. The ADM stated labeling and dating items in the refrigerator were important to prevent food born illnesses. The ADM stated sandwiches, to her knowledge, should have only been kept for one day and milk should not have been stored in the refrigerator in a glass since the expiration date was on the milk container and not the glass. The ADM stated the KMGR, and all kitchen staff have received food storage training and completed a food handler's certification. The ADM stated on-going training was conducted with the KMGR. The ADM stated staff should have practiced good hand hygiene between each task, such as serving plates, touching the handles of a wheelchair, and touching anything soiled. The ADM stated the potential negative outcome for a resident if items were not stored properly in the refrigerator could result in the resident getting sick, losing weight, and the resident not being comfortable eating food that could make them sick. The ADM stated staff not practicing good hand hygiene could result in residents getting sick.</p> <p>Record review of the facility policy titled Food Storage for the Nutritional Services Department, dated 8/1/2018 and revised on 2/6/2024, revealed the following documentation:</p> <p>Policy:</p> <p>Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Refrigerator:</p> <ul style="list-style-type: none"> o Opened containers of thickened liquids are stored in the refrigerator with both open and discard dates. o All foods are covered, labeled, and dated. <p>Record review of the facility policy titled Hand Hygiene for Staff and Residents for the Infection Control Department, effective 8/2018, revised on 8/2018, and reviewed 1/2022, revealed the following documentation:</p> <p>Purpose:</p> <p>To reduce the spread of infection with proper hand hygiene</p> <p>Policy:</p> <p>Proper hand hygiene technique is completed whenever hand hygiene is indicated.</p> <p>NOTE: Hand Hygiene is the most important component for preventing the spread of infection. Maintaining clean hands is important for residents/visitors as well as staff.</p> <p>Procedures:</p> <p>1. Hand hygiene is done:</p> <p>Before:</p> <ul style="list-style-type: none"> A. resident contact. B. eating or handling food. <p>After:</p> <ul style="list-style-type: none"> A. contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B. resident contact. <p>Record review of the FDA Food Code titled On-premises preparation; Prepare and hold cold: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking (Chapter 3) effective for 2022, revealed the following:</p> <p>On-premises preparation</p> <p>Prepare and hold cold</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.</p> <p>(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150</p> <p>Based on observations, interviews, 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 to help prevent the development and transmission of communicable diseases and infections for 4 of 4 Residents and 5 of 5 staff members (LVN A, CNA A, CNA C, CNA E and CNA F) observed for infection control practices (Resident #7, #15, #87, and #257). in that:</p> <ol style="list-style-type: none"> 1. CNA A failed to use proper hand hygiene before or after assisting with incontinent care for Resident #7. 2. CNA C failed to use proper hand hygiene before or after assisting with wound care for Resident #15. 3. LVN A failed to use proper wound care techniques and CNA D did not use proper hand hygiene before or after assisting with wound care for Resident #87 4. LVN A failed to use proper wound care techniques and CNA D did not wash hands before or after assisting with wound care for Resident #257. 5. CNA F failed to ensure using good hygienic practices while assisting with passing food trays. <p>These failures could place residents at risk for infection through cross contamination of pathogens.</p> <p>The findings included:</p> <p>Resident #7:</p> <p>Record Review of Resident #7's face sheet revealed a [AGE] year-old female, who was admitted to the facility on [DATE] with a primary diagnoseis of: Parkinsonism (is caused by one or more strokes, it refers to brain conditions that caused slowed movements), Tourette's disorder (a nervous system disorder involving repetitive movements or unwanted sounds), muscle wasting and atrophy, unsteadiness on feet, dependence on renal dialysis, hyperkalemia (a high level of potassium in the blood), and acidosis (a buildup of acid in the bloodstream).</p> <p>Record Review of Resident #7's Quarterly MDS dated [DATE] revealed Resident #7 had a BIMS score of 14 indicating that Resident #7 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During An observation was completed of CNA E aiding for CNA F with incontinent care for Resident #7 on 10/10/2024 at 12:01 PM. CNA E washed hands prior to assisting CNA F with incontinent care by the following steps: CNA E turned on the water and put two squirts of soap in her hands. CNA E immediately washed her hands under the water by rubbing her hands together. CNA E grabbed two clean paper towels and dried her hands and turned off the faucet with the same paper towel that she dried her hands with and disposed of the paper towel. After assisting with incontinent care for Resident #7, she turned on the water and quickly rinsed her hands and did not use any soap. CNA E grabbed two clean paper towels and dried her hands and turned off the faucet with the same paper towel that she dried her hands with and then disposed of the paper towel.</p> <p>During an interview with CNA E on 10/10/2024 at 2:13 PM, CNA E stated that she had been trained in hand washing and infection control practices once a month by in-services or verbal education. CNA E stated that the DON and the ADON was responsible for holding these trainings. CNA E stated that they do have skills checks monthly. CNA E stated that she did not provide proper hand washing techniques because she was nervous. CNA E stated that the negative potential outcome was the spread of infections and germs.</p> <p>Resident #15:</p> <p>Record Review of Resident #15's face sheet revealed an [AGE] year-old female, who was admitted to the facility on [DATE] with a primary diagnosis of: Senile degeneration of brain, atherosclerotic heart disease (a build-up of fats in and on the artery walls), muscle weakness, dementia (a group of thinking and social symptoms that interferes with daily functioning), psychotic disturbance, mood disturbance, and anxiety, pressure ulcer of sacral region, stage 2, cortical age related cataract (begins as white, wedge-shaped spots or streaks on the outer edge of the lens cortex), and age-related nuclear cataract (age-related change in the density of the crystalline lens nucleus).</p> <p>Record Review of Resident #15's Admission MDS dated [DATE] revealed Resident #15 had a BIMS score of 9 indicating that Resident #15 was cognitively moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of CNA C on 10/10/2024 at 9:30 AM, CNA C did not wash hands prior to gathering supplies to perform incontinent care for Resident #15. CNA C grabbed a clear trash bag and put the following supplies in the bag with her bare hands: hand sanitizer, towel, gloves, sheet, and couple of clear trash bags. CNA C knocked on the door and explained the procedure to Resident #15. CNA C shut the resident's door. CNA C put the supplies on the bedside table but did not clean the bedside table. CNA C went into the resident's bathroom to wash hands by performing the following steps: CNA C put two squirts of soap in her hands and then turned on the water faucet. CNA C immediately rinsed her hands under the water without lathering the soap for four seconds. CNA C grabbed two clean paper towels and dried her hands and disposed of the paper towel. CNA C turned off the water faucet with her bare hands. CNA C put the gait belt around Resident #15 and transferred from the wheelchair into the bed. CNA C removed the gait belt. CNA C put on a pair of clean gloves. CNA C raised the bed. CNA C grabbed a clean brief out of the dresser. CNA C disposed of gloves in the trash. CNA C put on hand sanitizer and put on pair of clean gloves. CNA C removed pants from off Resident #15 and removed the front of the old brief and stuffed it between the resident's legs. CNA C removed gloves and discarded in the trash. CNA C put on pair of clean gloves. CNA C took a wipe and began incontinent care by cleaning using the one wipe per swipe method starting on the center of groin area and wiping twice. CNA C asked Resident #15 to turn to the left side and she removed the backside of the old brief and discarded. CNA C removed gloves and discarded. CNA C put on hand sanitizer and put on pair of clean gloves. CNA C wiped the backside of Resident #15 using the one wipe per swipe method starting from the center and then going to the left and the right buttocks. CNA C placed a clean brief under the resident. CNA C asked resident to lay back and fastened the front of the brief. CNA C put on Resident #15's pants. CNA C removed gloves and put on a new pair of gloves. CNA C placed a gait belt around the resident and transferred back into the wheelchair. CNA C removed the gait belt off Resident #15. CNA C removed gloves and discarded in the trash. CNA C removed all trash and left Resident #15's room without washing hands.</p> <p>During an interview with CNA C on 10/10/2024 at 9:51 AM, CNA C stated that she had been trained in infection control practices and hand washing, every three months. CNA C stated that training included on-line training every three months, skills check every two months, and that the DON and the ADON were responsible for providing these trainings. CNA C stated that she should have washed her hands prior to gathering incontinent care supplies. CNA C stated that she should have washed her hands by lathering for twenty seconds instead of immediately rinsing hands and not lathering. CNA C stated that she should have cleaned the bedside table before and after incontinent care. CNA C stated that she should have washed her hands after incontinent care and does not know why she did not wash her hands. CNA C stated that she was so nervous that she could not think of what steps to take. CNA C stated that the negative potential outcome of not providing infection control practices is the spread of diseases, frequent UTI's, and sicknesses.</p> <p>Resident #87:</p> <p>Record Review of Resident #87's face sheet revealed a [AGE] year-old male, who was admitted to the facility on [DATE] with a primary diagnosis of fracture of unspecified part of neck of right femur, senile degeneration of brain (loss of intellectual ability), Guillain-Barre syndrome (condition in which the immune system attacks the nerves), acute cerebrovascular insufficiency (a number of rare conditions that result in obstruction of one or more arteries that supply blood to the brain), pain in right hip, muscle weakness, and dependence on wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #87's Admission MDS dated [DATE] revealed Resident #87 had a BIMS score of 12 indicating that Resident #87 was cognitively moderately impaired. MDS indicated under skin conditions indicated that Resident #87 had Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, under risk of pressure ulcer indicated that Resident #87 was at risk for pressure ulcers, under unhealed pressure ulcers/injuries were left blank and incomplete, under current number of unhealed pressure ulcers/injuries at each stage listed as 1, under current number of unhealed pressure ulcers/injuries at each stage were listed at 0 and 2 listed as a stage 4, under number of venous & arterial ulcers were listed as 0, under other ulcers, wounds, and skin conditions were listed as none, and under skin and ulcer/injury treatments were listed as pressure ulcer/injury care and pressure reducing device for bed.</p> <p>Record Review of Resident #87's Care Plan dated 10/02/2024 revealed Resident #87 had a skin tear on left hand dated 04/23/24, stage 4 pressure ulcer dated 06/07/2024, history of bruising and skin tears dated 11/08/2023, and history of pressure injury dated 06/20/2024.</p> <p>Record Review of Resident #87's Physician Orders dated 09/02/2024 revealed: pressure relieving mattress every shift.</p> <p>Record Review of Resident #87's Physician Orders dated 09/03/2024 revealed: non weight bearing to right lower extremity until seen by ortho.</p> <p>Record Review of Resident #87's Physician Orders dated 09/13/2024 revealed: Enhanced barrier precautions every shift due to current wounds needing treatment.</p> <p>Record Review of Resident #87's Physician Orders dated 09/19/2024 revealed: cleanse wound every am shift (6am-2pm). Cleanse the right heel with wound cleanser or normal saline, pat dry, apply calcium alginate cut to wound size and cover with silicone foam dressing.</p> <p>During an observation of LVN A providing wound care for Resident #87 on 10/10/2024 at 10:53 AM, LVN A provided hand washing and put on clean gloves. CNA D provided hand washing and put on clean gloves. CNA D removed resident sock on right foot and held Resident #87's foot up for LVN A to provide wound care. LVN A removed the old bandage dated 10/07/2024 and discarded in the trash. LVN A put on hand sanitizer and put on clean gloves. LVN A put wound cleanser on one gauze pad and placed it in the center wound, consistently using circular motion three times. LVN A lifted the gauze pad off the skin and used the same gauze pad using circular motion in the center of the wound, another three times. LVN A discarded gauze in the trash. LVN A used a dry gauze to pad dry in the center wound by touching the wound with the gauze, lifting, and touching the wound with the same side of the gauze five times. LVN A covered wound with bandage with initial and date. LVN A removed gloves and discarded. CNA D replaced Resident #87's sock on the right foot.</p> <p>During an observation on 10/9/2024 at 1:00 PM CNA F was seen entering the serving line after delivering a meal to a resident in the dining room. CNA F did not wash or sanitize her hands before obtaining another resident's meal to serve.</p> <p>During an observation on 10/9/2024 at 1:02 PM CNA F was seen entering the serving line after delivering a meal to another resident in the dining room. CNA F did not wash or sanitize her hands before obtaining another resident's meal to serve. CNA F was observed preparing the resident's meal by opening the silverware and cutting up food on the plate.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/9/2024 at 1:05 PM CNA F was seen entering the serving line after delivering a meal to another resident in the dining room. CNA F did not wash or sanitize her hands before obtaining another resident's plate to serve.</p> <p>During an observation on 10/9/2024 at 1:06 PM CNA F was seen entering the serving line after delivering a meal to another resident in the dining room. CNA F did not wash or sanitize her hands before obtaining another resident's plate to serve. CNA F was observed opening silverware and aligning the plate for the resident.</p> <p>During an observation on 10/9/2024 at 1:13 PM CNA F was seen entering the serving line after delivering a meal to another resident in the dining room. CNA F did not wash or sanitize her hands before obtaining another resident's plate to serve.</p> <p>During an observation on 10/9/2024 at 1:14 PM CNA F was seen entering the serving line after delivering a meal to another resident in the dining room. CNA F did not wash or sanitize her hands before obtaining another resident's plate to serve. CNA F was observed opening the silverware for the resident. CNA F was observed speaking with the residents at the dining while standing behind a resident's wheelchair and her hands were observed to be resting on the handles of the resident's wheelchair. CNA F did not wash or sanitize her hands after touching the handles of the resident's wheelchair.</p> <p>During an observation on 10/9/2024 at 1:16 PM CNA F was seen entering the serving line after delivering a meal to another resident in the dining room. CNA F did not wash or sanitize her hands before obtaining another resident's plate to serve. CNA F was observed exiting the serving line with three plates in her hands, and one plate was touching her scrub top as she was carrying it next to her body.</p> <p>During an observation on 10/9/2024 at 1:17 PM CNA F was seen obtaining a glass of milk and serving it to a different resident. CNA F did not wash or sanitize her hands before obtaining the glass of milk.</p> <p>During an interview with LVN A on 10/10/2024 at 2:18 PM, LVN A stated that it was best that once you lifted off the skin with the gauze to not retouch the skin. LVN A stated that she should have cleaned the skin with one gauze and once she lifted off the skin to discard of the gauze and get a new one. LVN A stated that she should have cleaned in a circular motion from inside the wound to outward. LVN A stated that she was nervous and was not used to being watched. LVN A stated that she had been trained by the wound care education center that the facility used, and she was trained in April 2024. LVN A stated that it was a hands-on training, and it was provided once a year. LVN A stated that the negative potential outcome for not cleaning wounds with the correct technique would be dispersing bacteria from inside the wound to another area of the skin.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of CNA D aiding with wound care with LVN A for Resident #87 on 10/10/2024 at 10:53 AM. CNA D aided with wound care by removing the sock and holding up Resident #87's foot during wound care. Prior to assisting with the wound care, CNA D washed her hands by the following steps: CNA D turned on faucet with her hands. CNA D put one squirt of soap in her hands and rubbed hands immediately under water without allowing the soap to lather. CNA D used a clean paper towel to dry her hands. CNA D used her elbow to turn off the faucet. After wound care CNA D placed Resident #87's sock back on, removed her gloves, and discarded in the trash. CNA D provided hand washing after assisting by the following steps: CNA D turned on the faucet. CNA D put two squirts of soap in her hands, rubbing her hands together for nine seconds and then rinsing her hands. CNA D grabbed two clean paper towels to dry her hands and discarded them in the trash. CNA D used her bare hands to turn off the faucet.</p> <p>During an interview with CNA D on 10/10/2024 at 2:30 PM, The CNA D stated that she should wash her hands longer and not use her elbow or bare hands to turn off the faucet. CNA D stated that she just sang the Happy Birthday song, too fast. CNA D stated that she should have lathered her hands instead of rinsing immediately. CNA D stated that she had been trained in infection control and hand washing by in-services and competency checks, monthly. CNA D stated that the negative potential outcome for not using proper handwashing techniques was transferring germs.</p> <p>Resident #257:</p> <p>Record Review of Resident #257's face sheet revealed a [AGE] year-old female, who was admitted to the facility on [DATE] with a primary diagnosis of spinal stenosis lumbar region (narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), urinary tract infection, type 2 diabetes mellitus with diabetic nephropathy, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), major depressive disorder, and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone).</p> <p>Record Review of Resident #257's Admission MDS dated [DATE] revealed Resident #257 with the BIMS left blank and incomplete. MDS indicated under skin conditions were left blank and incomplete, under risk of pressure ulcer were left blank and incomplete, under unhealed pressure ulcers/injuries were left blank and incomplete, under current number of unhealed pressure ulcers/injuries at each stage were left blank and incomplete, under current number of unhealed pressure ulcers/injuries at each stage were left blank and incomplete, and under number of venous & arterial ulcers were left blank and incomplete.</p> <p>Record Review of Resident #257's Care Plan dated 10/02/2024 revealed Resident #257 had Skin Breakdown: Pressure Ulcer, cleanse wound every am shift (6am-2pm), wound (pressure, diabetic, or stasis). Interventions of dietitian referral, inspect skin complete body head to toe every week and document, inspect skin daily with care and bathing, and report any changes to charge nurse, monitor nutritional intake, weight, lab values, report significant changes to MD, off load heels, position resident properly, use pressure-reducing or pressure-relieving devices, treatments, and dressings as ordered per physician.</p> <p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm). Cleanse right groin wound with wound cleanser or NS, pack with iodoform 1/2 inches packing strip, and cover with a silicone foam dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm), cleanse right foot wound with wound cleanser or normal saline, pat dry, apply calcium alginate, cover with a border gauze.</p> <p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm), cleanse right calf wound with wound cleanser or normal saline, pat dry, apply calcium alginate, cover with a border gauze.</p> <p>Record Review of Resident #257's Physician Orders dated 10/09/2024 revealed: Cleanse wound every am shift (6am-2pm), cleanse left foot wound with wound cleanser or normal saline, pat dry, apply calcium alginate, cover with a border gauze.</p> <p>During an observation of LVN A providing wound care for Resident #257 on 10/10/2024 at 1:43 PM, LVN A provided hand washing and put on clean gloves. LVN A checked Resident #257's wounds on right groin area. LVN A removed gloves and discarded in trash. LVN A used hand sanitizer and put on clean gloves. LVN A used a gauze pad with wound wash on it to blot the center of the wound and picked up the gauze off the skin and placed it back on the skin on same gauze, seven times. LVN A placed calcium alginate in the wound. LVN A removed dirty gloves and discarded in the trash. LVN A used hand sanitizer and put on clean gloves. LVN A used a clean gauze pad to pat dry the wound on the right groin area by blotting with the same gauze five times. LVN A removed gloves and discarded in trash. LVN A used hand sanitizer and put on clean gloves. LVN A used wound cleanser on a gauze pad to clean the wound on Resident #257's right foot using the blotting method, four times, using the same gauze pad. LVN A used a clean gauze pad and pat dry six times using the same gauze pad. LVN A removed gloves and discarded in the trash. LVN A used hand sanitizer and put on clean gloves. LVN A used wound wash on a clean gauze pad to clean wound on right calf by going in horizontal direction back and forth over the wound without lifting the gauze pad, nine times. LVN A used a dry clean gauze to pat dry, five times, using the same gauze pad. LVN A applied calcium alginate to the top of the foot and covered with bandage with date and initials. LVN A placed calcium alginate on wound on the right calf and covered with a bandage with date and initials. LVN A removed gloves and discarded in the trash. LVN A used hand sanitizer and put on clean gloves. LVN A used clean gauze pad with wound wash to clean the closed wound on the bottom of the right foot, going in a horizontal direction, back and forth, six times using the same gauze. LVN A discarded the gauze pad in the trash. LVN A used a dry clean gauze pad to pat dry the right bottom foot by blotting, five times. LVN A discarded the used gauze in the trash. LVN A covered the wound on the bottom of the foot with a bandage with date and initials. LVN A discarded gloves in the trash.</p> <p>During an observation of CNA D aiding with wound care with LVN A for Resident #257 on 10/10/2024 at 1:43 PM. CNA D did not wash hands before or after aiding with wound care for Resident #257. CNA D put on one pair of clean gloves throughout the process of assisting with holding of Resident #257's leg, removing clothing, and disposing of trash.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with LVN A on 10/10/2024 at 2:18 PM. LVN A stated that it was best that once you lifted off the skin with the gauze to not retouch the skin. LVN A stated that she should have cleaned the skin with one gauze and once she lifted off the skin to discard of the gauze and get a new one. LVN A stated that she should have cleaned in a circular motion from inside the wound to outward. LVN A stated that she was nervous and was not used to being watched. LVN A stated that she had been trained by the wound care education center that the facility uses, and she was trained in April 2024. LVN A stated that it was a hands-on training, and it was provided once a year. LVN A stated that the negative potential outcome for not cleaning wounds with correct technique would be dispersing bacteria from inside the wound to another area of the skin.</p> <p>During an interview with the KMGR on 10/11/2024 at 1:30 PM an interview had been conducted regarding concerns observed in the dining areas. The KMGR stated all staff that serve food should have washed or sanitized their hands before serving each resident's plate and as necessary when they touched anything contaminated. The KMGR stated all staff were trained on hand hygiene. The KMGR stated the potential negative outcome for residents when staff did not wash or sanitize their hands properly could be passing germs to residents and residents and/or staff could get sick.</p> <p>During an interview with the Administrator on 10/11/2024 at 1:47 PM an interview was conducted regarding concerns observed in the dining areas. The Administrator stated staff should have practiced good hand hygiene between each task, such as serving plates, touching the handles of a wheelchair, and touching anything soiled. The ADMIN stated staff not practicing good hand hygiene could result in residents getting sick.</p> <p>During an interview with the Administrator on 10/11/2024 at 2:37 PM, she the Administrator stated that she expected that staff wash their hands at least twenty seconds. The Administrator stated that staff should follow the policy for hand washing and infection control practices. The Administrator stated that the staff had been trained in hand washing and infection control practices. The Administrator stated that the facility holds skills fairs annually, and competency checks upon hire and monthly. The Administrator stated that the negative potential outcome would be the spread of germs, frequent UTI's, or infected wounds.</p> <p>During an interview with the DON on 10/11/2024 at 2:54 PM, she the DON stated that she expected handwashing to be done properly to keep from spreading infection. The DON stated that she believed the policy stated that staff should use soap and friction for full twenty seconds before rinsing. The DON stated that she expected staff to follow the policy. The DON stated that training and competency checks were provided for staff every month and they have a skills fair annually. The DON stated that the negative potential outcome was the spread of infection and transfer of bacteria.</p> <p>Record review of the facility policy titled; Infection Control date Revised July 2018 revealed:</p> <p>Purpose: The surveillance of infections is an essential part of any infection prevention and control strategy. The main objectives of a surveillance program are:</p> <p>I the prevention and early detection of outbreaks to allow timely investigation and control.</p> <p>II the assessment of infection rates over time to determine the need for, and measure the effect of, preventative or control measures.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Policy: This facility closely monitors all residents who exhibit signs/symptoms of infection through ongoing surveillance and has a systematic method of collecting, consolidating, and analyzing data concerning the frequency and cause of a given disease or event, followed by dissemination of that information to those who can improve the outcomes.</p> <p>I Decrease the spread of infection.</p> <p>II Increase knowledge of infections and how they are spread.</p> <p>Handwashing Surveillance</p> <p>Handwashing is monitored by direct surveillance of persons performing their normal job functions.</p> <p>It is best to complete this type of surveillance without notifying persons you are observing handwashing, to get accurate results.</p> <p>Monitor for short periods several times per month.</p> <p>Monitor as many different disciplines as possible (CNA, LVN, RN, housekeeping, therapy, and kitchen staff)</p> <p>ANALYZING</p> <p>Record review of the facility policy titled; Handwashing/ Hand Hygiene date Revised August 2018 revealed:</p> <p>Purpose:</p> <p>To reduce the spread of infection with proper hand hygiene</p> <p>Policy:</p> <p>Proper hand hygiene technique is completed whenever hand hygiene is indicated.</p> <p>NOTE: Hand Hygiene is the most vital component for preventing the spread of infection.</p> <p>Maintaining clean hands is important for residents/visitors as well as staff.</p> <p>Procedures:</p> <p>1. Hand hygiene is done:</p> <p>Before:</p> <p>A. resident contact.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. eating or handling food.</p> <p>G. taking part in a medical or surgical procedure.</p> <p>After:</p> <p>A. contact with soiled or contaminated articles, such as articles that are contaminated with body fluids.</p> <p>B. resident contact.</p> <p>C. contact with a contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids or wounds.</p> <p>D. toileting or assisting others with toileting, or after personal grooming.</p> <p>H. removal of medical/surgical or utility gloves.</p> <p>NOTE: Wash hands at end of procedures where glove changes are not required. For procedures in which change of gloves, e.g., clean gloves to sterile gloves, is indicated follow the specific standard of practice. If glove hands become contaminated as gloves are changed hands can be washed.</p> <p>Record review of the facility policy titled Hand Hygiene for Staff and Residents for the Infection Control Department, effective 8/2018, revised on 8/2018, and reviewed 1/2022, revealed the following documentation:</p> <p>Purpose:</p> <p>To reduce the spread of infection with proper hand hygiene</p> <p>Policy:</p> <p>Proper hand hygiene technique is completed whenever hand hygiene is indicated.</p> <p>NOTE: Hand Hygiene is the most vital component for preventing the spread of infection. Maintaining clean hands is important for residents/visitors as well as staff.</p> <p>Procedures:</p> <p>1. Hand hygiene is done:</p> <p>(continued on next page)</p>		

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 10/11/2024
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.			
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