

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment for residents, staff, and the public, for 2 of 4 shower rooms (Hall 200 and Hall 400) and 1 of 1 public toilet, reviewed for physical environment. The facility failed to ensure: The shower room on hall 200 had loose and missing tiles in numerous areas of the shower. The shower room on hall 400 had loose and missing tiles in numerous areas of the shower. The door to the shower room on hall 200 was broken. The vanity in shower room [ROOM NUMBER] contained water damage. The hand sink in shower room [ROOM NUMBER] contained corrosion and calcium build up under the sink faucet. The toilet seat in the public bathroom near the nurse's station was loose. This failure could lead to residents falls, injuries, and experiencing a diminished quality of life. Findings include: During an observation on 01/06/2026 at 02:10 PM, the public bathroom near the nurse's station was observed to have a broken toilet seat. The toilet seat was not secure and moved from side to side, 3 to 4 inches. During a confidential interview held on 01/07/2025 at 2:00 PM, 2 confidential residents stated there were numerous repairs that needed to be completed throughout the facility. The confidential residents did not want to specify what repairs were needed but stated the shower rooms should be checked. During an observation and interview on 01/07/2026 at 11:57 AM, the shower room on hall 200 was observed to have two large areas of red tape, approximately 12 by 12 inches, covering missing tiles in the shower. CNA E stated the tape had been on the shower wall since he had been employed at the facility for approximately one year. CNA E stated the MS was aware of the missing tiles, and a work order had been requested for the repair. The door to the shower room was observed to be broken at the top half of the door, with the wood separating down the side of the door. The separation was approximately 12 inches in length. CNA E stated the MS was aware of the broken door, and a work order had been requested for the door as well. During an observation on 01/07/2026 at 12:10 PM, the shower room on hall 400 was observed to have numerous areas of loose and missing tiles from the shower. The vanity was observed to have water damage and deteriorated particle board at the bottom right side of the cabinet. The sink was observed to have a thick build up of corrosion and calcium under the faucet. During an interview on 1/08/2026 at 12:35 PM, the MS stated he had worked at the facility for approximately ten years. The MS stated he was aware there was tape covering missing tiles in the shower in the shower room on hall 200, as well as loose tiles throughout the shower. The MS stated he was aware of the water damage to the vanity in the shower room on hall 200. The MS stated he was aware of the broken door in the shower room on hall 200, and he stated he needed to order a new door. The MS stated he was aware of the broken toilet seat in the public bathroom near the nurse's station. The MS stated he was aware of the corrosion and build-up under the faucet in the hand sink in the shower room on hall 400. The MS stated he was responsible for responding to all maintenance requested for the facility. The MS stated maintenance requests were communicated in a binder at the nurse's station. The MS stated any of their staff could have submitted a maintenance request for repairs needed. The MS stated some maintenance requests were communicated to him verbally, and he was responsible for ensuring they (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that was palatable, attractive and at a safe, and appetizing temperature for 3 of 3 food forms (Regular, Mechanical Soft, and Pureed) for 1 of 1 (Lunch) meal reviewed for palatability. 1) The facility failed to provide food that was palatable for the lunch meal on 01/07/26. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: During confidential individual interviews 3 of 15 residents voiced concerns related to food palatability. One resident stated the food was not good and lacked flavor. One resident stated the food lacked seasoning and tasted like nothing. One resident stated the food was very bland and had little taste. Observation on 01/07/26 at 12:38 PM the test trays arrived at the family dining room and were sampled by three surveyors at 12:40 PM with the following results: Regular Meal - Regular Texture Baked Ham - bland Mashed Potatoes - bland Spinach Bake - no issues Corn Bread - no issues Regular Meal - Mechanical Soft Texture Baked Ham - had a processed/plastic taste, lacked flavor Mashed Potatoes - bland Spinach Bake - no issues Corn Bread - no issues Regular Meal - Puree Baked Ham - had a processed/plastic taste, lacked flavor, very chunky and required chewing Mashed Potatoes - bland Spinach Bake - did not taste like the regular spinach bake, bad taste, very thick consistency Bread - bad taste Regular Meal - Substitution offered Tomato Soup - strong acidic taste, bad taste During an interview on 01/07/26 at 12:50 PM, the ADM was asked to try the test tray and stated the puree spinach bake and the regular spinach did not have the same taste. During an interview on 01/08/26 at 9:31 AM, [NAME] A stated sometimes he tasted the food before serving it to the residents, but not all the time. [NAME] A stated he added breadcrumbs to the puree spinach bake yesterday, and that was probably what changed the taste. [NAME] A stated the mechanical soft ham was delivered to the facility already chopped up like that. [NAME] A stated the puree form ham was made from the mechanical soft form ham. [NAME] A stated the ham had a different texture than the regular ham, but he did not know why because it was delivered that way. [NAME] A stated he tasted the puree ham from yesterday's lunch, and it did have a gritty taste to it. [NAME] A stated the residents had complained to him about the tomato soup not tasting good, but he had not changed anything yet. [NAME] A stated he had been trained in food palatability when he first started working at the facility. [NAME] A stated a potential negative outcome to the residents was choking on the food. During an interview on 01/08/26 at 11:00 AM, the DM stated [NAME] A had been trained in food palatability and proper puree form, but she could not give an exact date. The DM stated none of the residents or their families had complained to her about the taste of the food. The DM stated a potential negative outcome to the residents was that they would not want to eat and could lose weight if the food did not taste good. During an interview on 01/08/26 at 11:14 AM, the ADM stated the DM was responsible for food palatability. The ADM stated the dietary staff had been trained in food palatability. The ADM stated the residents had not complained to her recently about the food and she was not aware of the resident's making complaints about the tomato soup specifically. The ADM stated a potential negative outcome to the residents with the food not tasting good was they could not eat enough and have weight loss. Interview on 01/08/26 at 4:01 PM, the ADM stated the policy provided for food palatability was the most relevant policy she could find. Record review of the facility's grievance log from July 2025 to January 2026 revealed four complaints regarding food concerns. Record review of the facility's document titled, Resident Council Meeting Form, dated 08/25/25 revealed a dietary concern, Residents state food on the halls can sometimes be cold and flavorless. Record review of the facility's document titled, Resident Council Meeting Form, dated 10/27/25 revealed a dietary concern, Resident on Hall 1 stated that food on the hall trays are not always hot. Some residents stated they are inconsistent with seasoning. Record review of the facility's policy and procedure titled, Use of Recipes, with a revised date of 02/06/24, reflected the following: Policy: Recipes will be used when preparing menu items. Procedure: Recipes (in appropriate (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	portion sizes) for each menu cycle are available and maintained in the facility.Recipes will be printed to scale according to information derived from resident tray tickets and current census.Nutrition Services employees are expected to use and follow the recipes provided.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to store bowls and plates upside down, ensure the deep fryer was cleaned, ensure no expired food items were in the kitchen, ensure all food items in the refrigerator were properly labeled or stored in airtight containers, ensure all food items in the dry storage area were properly sealed, and ensure the oven door was clean. These failures could place residents at risk for food contamination and foodborne illness. The findings include: Observations during the initial tour on 01/06/26 at 9:45 AM revealed 5 stack of bowls (each stack of bowls contained 10 - 15 each), 2 stacks of small plates (each stack of plates contained about 20 each), 3 stacks of medium bowls (each stack bowls contained 2 - 9 each), and 1 stack of small bowls (7 bowls contained) on metal shelves and all of the items were stored right side up, meaning the inside of the bowls and plates were exposed. The deep fryer had small brown food crumbs along the inside and the food baskets, the oil in the fryer was a dark brown color and there were food crumbs and grease splatter along the insides of the fryer. The oven door had 7 lines of brown grease dripping from the top of the oven down to the bottom of the oven. In the refrigerator, there were 5 sandwiches that were unlabeled and undated, 1 block of yellow cheese that was undated and unlabeled, 1 pitcher of dark red juice that was undated and unlabeled, 1 pitcher of yellow/brown juice that was undated and unlabeled, and 1 pitcher of orange juice that was undated and unlabeled. The dry storage area contained a large container labeled salt that was not fully sealed and undated, 1 box of potato pearls that was not fully sealed and dated 01/04/26 and 1 box of baking soda that was not fully sealed and undated. The walk-in freezer contained 1 large container of hard-boiled eggs with a best use by date of 01/01/26. During an interview on 01/06/26 at 9:55 AM, the DM stated the prior shift had placed the items in the refrigerator and they had been trained that only a date was needed for the food items. During an interview on 01/06/26 at 9:57 AM, [NAME] A stated he had cleaned out the grease trap on the oven earlier that day and had forgotten to go back and clean up the grease mess on the oven door. During an interview on 01/08/26 at 9:31 AM, [NAME] A stated the kitchen staff were trained to clean as they went. [NAME] A stated sometimes they get busy and cannot clean up as they go. [NAME] A stated that was why the deep fryer was dirty, because he had not had a chance to clean it in a little over a week now. [NAME] A stated they were trained to clean the deep fryer once a week. [NAME] A stated he was last trained a couple months ago about labeling and dating all items in the refrigerator. [NAME] A stated the items were not labeled or dated probably due to laziness, but it was unknown why. [NAME] A stated a potential negative outcome to the residents was cross-contamination and some food items may not be fresh if there was no date on it. During an interview on 01/08/26 at 11:00 AM, the DM stated all the kitchen staff were responsible for labeling and dating all food items and keeping the kitchen cleaned. The DM stated she expected the staff to follow the cleaning schedule and deep clean the deep fryer every Friday. The DM stated the deep fryer was cleaned last Friday and had not been used again, so she was not sure why it was dirty. The DM stated she was confused on the labeling of the food items, but she was told all food items need to be labeled with what it is and the date. The DM stated she had instructed her staff to follow what corporate said to do regarding food storage. The DM stated the stacks of bowls and plates should have been stored upside down and she did not know why they were not stored that way. The DM stated she did not know the expiration date on the boiled eggs and thought they were ok because the container was new. The DM stated the risk to the residents was they could get sick or food poisoning. During an interview on 01/08/26 at 11:14 AM, the ADM stated she expected food items in the kitchen to be labeled or dated if they were not in their original containers. The ADM stated she expected there to be a safe, clean environment in the kitchen at all times. The ADM stated she expected food items like bowls and plates to be stored (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriately. The ADM stated the DM or an appointed designee were responsible for ensuring the kitchen was cleaned and all food items were properly labeled and stored. The ADM stated there was a risk for food borne illness or cross contamination. Record review of the facility policy titled, Food Storage, with a revised date of 04/08/25 reflected the following: Policy: .Food is stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination.Procedure:Storeroom: .Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened.Refrigerator: .All foods are covered, labeled, and dated.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 9 residents observed for infection control (Resident #33, #98, #94, and #8). LVN A failed to utilize enhanced barrier precautions (EBP) during medication administration for Resident #98. The facility failed to ensure Resident #94 had an EBP sign on her door and a personal protective equipment (PPE) box available. CNA B failed to remove the dirty pad from the bed during incontinence care for Resident #33. CNA C failed to change his gloves during incontinence care for Resident #8. CNA D failed to utilize hand hygiene between glove changes during incontinence care for Resident #8. These failures could place residents at risk for cross contamination and infection. The findings include: Resident #98 Record review of Resident #98's face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #98 had a medical history of gastrostomy (a surgical procedure creating a direct opening from the abdomen into the stomach for a feeding tube to deliver nutrition), tracheostomy (a surgically created opening in the neck into the windpipe to provide an airway), and dysphagia (difficulty swallowing). Record review of Resident #98's physician orders revealed an order for Enhanced Barrier Precautions (EBP). Trach, Peg Tube & implanted port with a start date of 1/07/2026. Record review of Resident #98's admission MDS Section C- Cognitive Patterns dated 10/03/2025 revealed a BIMS score of 13 which indicated Resident #98 was cognitively intact. Record review of Resident #98's care plan revealed an intervention of Resident on ENHANCED BARRIER PRECAUTIONS related to trach. Protective personal equipment to be worn provided in cart in resident's room dated 10/21/2025. During an observation of medication administration on 01/07/26 at 7:14 AM, LVN A provided medication administration via g-tube (feeding tube) to Resident #98, LVN A did not wear a PPE gown. A blue name tag was observed on the name plate next to the door behind Resident #98's name. During an interview on 01/07/26 at 7:38 AM, LVN A stated residents who were on EBP (infection control measures, primarily for nursing homes, requiring gowns and gloves for healthcare personnel during high-contact care for residents with multidrug-resistant organisms (MDROs), wounds, or devices, bridging standard precautions and contact precautions to prevent spread when standard methods aren't enough) have a blue tag behind their name. LVN A stated she was taught that if a resident had a blue tag behind their name, the staff needed to wear a gown and gloves when providing direct care. LVN A stated she did not notice if Resident #98 had a blue tag behind his name. LVN A stated she must have missed seeing the blue tag behind Resident #98's name to note that he was on EBP. LVN A stated the PPE box was usually kept right inside the room and the PPE box for Resident #98 had been placed in the bathroom and that was why she forgot to put a gown on to provide him with medications via g-tube. LVN A stated she had been trained last month on EBP in the facility, but she did not remember an exact date. LVN A stated the residents had an increased risk for infection with staff not wearing the proper PPE for EBP. LVN A stated EBP for the residents was to help protect the residents from infections. Resident #94 Record review of Resident #94's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #94 had a medical history of cerebral palsy (a permanent group of neurological disorders affecting movement, balance, and posture, caused by non-progressive damage to the developing brain), pressure ulcer of sacral region, unstageable, and hypertension (high blood pressure). Record review of Resident #94's quarterly MDS Section C- Cognitive Patterns dated 12/05/2025 revealed a BIMS score of 07 which indicated Resident #94 had a severe cognitive deficit. Record review of Resident #94's care plan revealed Resident (#94) has a stage 4 ulcer to her sacrum dated 1/07/2026. The Care plan revealed Resident (#94) on ENHANCED BARRIER PRECAUTIONS (EBP) related to wounds. Protective personal equipment to be worn provided in cart in resident's room. Post signs at resident's door informing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visitors to check in with licensed staff with questions regarding EBP. dated 1/08/2026. Record review of Resident #94's physician orders revealed an order for Enhanced Barrier Precautions (EBP) . wound dated 1/06/2026. The Physician orders revealed an order for Wound Care To Coccyx/Sacrum. dated 12/19/2025. During an observation on 1/7/2025 at 8:26AM, Resident #94's room did not have a PPE box or an EBP sign on her door. Resident #33 Record review of Resident #33's face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #33 had a medical history of Parkinson's disease (a progressive neurological disorder affecting movement), type 2 diabetes, muscle wasting and muscle weakness. Record review of Resident #33's admission data dated 12/29/2025 revealed a BIMS score of 14, which indicated Resident #33 was cognitively intact. The Bladder review section of the assessment data revealed Resident #3 was incontinent of bladder. Record review of Resident #33's care plan revealed a problem of bowel and bladder. Check and change, keep clean and dry dated 12/29/2025. During an incontinence care observation on 1/07/2026 at 10:00 AM, CNA B removed Resident #33's dirty brief and laid resident onto her back on a bed pad. CNA B turned Resident #33 onto her right side and cleaned Resident #33's bottom. CNA B laid Resident #33 onto her back and on the dirty bed pad. CNA B turned Resident #33 again on right side and placed a clean brief under Resident #33. CNA B did not remove the dirty pad before placing a clean brief on Resident #33. Resident #8 Record review of Resident #8's face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #8 had a medical history of chronic obstructive pulmonary disorder (a progressive lung condition causing airflow blockage and breathing problem), type 2 diabetes, alcohol dependence, unspecified cirrhosis of liver (scarring of the liver), and abnormal posture. Record review of Resident #8's quarterly MDS Section C- Cognitive Patterns dated 8/2/2025 revealed a BIMS score of 12 which indicated Resident #8 had moderate cognitive impairment. Record review of Resident #8's care plan revealed Urinary catheter. Resident will be free of complications of indwelling catheter. Care/changing of urinary catheter as ordered dated 8/05/2025. During a foley care observation on 1/07/2025 at 10:13 AM, CNA C cleaned Resident #8's foley and turned Resident #8 onto his right side. CNA C did not change gloves or utilize hand hygiene. CNA D assisted Resident #8 to turn onto his right side and provided CNA C with clean wipes as CNA C cleaned Resident #8's bottom. CNA D changed her gloves after finishing handing wipes to CNA C. No ABHS or hand hygiene was utilized during the glove change by CNA D. CNA C cleaned Resident #8's bottom and removed the dirty brief. CNA C did not utilize hand hygiene or change gloves. CNA C placed a new clean brief on Resident #8 with dirty gloves. During an interview on 1/08/2026 at 11:20 a.m., CNA B stated she had been trained on infection control. She stated had been trained on incontinence care on 1/7/2026 with a mannequin but had no training prior to that at this facility. She stated she was not sure why she did not change the pad out from Resident #33 after it became dirty but she was aware she should have done so. She stated the pad would be considered dirty after she removed the dirty brief from the resident and laid Resident #33 down on the bed pad. She stated the potential negative outcome of not changing the dirty pad during incontinence care would be spreading infection. During an interview on 1/08/2026 at 11:28 a.m., CNA C stated he had been trained on infection control and incontinence care. He stated his last training was in November 2025. He stated he had been trained to change his gloves when going from dirty to clean and to use hand hygiene in between glove changes. He stated he did not change his gloves because he was nervous at the time of the incontinence care and forgot to change them. He stated the potential negative outcome of not changing gloves or using hand hygiene during incontinence care could be spreading germs to other staff and to residents. He stated he would be reviewing the incontinence care steps more and making sure he is not missing any steps. During an interview on 1/08/2026 at 11:33 a.m., CNA D stated she had been trained on infection control and hand hygiene between glove changes. She stated her last training was in December 2025. CNA D stated she did not use hand hygiene between glove changes because she did not see the hand sanitizer on the table. She stated a potential negative outcome of not utilizing hand hygiene between glove changes could be spreading (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection and bacteria. She stated she would be carrying a bottle of hand sanitizer with her at all times and using it during glove changes. During an interview on 1/08/2026 at 11:48 a.m., the DON stated she was the infection preventionist. She stated staff had been trained on infection control, EBP, incontinence care and hand hygiene and the last training was 1/6/2026. She stated EBP was used as an intervention for infection control and to protect residents and staff from spreading infection. She stated she monitors compliance by going through the halls and would observe staff utilize EBP during direct patient care. She stated EBP was identified by the blue tags on the resident's doors. She stated EBP was used for residents who had a history of MDRO or who may have a catheter, IV, wound, or gastric tubes. She stated audits were done weekly and wound reports were looked at to ensure all the appropriate orders were in place as well as the PPE and EBP signs. She stated CMA F was responsible for ensuring the blue signs and PPE boxes were placed in the residents' rooms. She stated if a residents room had a blue sign on the door, and the staff were providing direct resident care such as toileting, EBP should be utilized. The DON stated the nursing staff are trained to identify the need for EBP even if there was no blue signs or PPE boxes in the room. She stated a G-tube would indicate to staff the need for EBP. She stated she was not sure why LVN A would not have worn EBP, there was no reason for LVN A to not have utilized EBP. The DON stated a potential negative outcome of staff not utilizing EBP or not having EBP signs on the doors could be an infection transmission risk to other residents. The DON stated staff are trained to use hand hygiene between glove changes and when going from a dirty area to a clean area. She stated she was not aware of staff not changing gloves during incontinence care or using hand hygiene between glove changes. She stated a potential negative outcome of not using hand hygiene or changing gloves could be spreading infection. The DON stated she would consider a pad dirty if a resident was laid down on the pad before they had been cleaned and the pad should have to be changed. She stated a potential negative outcome of not changing a dirty pad during incontinence care could be skin breakdown, the resident not being clean and infection concerns. She stated she was not aware of the dirty pads not being changed during incontinence care. During an interview on 1/08/2026 at 2:31 p.m., CMA F stated EBP can be initiated anytime a resident may have a wound or an invasive tube such as a catheter. She stated the nurse who identified the need for the EBP would be responsible for ensuring they get an order from the physician and notify her of the new order. She stated she would then put a blue sign on the door and a PPE box in the room. She stated Resident #94 had a wound on her coccyx that had healed in December of 2025 and the EBP had been removed. She stated over the last few days, the wound re-opened and she had not been made aware therefore the EBP signs and PPE box had not been placed in her room. She stated a potential negative outcome of not having the EBP signs on the door could be spreading infection. She stated compliance was monitored by reviewing the wound logs and invasive devices log and ensuring the EBP policy is implemented. She stated monitoring was done 2-3 times a week. She stated EBP should be implemented immediately once the need for it is identified. During an interview on 1/08/2026 at 3:03 p.m., the ADM stated staff had been trained on infection control and the last training was in December of 2025. She stated staff had been trained on EBP. She stated the EBP was identified through blue tags on resident doors and staff was trained to know they would need to use PPE when providing direct resident care. She stated residents with wounds or a history of MDRO require EBP. She stated EBP is used to protect the resident and staff from spreading infection to themselves and to others. She stated the nurses are responsible for obtaining the EBP order and implementing those orders but the DON would ultimately be responsible. She stated staff are trained to recognize when the use of EBP is needed and if a resident did not have a current sign or PPE box they would need to follow up and make sure it was put into place. She stated she was not sure why LVN A did not utilize EBP but she had been trained to recognize when residents need the EBP and should have worn the PPE. She stated a potential negative outcome of not using EBP or having the EBP signs on the doors could be spreading infection to other residents. The DON stated staff are trained to change their gloves during (continued on next page)		

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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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence care. She stated staff are trained to utilize hand hygiene between glove changes. She stated glove changes should be done when going from dirty to clean and hand hygiene in between. She stated she was not aware that staff were not utilizing hand hygiene and glove changes during incontinence care. She stated a potential negative outcome of not using hand hygiene or glove changes could be spreading infection. The DON stated she would consider a bed pad dirty if a resident was laid on it before being cleaned. She stated she expected staff to change the dirty pad before placing a clean brief on the residents. She stated the potential negative outcome of not changing a dirty bed pad during incontinence care could be spreading infection, dignity concerns and dirtying what had been cleaned. Record review of facility policy titled Enhanced Barrier Precautions last revised April 1, 2024, revealed; Many residents in nursing homes are at increased risk of becoming colonized and developing infections with multi-drug-resistant organisms (MDROs). This facility utilizes Enhanced Barrier Precautions (EBP) as a strategy to decrease transmission of CDC-targeted and epidemiologically important MDROs when Contact Precautions do not apply. A. Indications. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. 3. High Contact Resident Care Activities: .g. Device care or use: Central line, Urinary catheter, feeding tube, tracheostomy, h. Wound Care: any skin opening requiring a dressing. Communication. 1. Indicate the residents who are on EBP by subtle means, such as an alternate color of the resident's name badge on door, to maintain a home-like environment. Record review of facility policy titled Hand Hygiene for Staff and Residents last revised July 2018 revealed; Policy: Proper hand hygiene technique is completed whenever hand hygiene is indicated. Procedures: Hand hygiene is done after. H. removal of medical surgical or utility gloves. Wash hands at end of procedures where glove changes are not required. For procedures in which change of gloves. indicated follow the specific standard of practice. If glove hands become contaminated as gloves are changed hands can be washed. Record review of facility policy titled Perineal Care last revised April 10, 2023 revealed; Procedure: Staff will provide perineal care in accordance with the standards of practice to prevent skin breakdown and infection. Procedure: .8. Turn resident to clean all areas of buttocks with new wipe or section of washcloth wiping front to back to remove feces present ., 9. Dispose of gloves and used supplies and perform hand hygiene, 10. Apply new gloves and place new brief and change linens as needed.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I assessments accurately reflected the resident's status for 2 of 24 residents (Residents #16 and #5) reviewed for PASRR screening, in that: The facility failed to ensure: Residents #5 and #16's PASRR Level 1 assessment did not indicate a diagnosis of mental illness. These failures could place residents who had a mental illness at risk for not receiving care and services to meet their needs. The findings were as follows: Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #5 had a primary diagnosis of syringomyelia and syringobulbia (a spinal disorder with a fluid-filled cyst (syrinx) in the spinal cord, while syringobulbia is when that syrinx extends into the brainstem) and a medical history of bipolar II (a mood condition marked by significant depressive episodes and less intense up periods called hypomania, without full-blown mania), multiple sclerosis (a chronic autoimmune disease where the immune system mistakenly attacks myelin) and type 2 diabetes. Record review of Resident #5's admission MDS assessment dated [DATE] revealed Section C- Cognitive Patterns, a BIMS score of 12 indicated the resident was moderately, cognitively impaired. Section I- Active Diagnosis revealed resident had a psychiatric/Mood disorder of bipolar disorder. Record review of Resident #5's care plan revealed Medication: Potential for discomfort and side effects related to the use of antipsychotic medication. Administer medication as ordered Physician to review medication Report pertinent lab results to physician, Monitor for Adverse Consequences possible side effects every shift via concurrent review dated 12/31/2025. Record review of Resident #5's physician orders revealed and order for Aripiprazole (an antipsychotic medication used to treat schizophrenia, bipolar disorder, major depressive disorder) 15mg tablet once a day, dated 9/25/2025. Record review of Resident #5's PL1 form dated 9/24/2025 revealed under section C0100 Mental Illness an answer of NO, indicated the resident did not have a mental illness. Resident #16 Record review of Resident #16's face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #16 had a primary diagnoses of lack of coordination and a medical history of bipolar II, type 2 diabetes, muscle weakness, and dementia. Record review of Resident #16's quarterly MDS assessment dated [DATE] revealed Section C- Cognitive Patterns, a BIMS score of 0 indicating the resident was unable to complete the interview. Section I- Active Diagnosis revealed resident had a psychiatric/Mood disorder of bipolar disorder and depression. Record review of Resident #16's care plan revealed Medication: Potential for discomfort and side effects related to the use of anticonvulsant medication. Administer medication as ordered, Physician to review medication, report pertinent lab results to physician Monitor for Adverse Consequences possible side effects every shift via concurrent review dated 07/28/2025. Record review of Resident #16's physician orders revealed and order for Divalproex Sodium (an anticonvulsant medication, FDA-approved treatment for the manic and mixed episodes associated with bipolar disorder), 500mg tablet, twice a day, dated 6/25/2025. Record review of Resident #16's PL1 form dated 4/08/2024 revealed under section C0100 Mental Illness an answer of NO, which indicated the resident did not have a mental illness. Section C0090 revealed an answer of yes, which indicated the resident had a primary diagnosis of dementia. During an interview on 1/08/2026 at 11:43AM, with the MDS Nurse, she stated she was responsible for obtaining the PASRR from the admissions coordinator and reviewing them for accuracy. She stated when she reviewed the PASRR she looked at the residents diagnosis and social security to make sure they are accurate. She stated if the PASRR was incorrect they would request the facility that was transferring the resident, to do another screening but if the resident was in the facility, they would correct it via their online system SIMPLE (a healthcare software company designed to streamline workflows for providers .especially concerning long-term care and Preadmission Screening and Resident Review (PASRR) processes). The MDS Nurse stated Resident #16 did not have a primary diagnosis of dementia but did (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have a current diagnosis of dementia. She stated Resident #16's primary diagnosis was lack of coordination. She stated Resident #5 had a primary diagnosis of syringomyelia and syringobulbia. She stated both Resident #5 and #16 had a diagnosis of Bipolar II. She stated Bipolar II is classified as a mental illness. She stated she considered Resident #5 and Resident #16's PASRR to be accurate. She stated Resident #5 would need to have a re-evaluation by the local authority to correct the PASRRs but Resident #16 could have his dementia as his primary diagnosis. She stated PASRRs are reviewed for accuracy every three months and anytime there are changes to residents' diagnosis. She stated the potential negative outcome of not having an accurate PASRRs could be residents missing out on services that they may qualify for. During an interview on 1/08/2025 at 3:03 PM with the ADM, she stated the admission coordinator receives the PASRRs from the transferring facility and gives it to the MDS Nurse for review. She stated the MDS Nurse was responsible for requesting any changes or updates on the PASRRs. She stated she did not believe Resident #16 had a primary diagnosis of dementia and Resident #5 did not have a primary diagnosis of dementia. She stated Resident #5 and Resident #16 had a diagnosis of Bipolar II. She stated Bipolar II is classified as a mental illness. She stated she did not believe PASRRs to be accurate for Resident #5 and Resident #16. She stated she expected the MDS Nurse to send a request for a new PASRR screening for both Resident #5 and #16 to the local authority. She stated she believed the PASRRs are reviewed quarterly for accuracy and any changes. She stated the potential negative outcome of not having an accurate PASRR could be residents not receiving the services they may need or qualify for. Facility policy for PASRR requested. On 1/14/2025 at 5:05 p.m., the ADM stated the facility followed the state process and did not have a separate policy for PASRR.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure each resident received, and the facility provided food prepared in a form designed to meet individual needs for 1 of 1 noon meals observed for puree texture. The facility failed to ensure puree meat, and spinach bake were prepared to a smooth uniform texture on 01/07/26. This failure could place residents at risk of decreased food intake, choking and aspiration. The findings included: During an observation on 01/07/26 at 12:40 PM [NAME] A prepared puree ham, bread, spinach bake, and potatoes and provided a sample tray to the surveyors. The surveyors tasted the puree ham, and it had small chunks of meat and required chewing. The spinach bake had a very thick consistency and required a small amount of chewing. During an interview on 01/08/26 at 9:31 AM [NAME] A stated he was last trained on food form when he started working at the facility. [NAME] A stated puree should be a pudding-like texture and be smooth when your tongue touches the food to the top of your mouth. [NAME] A stated he tasted the puree ham from yesterday and tasted a gritty texture. [NAME] A stated a potential negative outcome to the residents was they could choke on his food. During an interview on 01/08/26 at 11:00 AM, the DM stated [NAME] A was trained on puree texture. The DM stated she did not know why the puree ham and the puree spinach was not the proper texture for puree form. The DM stated she would work with [NAME] A more on food form. The DM stated a potential negative outcome to the residents was they could choke and not be able to swallow the food. During an interview on 01/08/26 at 11:14 AM the ADM stated she expected the puree foods to be smooth in texture and not require chewing. The ADM stated the kitchen staff were trained in proper food forms, but she did not remember the last time prior to 01/07/26 they had been trained. The ADM stated a potential negative outcome to the residents was possible issues with swallowing, choking or pocketing food. During an interview on 01/08/26 at 4:01 PM, the ADM stated the policy provided for food form was the most relevant policy she could find. Record review of the facility's policy and procedure titled, Use of Recipes, with a revised date of 02/06/24, reflected the following: Policy: Recipes will be used when preparing menu items. Procedure: 1. Recipes (in appropriate portion sizes) for each menu cycle are available and maintained in the facility. 2. Recipes will be printed to scale according to information derived from resident tray tickets and current census. 3. Nutrition Services employees are expected to use and follow the recipes provided.		