

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Crown Point Health Suites		STREET ADDRESS, CITY, STATE, ZIP CODE 6640 lola Avenue Lubbock, TX 79424	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to be treated with respect and dignity for one of six resident (Resident #1).</p> <p>The facility failed to ensure staff did not go through and/or remover Resident #1's personal possessions without the resident's permission.</p> <p>This failure could place residents at risk of feeling disrespected, having reduced dignity and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet revealed a [AGE] year-old male who was admitted on [DATE] with the following diagnoses: Post-Traumatic Stress Disorder (a condition of persistent mental and emotional stress as a result of injury or psychological shock), Chronic Respiratory Failure (inability to maintain adequate oxygenation and removal of carbon dioxide from tissues), Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Chronic Pain, Primary Hypertension (high blood pressure that does not have one distinct cause), Generalized Muscle Weakness.</p> <p>Record review of Resident #1's annual MDS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact.</p> <p>Record review of Resident #1's care plan indicated resident was independent, required supervision and/or set-up assistance with activities of daily living.</p> <p>In an observation and interview on 09/05/24 at 9:51 AM, Resident #1 laying in the hospital bed, stated he felt that his rights and privacy were violated when facility staff went through and removed his personal belongings without his consent while he was hospitalized .</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/05/2024 at 1:00 PM with Adm and DON. Adm stated ADON A had found upon entrance to Resident #1's room nightstand drawer open and observed multiple illicit items: liquid adaptogenic mushrooms, THC/CBD gummies with THC listed on the jar, vape with unknown substance plus a plastic container that had gummies that appeared to be candy with hard candy on outside. The DON stated she spoke with Resident #1's family member on Friday, August 30th and they stated they would come the next day (Saturday) to gather up Resident #1 belongings (the items in the plastic bags and other items in the resident's room). The Adm stated it was a long holiday weekend, on Tuesday the resident's family member had not picked up the contents in the plastic bags retrieved from Resident #1's nightstand. She stated she sent the maintenance supervisor to Resident #1's room to see if any of the items had retrieved from Resident #1's room. The Adm stated the maintenance supervisor found five knives and one straight razor. The Adm and DON stated the family member did not give consent to the facility to go through Resident #1's belongings and still has not picked them up as of 09/05/2024.</p> <p>In an observation on 09/05/2024 at 2:16 PM, the Adm presented five assorted sizes of knives and one straight razor.</p> <p>In an interview on 09/05/2024 at 2:49 PM, Maintenance Supervisor stated the administrator gave him permission to go through Resident #1's belongings. He stated he did take ADON A with him. He stated the top nightstand drawer was open, however, there were two drawers on the nightstand, and he did open the bottom drawer plus six drawers on the dresser where he obtained five knives and one straight razor. He stated he took those back to the administrator.</p> <p>In an interview on 09/05/2024 at 3:01 PM, DON stated she was not aware of any inventory list the resident completed upon admission, not on nursing side. She stated social services may have something.</p> <p>In an interview on 09/05/2024 at 3:18 PM, Social Services Techs stated there was not an inventory list completed upon admission or updated during the resident stay.</p> <p>In an interview on 09/05/2024 at 3:45 PM, Resident #5 stated he did not have any issues with the staff.</p> <p>In an interview on 09/05/2024 at 3:50 PM, Resident #6 stated he did not have any issues with the staff.</p> <p>In an interview on 09/05/2024 at 4:03 PM, Resident #3 stated he had no issues with the staff.</p> <p>In an interview on 09/05/2024 at 4:06 PM, Resident #4 stated she had no issues with the staff.</p> <p>Record review of the facility's policy titled Personal Property revised dated August 2022 stated the following:</p> <p>Policy Statement</p> <p>Residents are permitted to retain and use personal possessions, including furniture and clothing, space permits, unless doing so would infringe on the rights or health and safety of other residents.</p> <p>Policy Interpretation and Implementation</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.</p> <p>4. A representative of the admitting office advises the resident, prior to or upon admission, of the types and amount of personal clothing and possessions that the resident may keep in his or her room.</p> <p>5. If restrictions are placed on the use of personal belongings, the reason for the restriction is explained to the resident or representative.</p> <p>6. If it is determined through observation of the resident that he or she may have brought an illegal substance(s) into the facility, it is immediately reported to the charge nurse or supervisor. The supervisor and the DNS determine whether the situation warrants a referral to law enforcement .</p> <p>9. Facility staff does not conduct searches of a resident or their personal belongings unless the resident or representative agrees to the search and understands the reason for the search.</p> <p>10. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary . [Sic]</p>

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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>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305</p> <p>Based on observation, interview, and record review, the facility failed to ensure the right to personal privacy, including the right to receive unopened mail and other letters, packages and other materials delivered to the facility for 1 (Resident #1) of six resident reviewed for privacy.</p> <p>Facility staff opened a package mailed to the facility addressed to Resident #1 without the consent or presence of the resident.</p> <p>This failure could place residents at risk of feeling disrespected, having reduced dignity and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet revealed a [AGE] year-old male who was admitted on [DATE] with the following diagnoses: Post-Traumatic Stress Disorder (a condition of persistent mental and emotional stress as a result of injury or psychological shock), Chronic Respiratory Failure (inability to maintain adequate oxygenation and removal of carbon dioxide from tissues), Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Chronic Pain, Primary Hypertension (high blood pressure that does not have one distinct cause), Generalized Muscle Weakness.</p> <p>Record review of Resident #1's annual MDS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact.</p> <p>Record review of Resident #1's care plan indicated resident was independent or required supervision or set-up assistance with activities of daily living.</p> <p>Observation on 09/05/25 at 3:30 PM of Resident #1's belongings revealed a medium size opened padded envelope addressed to Resident #1.</p> <p>In an interview on 09/05/25 at 3:47 PM with ADON A, he stated the package addressed to Resident #1 was set on his desk. He stated Resident #1 was a member of the VA and would receive medications in the mail. ADON A stated he opened the package because he believed it to contain medication. He stated the package arrived after the resident discharged to the hospital.</p> <p>In an interview on 09/05/24 at 2:22 PM with the ADM, she stated staff was not to open resident's mail unless resident had requested them to. The ADM stated in this case of Resident #1's package, ADON A opened the package thinking it was medication from the VA. The packaging looks the same in white plastic bubble packaging; in the package was ammunition. ADM stated the ADON informed herself of the contents and turned the package to her. ADON stated the family member was aware of the contents of the package and he stated he would pick up the package. ADM stated going forward all mail/packages addressed to residents will be delivered to the residents and have the resident &/or resident representative to open the package or have staff open it in front of them.</p> <p>(continued on next page)</p>		

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