STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676279	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Suites	6640 Iola 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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify, consistent with his or her authority, the resident representative(s) when there was a change in the residents physical, mental, or psychosocial status for 1 of 5 residents (Residents #1) reviewed for notification of changes. The facility failed to notify the resident representative for Resident #1 regarding a fall on 09/29/25. This failure could affect the residents by causing their representatives to be unaware of changes in a Resident's condition. Findings include: Record review of Resident #1's admission record, dated 10/03/25, revealed a [AGE] year-old male who was admitted on [DATE] with the following diagnoses: encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below knee, and dysphagia (difficulty swallowing). Record review of Resident #1's comprehensive MDS, dated [DATE], Section C- Cognitive patterns revealed Resident #1 had a BIMS score of 10, which indicated Resident #1's cognitive level was moderately impaired. Record review of Resident #1's incident report titled, Fall, dated 09/29/25 at 10:30 AM, revealed in the incident description: Nursing Description: CNA [CNA B] came to get this nurse d/t guest leaned too far forward during sliding board transfer and had to be assisted to the floor with gait belt. Guest sitting up on floor in room beside w/c 3 tiny skin tears to top of right hand. 0 other injuries noted at this time. Agencies/People notified: Family/Responsible party [Family Member CC] Date: 09/30/25 at 4:14 PM. Record review of the facility document titled, Nurse Statement - Fall Incident Notification The date of the statement was 09/30/25 and the date of the incident was 09/29/25 reflected the following: Statement of Events: On 09/29/25, a fall occurred involving [Resident #1]. The fall was witnessed and guided by the CNA on duty. I assessed the resident at the time of the fall. Small skin tears noted, treated, and the resident proceeded to dialysis for his regularly scheduled treatment that day. Throughout my shift, I continued to prioritize the care of other residents. The resident was observed to be in phone contact with his family, and I believed they were aware of the fall based on those conversations. I did not personally notify the family of the fall on the same day. I did provide a follow-up call the following morning to inform the family of the incident and to apologize for the delay in notification.Acknowledgement: I agree that the above statement accurately reflects my account of the incident and my actions regarding family notification. Nurse Signature: [LVN A]Date: 09/30/25 Attempted interview on 10/03/25 at 8:05 AM revealed Resident #1 was receiving patient care services at this time. Unable to interview. Interview on 10/03/25 at 8:58 AM, Family Member CC stated the facility had not called to notify her of Resident #1's fall on 09/29/25. Family Member CC stated she spoke with Family Member DD on the phone and they asked if she had been notified that Resident #1 fell in the morning on 9/29/25 and hit his head. Family Member CC stated she then made a phone call to the facility to talk to the administrator about the incident. Interview on 10/03/25 at 9:08 AM, Family Member DD stated she was on a face time call with Resident #1 on 9/30/25 when she noticed he had a bandage on one of his hands. Family Member DD stated she was unsure which hand had the bandage due to the camera inverting images during face time calls. Family Member DD stated she asked Resident #1 what happened, and he told her that he fell the day before. Family Member DD stated she then called Family Member CC to see if the facility had given her a courtesy call about the fall and she was told no, no one had been notified that Resident #1 fell at the facility. Family Member DD stated they went to the facility in the evening on 9/30/25 and that was when the nurse went in and notified them of the fall and what happened. Interview on 10/03/25 at 9:37 AM, LVN A stated the charge nurse was responsible for notifying the family if a resident had a fall or any health changes. LVN A stated on 9/29/25, the CNA for Resident #1 had called her into the room that morning and stated she assisted him to the floor. LVN A stated when she went in Resident #1's room, he was sitting on the floor and she began assessing him for injuries. LVN A stated she noted a couple of skin tears to the top of his right hand and no other complaints of pain at that time. LVN A stated she cleaned up his hand and put a bandage on it and then Resident #1 was sent to dialysis that day. LVN A stated she was approached by another resident's family after the incident and the incident with Resident #1 must have slipped my mind and she did not contact the family to notify them of the fall. LVN A stated Resident #1's family member went to her desk in the evening on 10/03/25 and she was upset about not being notified of the fall. LVN A stated she felt like Resident #1 was good and only saw injuries to his hand. LVN A stated Resident #1 called his family all of time and she thought he notified his family. LVN A stated she knew the nurse was responsible for calling the family for every fall. LVN A stated she had been trained on notifications of change but could not remember