STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676028	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Specialty Rehab & Nursing	4320 W 19th St Lubbock, TX 79407

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46425 Based on interviews and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 3 of 28 residents (Residents #17, 29 and #67) reviewed for PASRR screening, in that: Residents #17, 29 and #67 did not have an accurate PASRR Level 1 assessments when they had a diagnosis of mental illness. These failures could place residents with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation at risk for not receiving care and services to meet their needs. The findings were: Resident #17 Record review of Resident #17 electronic face sheet revealed a [AGE] year-old female most recently admitted to the facility on [DATE]. The face sheet listed under Diagnoses Information, bipolar disorder. Record review of Resident #17's Quarterly MDS dated [DATE], revealed under section I Active Diagnoses, a diagnosis of bipolar disorder. Additionally, under Section C Cognitive Patterns, the MDS revealed a BIMS of 13 indicating the resident was cognitively intact. Record review of Resident #17's most recent care plan, undated, revealed a focus area and diagnosis of bipolar disorder, this problem started 03/04/2024. Resident #17 was prescribed Buspirone 10mg 3 times a day, Cymbalta 60MG once a day, and Escitalopram 10MG once a day. Record review of Physician progress notes for Resident #17 dated 03/07/2024 revealed under current medications, Resident #17 was prescribed Buspirone 10mg 3 times a day, Cymbalta 60MG once a day, and Escitalopram 10MG once a day for bipolar disorder. Record review of Resident #17's Preadmission Screening and Resident Review Level One (PL1) form dated 1/11/2024 revealed under section C0100 Mental Illness an answer of No, indicating the resident did not have a mental illness. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29 Record review of Resident #29's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. The face sheet indicates under Diagnoses Information, Major Depressive Disorder, Recurrent, Unspecified. Record review of Resident #29's Annual MDS dated [DATE], revealed under section I Active Diagnoses, a diagnosis of depression. Additionally, under Section C Cognitive Patterns, the MDS revealed a BIMS of 12 indicating the resident had moderately impaired cognition. Record review of Resident #29's most recent care plan, dated 2/20/2024, revealed a diagnosis of Major Depressive Disorder. Record review of Physician orders for Resident #29 dated 03/06/2024 revealed under Diagnoses, Resident #29 has a diagnosis of Major Depressive Disorder. Record review of Resident #29's Preadmission Screening and Resident Review Level One (PL1) form dated 09/14/2016 revealed under section C0100 Mental Illness an answer of No, indicating the resident did not have a mental illness. Resident #67: Record review of Resident #67's electronic face sheet revealed a [AGE] year-old female most recently admitted to the facility on [DATE]. The face sheet listed under diagnosis information a diagnosis of major depressive disorder. Record review of Resident #67's Quarterly MDS dated [DATE], revealed under section I Active Diagnoses, a diagnosis of schizophrenia. Additionally, under Section C Cognitive Patterns, the MDS revealed a BIMS of 10 indicating the resident was moderately cognitively impaired. Record review of Resident #67's most recent care plan, undated, revealed a focus area and diagnosis of schizophrenia, this problem started 11/08/2023. Resident #67 was prescribed Seroquel 50MG once a day to address this diagnosis. Record review of Physician progress notes for Resident #67 dated 03/07/2024 revealed under current medications, Resident #67 was prescribed Seroquel 50MG once a day to address diagnosis of schizophrenia. Record review of Resident #67's Preadmission Screening and Resident Review Level One (PL1) form dated 11/07/2023 revealed under section C0100 Mental Illness an answer of No, indicating the resident did not have a mental illness. During an interview conducted on 03/03/24 at 2:15PM with the MDS Nurse, she verified Residents #17, #29, #67 had a diagnosis of mental illness. The (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS Nurse verified Residents #17, #29, and #67 did not have PASRR 2 Evaluations as their PASRR 1s were negative. The MDS Nurse stated the purpose of the PASRR 1 was to identify Residents who required additional services. She said if the PASRR 1 was positive then it gets put into an online system and they reach out to the necessary people to ensure a PASRR 2 Evaluation was done. She said she was responsible for entering the PASRR 1 into the system, the MDS nurse was also responsible for ensuring PASRR 1s were accurate by comparing them to medical records. The MDS Nurse stated the potential harm if a resident with a diagnosis of a mental illness had a negative PASRR 1, and no subsequent level PASRR 2 evaluation was the residents could potentially go without services. During an interview with the ADM on 03/07/24 at 11:30PM, she verified Residents #17, #29, and #67 had diagnosis of mental illnesses. The ADM confirmed Residents #17, #29, and #67 did not have PASRR 2 Evaluation as their PASRR 1s were negative. The ADM stated it was the MDS nurses' responsibility to ensure every resident admitted to the facility had an accurate PASRR 1. The ADM also stated it was the MDS nurses' responsibility to ensure PASRR 1s are completed accurately by comparing them to the residents' medical records. The ADM stated positive PASRR 1 should be referred to the local mental health authority for completion of a PASRR 2 Evaluation. The ADM stated the potential harm to a resident without an accurate PASRR 1 and a subsequent PASRR 2 Evaluation was the residents will not receive the services they need. Record Review (PASRR) Policy Revised March 2019: The facility policy for PASARR states all applicants admitted to a Medicaid-certified nursing facility are evaluated for mental health prior to admissions and offered the most appropriate setting for their needs. If the PASARR level one screening indicated the individual may have an Intellectual Disability or a Mental Illness diagnosis the facility will confer with local mental health providers to complete a PASARR level two screening. Following the completion of the level two screening a care plan will be developed by the facility in order to meet the needs of a resident with an Intellectual Disability or a Mental Illness diagnosis. 49927

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder or had a urinary catheter received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 21 Residents (Resident #271) reviewed for incontinent care, in that: The facility failed to ensure Resident #271 had the correct foley catheter inserted per physician orders. This failure could affect residents by placing them at increased risk of discomfort, skin ulcerations and improper medical treatment. Findings include: Record review of Resident #271's face sheet, dated 03/05/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include acute and chronic respiratory failure (lung disease), quadriplegia (paralysis in limbs below neck), and gastrostomy status (g-tube). Record review of the comprehensive MDS assessment dated [DATE] revealed Resident #271 was in a persistent vegetative state/no discernible consciousness. The MDS further revealed Resident #271 had an indwelling catheter. Record review of the order summary report for Resident #271, dated 03/05/24, revealed orders for: Urinary Catheter 18 French 30 cc to gravity drainage every shift with a start date of 12/05/23. Record review of Resident #271's Comprehensive Care Plan, revised on 01/08/24, revealed the resident had a focus area: [Resident #271] has an indwelling catheter: Neurogenic bladder (loss of bladder control); Focus: [Resident #271] will be/remain free from catheter-related trauma through review date. During an observation on 03/06/24 at 3:45 PM, Resident #271 was receiving wound care and it was noted that Resident #271's foley catheter was a 20 French foley catheter. Interview on 03/06/24 at 4:17 PM, ADON A stated it was unknown why Resident #271 had the wrong size foley catheter inserted. ADON A stated every nurse every shift is responsible for checking the foley catheter size with the physician orders. ADON A stated the potential negative outcome to the resident was leaking or skin breakdown. Interview on 03/06/24 at 4:45 PM, the DON stated it was unknown why Resident #271 had the wrong size foley catheter inserted, but she would look into it. The DON stated the nurses are responsible for ensuring foley catheter sizes are correct with physician orders. The DON stated the potential negative outcome for the resident was possible leaking and pain. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/07/24 at 9:52 AM, the ADM stated they were able to investigate why Resident #271 had a different foley catheter size inserted that what the physician ordered and it was because he came back from the hospital with the different sized foley catheter. The ADM stated the admitting nurse missed this and did not notify the MD. The ADM stated the foley catheter should have been followed up on assessment, she was did not know how often the nurses did a reassessment. The ADM stated the potential negative outcomes to the resident were possible pain and urethral damage. Interview on 03/07/24 at 10:45 AM, the Regional Consult Nurse stated the facility did not have a specific policy related to physician orders for foley catheters. Record review of the facility's policy titled, Catheter Care with a revised date of 02/13/07, reflected the following: General Guidelines: 9. Review the resident's plan of care daily for [NAME]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview, and record review, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 12 residents fed by gastrostomy tube (g-tube) (Resident #271), in that: The facility failed to ensure Resident #271's feeding pump was infusing at the correct rate as ordered by the MD. These failures could result in weight loss and poor wound healing in residents with a g-tube. The findings include: Record review of Resident #271's face sheet, dated 03/05/24, revealed a [AGE] year-old-male was admitted to the facility on ,d+[DATE] 5/23 and readmitted on [DATE] with diagnoses to include acute and chronic respiratory failure (lung disease), quadriplegia (paralysis in limbs below neck), and gastrostomy status (g-tube). Record review of the comprehensive MDS assessment dated [DATE] revealed Resident #271 was in a persistent vegetative state/no discernible consciousness. The MDS further documented Resident #271's Nutritional Approach While a Resident was feeding tube. Record review of the current care plan for Resident #271, last revised on 01/28/24, revealed a focus area for: [Resident #271] requires a tube feeding r/t (related to) dx (diagnosis) of dysphagia; Focus: [Resident #271] will remain free of complications related to tube feeding through review date, [Resident #271] will maintain adequate nutritional and hydration status aeb (as evidence by) weight stable, no s/sx (signs or symptoms) of malnutrition or dehydration through review date; Interventions: The resident is dependent on tube feeding and water flushes. See MD orders for current feeding orders. Record review of the order summary report for Resident #271, dated 03/05/24, revealed orders for: Enteral Feed Order every shift Isosource 1.5 85mLs/hr for 22 hr 45mLs/H2O with 2hr gut rest with a start date of 12/05/23. During an initial tour observation on 03/05/24 at 10:01 AM, Resident #271 was observed laying in bed with a feeding tube connected to a feeding pump. The feeding pump was observed to have a bag hanging labeled Isosource 1.5 and the feeding pump was infusing at a rate of 70mL/hr. Observation on 03/05/24 at 4:07 PM revealed Resident #271's feeding pump was infusing Isosource 1.5 at a rate of 70mL/hr. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/06/24 at 8:44 AM revealed Resident #271's feeding pump was infusing Isosource 1.5 at a rate of 70mL/hr. Interview on 03/06/24 at 8:50 AM, LVN A stated this was her first day back at work in 3 weeks and she was unsure why Resident #271's feeding pump rate was infusing at the wrong rate. LVN A stated the nurse is responsible for ensuring the resident's feeding pumps are infusing at the correct rate. LVN A stated the potential negative outcome to the resident was a slower feeding rate. Interview on 03/06/24 at 8:56 AM, the DON stated she was unsure why Resident #271's feeding pump was infusing at the wrong rate. The DON stated maybe the RD had recommending a new dietary order, but she was unable to locate a new order from the RD. The DON stated the nurses are trained to check the feeding pump rate when new bags of formula are hung. The DON stated the potential negative outcome to the residents were weight loss, it could affect wound healing and it could lead to cardiac issues due to that being Resident #271's only nutrition. Interview on 03/07/24 at 9:52 AM, the ADM stated she expects the feeding pump flow rates to be checked daily. The ADM stated the charge nurse is responsible for ensuring the feeding pump flow rates are correct with the physician orders. The ADM stated the potential negative outcome to the residents was weight loss. Record review of facility's policy, titled, Enteral Nutrition, with a revised date of 02/13/07 reflected the following: We will provide nutritionally complete enteral or parental feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observations, interviews, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for 1 (Hall 300) of 1 medication carts observed for drug storage. The facility failed to ensure staff locked medication cart at end of Hall 300 when it was left unattended. This failure could result in harm due to unauthorized access to medications, misappropriation, and drug diversion. The findings were: Record review Resident #4's face sheet dated 03/07/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (cognitive loss), anxiety (nervousness, feeling of fear), hypertension (high blood pressure), and depression (feeling of sadness). Record review of Resident #4's comprehensive MDS assessment, dated 02/15/24 revealed a BIMS score of 00, which indicated severely impaired cognition. Record review of Resident #4's care plan dated 02/23/24 revealed a focus area Resident #4 wanders occasionally related to dementia, with goals to distract her from wandering, identify pattern of wandering and activities resident likes. During an observation and interview on 03/07/24 at 10:16 AM the medication cart for Hall 300 was at the end of hall 300 across from the employee breakroom. The cart was unlocked. All drawers to the cart were unlocked and able to be opened by the state surveyor. Over the counter medication and resident prescription medication cards were visible. The narcotic box was locked. Observation of resident (Resident #4) approx. 2-3 feet from unlocked medication cart. At 10:18 AM MA A exited the breakroom and returned to medication cart and locked the cart. She stated she was assigned this medication cart. She stated she was not sure why the medication cart was unlocked. She stated she locked the cart before going into the breakroom. She stated she is not sure if any other staff has a key to her medication cart. She stated she had been trained on securing the medication cart. She stated the potential negative outcome could be resident or anyone getting in the cart and take medications not prescribed for them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/07/24 at 10:22 AM with the ADM, she stated medication carts should always be secured when not in use. She stated all staff have been trained to secure carts. She stated the nurse or medication aide assigned to cart is responsible for keeping cart locked when not being used. She stated all nurses and medication aides have been trained. She stated there is only one key for each medication cart and is kept with the nurse assigned to the medication cart. She stated her expectation are for all medication carts to be locked when not in use. During an interview on 03/07/24 at 11:25 AM with the DON, she stated medication carts should always be locked when not in use. She stated all nurses and medication aides have been trained. She stated nurses and medication aides are assigned a cart at the beginning of each shift and keys are given to them from the staff going off duty. She stated there is only one set of keys per medication cart. She stated the potential negative outcome could be residents getting into unlocked cart and taking medications not prescribed for them. She stated her expectations are for medication cart to be locked when not in use. Record review in-service training report titled Narcotic and Med Cart Management dated 2/5/24 revealed the following: Summary of Subject Matter . Medication carts are to be locked at all times. The only exception to the cart being unlocked is if the Nurse or Medication Aide assigned to that cart are pulling meds, counting narcotics for shift change, or doing a cart audit. You are not to walk away from the cart at any time with it unlocked. Those attending: . MA A . Review of facility policy titled Medication Administration Procedures dated 2003 revealed the following: 5 . During the medication administration process, the unlocked side of the cart must always be in full view of the nurse . 8. After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41480 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, in that: The facility failed to ensure staff used good hygienic practices while preparing food. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 03/04/24 at 11:00 AM during observation of puree meal preparation: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 03/04/2024 at 11:00AM, [NAME] A was observed washing her hands then she picked up a pan of hamburger patties and tongs and placed the hamburger patties in the processor bowl using the tongs. She walked over and set the pan and tongs down. She covered a larger pan with hamburger patties in it with the foil wrap and placed oven mitts on both hands and opened the oven door and placed the larger pan in the oven. She removed oven mitts and walked over to the table where the puree machine was located and turned the puree machine on to puree the hamburger patties. She put her hand inside the center opening of the lid for the puree machine, while turning the lid to remove the lid. She touched plastic spoons and sampled the pureed hamburger patties. [NAME] A then picked up the lid and returned it to the bowl on the puree machine and placed her hand in the center opening of the lid. She turned the machine on and continued to puree the food. She turned the machine off and placed her hand in the center opening of the lid to remove lid and then touched plastic spoons and sampled the food. She walked away from the table where the puree machine was located and placed an oven mitt on her left hand then picked up a sauce pan from the stove top and poured broth in the puree bowl. She returned the sauce pan to the stove top and removed the oven mitt. She returned to the puree machine and placed her hand inside the center opening of the lid and replaced the lid on the bowl and turned the machine on. She placed her hand in the center opening of the lid and removed the lid. She touched plastic spoons and sampled the pureed food. She picked up a small pan and a spray bottle of vegetable nonstick spray and sprayed the pan. She picked up a spatula, then removed the puree bowl from the puree machine and poured the puree hamburger patties in the pan and covered the pan with foil. She then placed the puree bowl, lid, and blade in the dishwasher. She took the bowl, lid, and blade out of the dishwasher and returned it to the puree machine. She walked over to the table, put an oven mitt on her left hand, and picked up a pan of broccoli, carried it to the puree machine and scooped broccoli in the puree bowl. She carried the pan back to the table and placed it on the table and removed the oven mitt. She returned to the puree machine and placed the lid on the bowl and placed her fingers inside the opening of the lid. She turned the puree machine on and pureed the broccoli. She placed her hand on the lid and her fingers inside the opening of the lid and turned the lid to remove it. She picked up plastic spoons and sampled the pureed broccoli. She picked up a pan and sprayed the pan with the vegetable non-stick spray. She removed the bowl and blade from the puree machine and picked up a spatula and used the spatula to transfer the pureed broccoli from the puree bowl to the pan. She carried the pan of pureed broccoli to the table and covered it with foil wrap. She picked up the puree bowl and blade and placed it in the dishwasher. There was no observation of her washing hands during the pureed food process except when she first started. During an observation on 03/05/2024 at 12:05 PM, DS A use a food scoop to place bread pudding in bowls for the lunch meal. She was not wearing gloves and placed her left thumb on the outer edge of the pan, moving her left thumb along the outer bottom edge of the pan. Observed a piece of the bread pudding fall on the edge of the pan where her left thumb had been placed. She used the scoop to push the piece of bread pudding back into the pan and scooped it into a serving bowl. Observed DS A scoop bread pudding into scoop with her right hand then she turned around to serving window and picked up napkin and silverware with her left hand from another employee and walked to the other side of the kitchen with the scoop in her right hand with bread pudding in the scoop. She returned to the prep table where the pan of bread pudding was at with the scoop in her right hand and placed the bread pudding in a bowl. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/06/2024 at 2:28 PM, [NAME] A was asked about the observations made of the puree process for the lunch meal on 3/5/24 and when hand hygiene should be completed during the puree process. She stated, about every 20 minutes or so. She stated she did recall she touched several items yesterday and did not washing her hands in between tasks. She stated she was moving too fast during the process and did not wash her hands. She stated the potential negative outcome of not washing hands could be spread of bacteria or food poisoning. She stated she was trained on hand hygiene by the facility. During an interview on 03/06/2024 at 2:35 PM with the DM, she stated staff should have washed their hands between tasks. She stated staff have been trained as to when they need to wash hands. She stated DS A should have washed hands and not walked around the kitchen with the bread pudding in the scoop. She stated DS A should have left the scoop in the pan with the bread pudding, completed the other task then then washed her hands before returning to the task with the bread pudding. She stated the potential negative outcome of not washing your hands between tasks could be cross contamination, bacteria, food poisoning and illness to the residents. She stated staff are good at washing hands, not sure why they didn't. She stated all staff have been trained on hand washing. During an interview on 03/07/24 at 10:22 AM with the ADM, she stated dietary staff should wash hands between each task. She stated the DM was responsible for monitoring staff for compliance. She stated staff had been trained on hand washing. She stated the potential negative outcome could be spread of infection to the residents. She stated her expectation were for staff to wash hands between each task. Record review of facility policy titled Hand Washing dated 2012, revealed the following: We will ensure proper hand washing procedures are utilized. Employees are to frequently perform hand washing as outlined below. Procedure: 1. Hand washing occurs in sinks provided for that purpose; sink areas provide hot/cold running water, soap in dispensers, and paper towels, and should have a sign posted conspicuously near or above wash basin .

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Southern Specialty Rehab & Nursing	4320 W 19th St Lubbock, TX 79407

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observations, interview and record review, the facility failed to keep confidential all information contained in residents' records for 7 of 7 residents (Resident #12, #20, #30, 43, #50, 58, and #322). The facility failed to protect Residents #12, #20, #30, 43, #50, 58, and #322's identifiable information, leaving resident information exposed and unattended. This failure could place residents at risk of having medical information exposed to others. Findings Included: Resident #12: Record review of Resident #12's face sheet indicated Resident #12 was a [AGE] year-old male who admitted on [DATE] with the following diagnoses: urinary tract infection, hyperlipidemia (elevated concentrations of lipids or fats within the blood), atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow), chronic respiratory failure, fast heart rate, muscle wasting, sepsis (a life-threatening complication of an infection), bacterial infection, iron deficiency, dementia, anxiety, depression, impaired coordination, neurocognitive disorder with Lewy bodies (a type of dementia associated with abnormal deposits of a protein), seizures, polyneuropathy (many nerves in different parts of the body are involved), metabolic encephalopathy (an acute condition of global cerebral dysfunction in the absence of primary structural brain disease), high blood pressure, congestive heart failure, acid reflux, acute cholecystitis (inflammation of the gallbladder), muscle weakness, dry skin, overactive bladder, difficulty swallowing, shortness of breath, osteoporosis (a condition in which bones become weak and brittle). Record review of Resident #12's annual MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Resident #20: Record review of Resident #20's face sheet indicated Resident #20 was a [AGE] year-old female who was admitted on [DATE] with the following diagnoses: pure hypercholesterolemia (a common inherited disorder associated with elevated low-density cholesterol levels and premature coronary heart disease, urinary incontinence, unsteadiness on feet, hyperlipidemia (elevated concentrations of lipids or fats within the blood), muscle weakness, irritable bowel syndrome, difficulty in walking, lack of coordination, retention of urine, depression, hypothyroidism (deficiency of thyroid hormones), type 2 diabetes, high blood pressure, cellulitis (a common and potentially serious bacterial skin infection), chronic kidney disease, urinary tract infection. Record review of Resident #20's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 indicating cognition is intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #30: Record review of Resident #30's face sheet indicated Resident #30 was a [AGE] year-old female who admitted on [DATE] with the following diagnoses: dementia, urinary tract infection, paranoid schizophrenia, hypothyroidism (deficiency of thyroid hormones), parkinsonism (a disorder of the central nervous system that affects movement, often including tremors). Record review of Resident #30's annual MDS assessment dated [DATE] revealed a BIMS score of 06 indicating severe cognition impairment. Resident #43: Record review of Resident #43's face sheet indicated Resident #43 was a [AGE] year-old male who admitted on [DATE] with the following diagnoses: stroke, muscle spasm, metabolic encephalopathy (an acute condition of global cerebral dysfunction in the absence of primary brain disease), high blood pressure, hypertensive encephalopathy (an uncommon hypertensive emergency manifestations), difficulty swallowing, acute kidney failure. Record review of Resident #43's annual MDS assessment dated [DATE] revealed a BIMS score of 01 indicating a severe cognitive impairment. Resident #50: Record Review of Resident #50's face sheet reveals a [AGE] year-old female, admitted on [DATE] with a diagnosis of: type 2 diabetes, anxiety, quadriplegia (is a condition in which all four limbs have paralysis), high blood pressure, pneumonia, acute respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues of your body), muscle weakness, dysphagia (difficulty swallowing), tracheostomy (is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), colostomy (is an opening in the large intestine, or the surgical procedure that creates one), Record review of resident #50's MDS with a date of 12/07/2023, reveals a BIMS score of 12 which indicates Resident #50 is moderately cognitively impaired. Resident #58: Record Review of Resident #58's face sheet reveals a [AGE] year-old male, originally admitted on [DATE] and readmitted on [DATE] with a diagnosis of: respiratory failure, local infections of the skin, low potassium, epileptic seizures related to external causes, high blood pressure, acute kidney failure, dysphagia (difficult swallowing), tracheostomy ((is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), colostomy (is an opening in the large intestine, or the surgical procedure that creates one), pneumonia. Record review of resident #58's MDS with a date of 11/12/2024, reveals a BIMS score left blank and incomplete. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #322: Record review of Resident #322's face sheet indicated Resident #322 was a [AGE] year-old male who admitted on [DATE] with the following diagnoses: urinary tract infection, chronic viral hepatitis C, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), cardiomyopathy (an acquired or inherited disease of the heart muscle), acid reflux, unsteadiness on feet, weakness, muscle wasting, thrombocytopenia (a low number of platelets in the blood), type 2 diabetes, anxiety, schizophrenia, metabolic encephalopathy (an acute condition of global vertebral dysfunction in the absence of primary structural brain disease), high blood pressure, heart failure, personal history of traumatic brain injury. Record review of Resident #322's quarterly MDS assessment dated [DATE] revealed a BIMS score of 07 indicating severe cognitive impairment. Observations: During an observation of initial tour of MA B on 03/05/2024 At 9:45 AM. During initial tour of survey process, MA B was observed administering medications to Resident #43. While she was in the room with Resident #43, she left her screen up with his information on the screen and unattended. MA B was in Resident #43's room for approximately five minutes while his information was up on her computer screen in the hall and unattended. During an observation of medication pass with LVN A on 03/06/2024 at 10:13 AM. During the medication pass, LVN A proceeded into Resident #58's room to administer his medications and left her computer screen open, in the hall, and left unattended, with Resident #58's information on the screen. It was observed that LVN A was in Resident #58's room for approximately 16 minutes. During an observation of medication pass with LVN A on 03/06/2024 at 1:38 PM. LVN A was in the hall at her cart and was observed walking away to go look for supplies and her screen was left up with her cart parked in the hall with Resident #50's medical information pulled up while unattended. It was observed that LVN A was away from the cart with her computer pulled up for approximately 4 minutes, During an observation with MA on 03/07/2024 at 9:20 AM. During tour of facility, it was observed that MA's cart was left in front of the breakroom across the hall with 5 empty medication cards turned face down, but with residents' information labels on the cards. It was observed that the empty medication cards with resident information on them was left unattended while MA was on break. It was observed that the empty medication cards left on the cart were left unattended for approximately 9 minutes. It was observed that the empty medication cards belonged to Resident #30, #20 (12), #322, and #12. During an Interview with MA B on 03/05/2024 at 9:55 AM. She stated that she does realize that leaving her computer screen up to expose a resident's information is a HIPAA violation. The MA B stated that she has had training for HIPAA, and it had been through in-services monthly. She stated that they also have HIPAA training online once a year. She stated that the negative potential outcome for exposing a resident's information is that someone will see their private information. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview with LVN A on 03/06/2024 at 2:01 PM. The LVN A stated that she did not mean to leave her screen up with resident information up twice and that she is aware that it is a HIPAA violation. She stated that she had been trained through in-services randomly, approximately monthly. The LVN stated that the negative potential outcome for exposing resident information is that other people could see their information and possibly use it and violating a resident's HIPAA rights. During an Interview with MA on 03/07/2024 at 9:30 AM. The MA stated that she was only in the breakroom for a little bit and did not know that by leaving the empty medication cards on the cart unattended would be exposing the resident, but it does make sense after she thought about it. The MA stated that is a routine that she usually does. The MA stated that she had been trained in protecting a resident's personal information through in-services, approximately monthly or as needed. The MA stated that the negative potential outcome for exposing a resident's information is that someone could take advantage of their personal information. During an Interview with the Administrator on 03/07/2024 at 11:20 AM. She stated that staff had been given a screen to protect residents to not violate HIPAA. The Administrator stated that the staff have been trained through in-services monthly for HIPAA and online once a year and upon hire. The Administrator stated that the negative potential outcome for a resident's information being exposed is personal information could be obtained by someone else. During an Interview with the DON on 03/07/2024 at 11:50 AM. She stated that she provides training through educating staff and monitoring throughout the day. The DON stated that other forms of training were online and that is given yearly and upon hiring. She stated that the negative potential outcome for exposing resident information is that the resident's private information is being exposed and could fall into unsafe hands. The DON stated that she and the ADON are responsible for training staff, and it is given as needed through verbal and handouts. Record review of a facility provided policy, labeled, Resident Rights policy, date not provided; revealed. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Privacy and confidentiality: The resident have a right to personal privacy and confidentiality of his or her personal and medical records. 3. The resident has a right to secure and confidential personal and medical records. a). The resident has the right to refuse the release of personal and medical records except as provided at 483.70 (i) (2) or other applicable federal or state laws. Record Review of website, labeled, HIPAA and Medical Privacy Laws, (OAG PowerPoint Template (texasattorneygeneral.gov), date not provided, revealed: What Information Does the HIPAA Privacy Rule Protect? Protected Health Information (PHI), (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All individually identifiable health information held or transmitted by a covered entity or its business associate in any form or media, whether electronic, paper, or oral, Information relating to a person's past, present or future physical or mental condition, the provision of health care, Examples of PHI: Medical records Lab report HIPAA General Rule: PHI may not be used or disclosed except as the HIPAA Privacy Rule permits or requires. 18 Identifiers: Names, all elements of date (except year), telephone numbers, social security numbers, medical record numbers, biometric identifiers, full face photos, any other unique identifying number, characteristic or code. HIPAA Minimum NECESSARY RULE: Even when a use or disclosure of PHI is permitted by HIPAA, only disclose the minimum necessary to accomplish the intended purpose of the use or disclosure.

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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** 43150 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 to help prevent the development and transmission of communicable diseases and infections for 4 of 4 residents reviewed for infection control practices (Resident #9, #50, #58 and #63) 1. MA A did not wash hands prior to preparing or administering the medication for Resident #9. MA A failed to wash hands properly by washing her hands under the water instead of allowing the soap to lather or use friction while washing hands. MA A used a dirty paper towel to turn off the faucet. 2. LVN A did not wash her hands prior to preparing the medications for g-tube medication administration for Resident #50. LVN A did not wash off syringe for g-tube after administering medications for Resident #50. 3. LVN A did not wash hands but put on clean pair of gloves. LVN A used the clog remover and inserted it in g-tube tubing to clog the line for Resident 58. 4. LVN A did not wash her hands or use gloves prior to preparing the medications for g-tube medication administration for Resident #58. LVN A did not use separate clean paper towels to dry her hands. LVN A used the dirty paper towels to turn off the water faucet. LVN A did not wash the syringe that was used to administer #58's medication through g-tube. 5. LVN B used a dirty paper towel to wash hands after administering g-tube medications for Resident #63. These failures could place residents at risk for infection through cross contamination of pathogens and spread of infections. The findings included: Resident #9: Record Review of Resident #9's face sheet reveals a [AGE] year-old male, originally admitted on [DATE] and readmitted on [DATE] with a diagnosis of: urinary tract infection, bacterial infection, iron deficiency, muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), sepsis (a life threatening complication of an infection), local infection of the skin, dermatitis (inflammation of the skin), pressure ulcer of the sacral region, osteomyelitis (inflammation of bone caused by infection generally in the legs, arms, or spine), chronic viral hepatitis C, elevated white blood count, quadriplegia (paralysis affecting a person's limbs and body from the neck down), ulcer, gastrointestinal hemorrhage (gastrointestinal bleeding), muscle weakness. Record review of resident #9's MDS with a date of 12/22/2023, reveals a BIMS score of 11 which indicates Resident #9 is moderately cognitively impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of MA A during medication pass for Resident #9 on 03/06/2024 at 8:57 am. MA A did not wash hands prior to preparing or administering the medication for Resident #9. MA A proceeded with administering medications to Resident 9. MA A did wash hands after administering eight medications to Resident #9 but only washed her hands for 4 seconds and did not correctly wash hands. MA A put liquid soap on left hand and started to rub her hands together but immediately placed both hands under the water while she was rubbing them together, washing the soap off immediately. MA A did not use a clean separate paper towel to dry each hand, she used two paper towels to dry both hands, the same paper towel for both hands. MA A used the dirty paper towel that she used to dry hands to also turn off the faucet. Interview with MA A on 03/07/2024 at 11:12 AM. MA A stated that she does know that she should have washed her hands longer, but she was in a hurry. She stated that she had been trained in hand washing through in-services approximately every other Tuesday. She stated that the facility does provide competency checks but she had only had one because she had only been working for the facility for 2 months. She stated she is unaware what the policy stated about hand washing but she does know she should have washed hands outside of the water and allow the soap to lather. Resident #50 Record Review of Resident #50's face sheet reveals a [AGE] year-old female, admitted on [DATE] with a diagnosis of: type 2 diabetes, anxiety, quadriplegia (is a condition in which all four limbs have paralysis), high blood pressure, pneumonia, acute respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues of your body), muscle weakness, dysphagia (difficulty swallowing), tracheostomy (is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), colostomy (is an opening in the large intestine, or the surgical procedure that creates one), Record review of resident #50's MDS with a date of 12/07/2023, reveals a BIMS score of 12 which indicates Resident #50 is moderately cognitively impaired. Observation of LVN A during medication pass for Resident #50 on 03/06/2024 at 1:39 PM. LVN A did not wash hands or use gloves prior to preparing medications for Resident #50. LVN A proceeded in crushing medications (Tylenol 3 300/30 mg one tab, buspirone 5 mg one tab, gabapentin 100 mg one tab, baclofen 10 mg one tab, and pro-stat 30 ml). LVN A crushed each individual medication and placed into separate plastic cups 1/3 full of water and stirred the medication vigorously to mix. LVN A put on clean gloves without washing hands or using hand sanitizer. LVN A took each cup with the mixture of medication and water and placed on the bedside table of Resident #50. LVN A checked for placement of g-tube by using a stethoscope and syringe. LVN A confirmed placement. LVN A placed syringe with 30 ml of water flush. Observed the fluid not going down due to a clog in the tube. LVN A began mashing on the tube to clear the line of the clog. LVN A proceeded in placing each medication one after the other in the syringe with no water flush in between. LVN A put 10 ml. of water flush at the end and removed the syringe. LVN A did not wash syringe when done with administering medications. LVN A went to Resident #50's restroom to wash hands. LVN A turned on warm water, put soap in hands, and began washing hands for 12 seconds. LVN A rinsed hands, grabbed one clean paper towel and dried both hands and then used the same dirty paper towel to turn off the water faucet. Resident #58 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #58's face sheet reveals a [AGE] year-old male, originally admitted on [DATE] and readmitted on [DATE] with a diagnosis of: respiratory failure, local infections of the skin, low potassium, epileptic seizures related to external causes, high blood pressure, acute kidney failure, dysphagia (difficult swallowing), tracheostomy ((is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), colostomy (is an opening in the large intestine, or the surgical procedure that creates one), pneumonia. Record review of resident #58's MDS with a date of 11/12/2023, reveals a BIMS score left blank and incomplete. Observation of LVN A during medication pass for Resident #58 on 03/06/2024 at 10:13 am. During observation of medication pass with LVN A for Resident #58, LVN A did not wash her hands or use gloves prior to preparing the medications for g-tube medication administration. LVN A crushed each medication (Senna 2 tabs 8.6 mg, vitamin B1 1 tab 100 mg, and Pepcid 1 tab 20 mg) separately. LVN A had three cups filled with a half cup of water and she placed the three different medications in them and stirred vigorously. LVN A grabbed the four different cups containing three different medications. LVN A placed on clean gloves without washing hands. LVN A checked for gastric return with a small amount of return. LVN A placed a syringe in the g-tube to administer medications. LVN A had placed the senna/water solution in the syringe, then 5 ml. water flush, vitamin B1/water solution was added to the syringe, then Pepcid/water solution, 30 ml. water flush. All medications were added by slow gravity. Observed water not going down and just sitting in the syringe. LVN A stated that the line was clogged. LVN A grabbed a plastic cup and took the contents in the syringe and poured it into the cup. LVN A mashed down on the line to try and clear the line. LVN A re-inserted the empty syringe and poured the contents from the plastic cup back into the syringe. The fluid content would not go down. LVN A poured the contents back into the plastic cup and took out the syringe. LVN A removed dirty gloves and discarded. LVN A left Resident #58's room to go to the supply closet to get enteral feed clog remover. LVN A came back into Resident #58's room. LVN A did not wash hands but put on clean pair of gloves. LVN A used the clog remover and inserted it in g-tube tubing to clog the line. LVN A removed the clog remover. LVN A put the syringe back into the g-tube and poured the contents from the plastic cup back into the syringe. The contents would not go down. The clog was still there. LVN A poured the contents back into the plastic cup and removed the syringe. LVN A used the clog remover to attempt unclogging the line. LVN A removed the clog remover from the g-tube line. LVN A placed the syringe in the g-tube line and poured the liquid contents back into the syringe and contents went into the resident. LVN A removed the syringe and placed on a paper towel on Resident #58's table. LVN A did not wash the syringe. LVN A removed dirty gloves and discarded. LVN A went to Resident #58's restroom to wash hands. LVN A turned on warm water and put soap in her hands. LVN A allowed soap to lather and used friction while washing her hands for 10 seconds. LVN A rinsed her hands under the water and shook off excess water. LVN A used two clean paper towels to dry both hands. LVN A did not use separate clean paper towels to dry her hands. LVN A used the dirty paper towels to turn off the water faucet. Interview with LVN A on 03/06/2024 at 2:01 pm: LVN A stated that she does not know what policy stated about washing hands. LVN A stated that she had been trained in infection control practices. LVN A stated that she did know that she forgot to wash the syringe used for g-tube medication administration. LVN A stated that the facility had provided in-services for washing hands. LVN A stated that a guy with the state had come in and taught a class also. LVN A stated that the negative potential outcome of not washing hands correctly and not washing off syringe would be cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #63: Record Review of Resident #63's face sheet reveals a [AGE] year-old female, originally admitted on [DATE] and readmitted on [DATE] with a diagnosis of: acute respiratory failure, gastrostomy status (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), tracheostomy (is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck), difficulty swallowing, metabolic encephalopathy (acute condition of global cerebral dysfunction in the absence of primary structural brain disease), anxiety, congestive heart failure, acid reflux, hyperlipidemia (a condition in which there are high levels of fat particles in the blood, high blood pressure, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear down), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), depression, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), respiratory failure. Record Review of Resident #63's MDS with a date listed as 02/16/2024 revealed Resident #63 had a BIMS of 03 meaning severe cognitive impairment: Observation of LVN B during medication pass for Resident #63 on 03/06/2024 at 10:47 am. During observation of LVN B administering medications, LVN B used hand sanitizer prior to putting on clean gloves to prepare medications for g-tube administration. LVN B verified resident next to medication (ondansetron 4 mg one tab) to make sure of correct resident. LVN B crushed Ondansetron 4 mg medication and poured powder into 1/3 cup full of water and then stirred the mixture. LVN B removed dirty gloves, used hand sanitizer, and placed on clean gloves. LVN B checked for g-tube placement by using the stethoscope and air by syringe. LVN B verified placement. LVN B discarded dirty gloves, used hand sanitizer, and placed on new clean gloves. LVN B placed open ended syringe on port on g-tube and placed 10 ml of flush, once emptied, LVN B poured Ondansetron /water mixture into the syringe and administered by gravity. LVN B waited for the syringe to empty and immediately poured a 10ml flush to ensure medication was completely out of syringe. LVN B removed dirty gloves and discarded. LVN B went to staff restroom to wash hands, turned on warm water, put soap in hands, lathered the soap, and scrubbed hands for 18 seconds. LVN B rinsed hands, took a clean paper towel, and dried the right hand and discarded paper towel. LVN B took another clean paper towel and dried the left hand and then used the same paper towel and dried in between fingers on right hand, then used the same dirty paper towel to turn off the water faucet. Interview with LVN B on 03/06/2024 at 11:18 AM. LVN B stated that he should not have used a dirty paper towel to turn off the faucet and should have used a clean one, but he didn't think about it. He stated that he had been trained in infection control practices for hand washing by in-services, monthly. He stated that the DON and ADON are responsible for providing the training. He stated that the negative potential outcome for not using proper infection control practices would be the transmission of bacteria from one contact to another. Interview with Administrator on 03/07/2024 at 11:20 AM. Administrator stated that her expectations for hand washing while administering medication would be for staff to effectively use hand washing practices. She stated that the facility provides in-services monthly for training and skills competency checks are completed upon hire and yearly. Administrator stated, We have done tons of in-services for hand washing. Administrator stated that the DON is responsible for the training and making sure that it is completed. She stated that the negative potential outcome for not washing your hands effectively or at all is the spread of germs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676028	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Specialty Rehab & Nursing	4320 W 19th St Lubbock, TX 79407

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with DON on 03/07/2024 at 11:50 AM. DON stated that her expectations for handwashing is that all staff is in compliance with the handwashing policy. She stated that training is by holding in-services for handwashing quarterly and as needed. DON stated that verbal education is provided as well as yearly competency skills checks and upon hire. DON stated that the negative potential outcome for poor infection control practices is the spread of infection and bacteria. Record review of facility policy titled, Hand Hygiene, No date provided revealed: c Before and after performing any invasive procedure (e.g., fingerstick blood sampling) c Before and after assisting a resident with personal care c Upon and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident). c After contact with a resident's mucous membranes and body fluids or excretions c After removing gloves or aprons.