STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455942	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Health Care Center	4120 22nd Pl Lubbock, TX 79410

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033 Based on observations, interviews, and record reviews, the facility failed to ensure a resident was free from any physical or chemical restraints imposed for purposes of discipline or convenience for 1 (Resident #1) of 3 residents reviewed for physical restraint. The facility failed to ensure the Licensed Vocational Nurse (LVN D) notified the physician (P J), Director of Nurses (DON), and Member F prior to tying Resident #1's hand to his bed on 02/18/25, and as of 03/04/25 the physician confirmed he had not written an order for this restraint. This LVN said he tied Resident #1's hand to prevent him from pulling out his dialysis port, while he administered the residents' medications. The port is defined as a (medical device used to provide access to a patient's bloodstream for hemodialysis treatment, which is a procedure that removes waste products and excess fluid from the blood when the kidneys are unable to do so). This failure could prevent residents from having an environment that was free from any physical or chemical restraints. Findings included: Record review of Resident #1's Face Sheet, dated 03/04/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included metabolic encephalopathy (brain function is impaired.), sepsis (a life-threatening complication of an infection.), acute posthemorrhagic anemia (occurs when someone rapidly loses a large amount of blood, resulting in a low red blood cell count of hemoglobin levels.), myocardial infarction (occurs when blood flow to the heart muscle is blocked, causing damage of death of heart tissue.), atrial fibrillation (an irregular, often rapid heart rate that commonly cause poor blood flow.), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should.), and acute kidney failure with tubular necrosis (a type of kidney injury characterized by damage to the kidney tubules, which are responsible for filtering waste products from the blood). Record review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated, he had a Brief Interview for Mental Status (BIMS) score of 12 (moderately impaired). This MDS indicated his Self-Care assessment required substantial/maximal assistance for toileting, lower body dressing, putting on/taking off footwear, and was dependent for a shower/bath. This MDS indicated Resident #1 required substantial/maximal assistance to rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff to transfer from chair/bed-to-chair. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Order Summary Report with Order Date Range between 02/01/25 to 02/28/25 did not include applying a restraint on Resident #1. Record review of Resident #1's Order Summary Report with Active Orders as of 02/28/25 did not include an order for applying a restraint. Record review of Resident #1's chart form 02/16/25 to 03/05/25 did not include documentation by LVN D indicating he had tied Resident #1's hand to the bed, nor that an order for a restraint had been pursued from the physician. Record review of Resident #1's Care Plan Report, dated 01/14/25, addressed the need for dialysis that was initiated on 12/11/24. This plan was edited on 03/04/25 to reflect Resident #1's behavior of pulling his dialysis port after he returned from the hospital on 02/16/25. The steps included allowing resident to make decisions about his treatment, education, wrapping with ace bandage, double shirts, and adhesive dressings, and if resident resist with ADLs, leave and return 5 minutes later and try again. Record review of Resident #1's Nursing Note dated 02/16/25 indicated he was readmitted to the facility from the hospital via post fall. Resident #1's decision making was poor, required reminders, cues, and supervision in planning, organizing, and correcting daily routines. Resident #1 was not oriented to person, place, time, nor situation, and his Activities of Daily Living (ADL) assistance needs were bed mobility and transfers with 2 persons assist, and eating, toileting, dressing/hygiene, and bathing with 1 person assist. Record review of Resident #1's SBAR 3.0 - V4 report dated 02/17/25 at 1:45 pm with admitted [DATE], indicated he was having a behavior change that started on 02/17/25 due to being a danger to self or others. The treatment initiated at 8:16 am he was administering Tramadol, because he might be agitated due to pain, and a bandage was placed over the dialysis port. This condition, symptom, or sign had not occurred before. Resident took bandage off and continued to pull his port. The MD or NP were notified on 02/17/25 at 1:41 pm. The new order was for hydroxyzine 50 mg (milligrams) PRN (as needed) every 6 hours. This report included date and time of notification as 02/17/25 at 6 pm, and LVN A signed this report on 02/18/25. Record review of CNA H's written Witness Statement dated 02/18/25 revealed I was doing round when I noticed pt (Resident #1) hand restraint to the bed. Notified the charge nurse (LVN D) and charge nurse confirmed that it was in protection of pt. and everything was taken care of. Record review of LVN D's personnel file revealed he signed Restraint Reduction dated 03/09/21 indicating All residents must have an order from the physician before a restraint can be applied. Seat belts, lap trays, and any device that keeps a resident from accessing willful movements are considered a restrain. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 10:39 AM, Physician J (P J) indicated Resident 1's restraint on 02/18/25 was unfortunate. If LVN A had called him or his nurse practitioner and informed them that Resident #1 was making attempts to remove his dialysis port, he would have discussed the situation and tried other avenues instead of a restraint. P J said if Resident #1 had removed his port, which was deep into his veins, he could have suffered uncontrolled bleeding that would have required putting pressure on the wound and calling 911. In addition, pulling on this port could have resulted on a piece breaking off inside his body leading to a serious outcome. During an interview on 03/04/25 at 11:25 AM, Resident #1, who was sitting in his wheelchair and had a port attached to the upper right chest area, did not respond to questions asked of him. Observation on 03/04/25 at 11:30 am indicated Resident #1's bed had a metal frame that was under and around his mattress. During an interview on 03/04/25 at 12:57 AM, the Director of Nurses (DON) indicated on 02/18/25 at 7 AM he discovered Resident #1's hand was tied to a blanket and to the bed frame. The DON questioned Licensed Vocational Nurse (LVN A), and Certified Nurse Aide (CNA B and C), who said they were unaware of Resident #1's restraint. The DON assessed Resident #1, who had no injuries or bruises noted, and asked him if he was hurting; however, he responded by mumbling but did not answer questions asked of him. Afterwards, The DON said he interviewed LVN D, who cared for Resident #1 from 6 PM on 02/17/25 to 6 AM on 02/18/25, and he confirmed he had tied Resident #1's hand to protect him from pulling out his dialysis port. The DON said LVN B confirmed he failed to notify Resident #1's physician, responsible party, and the DON, before applying this restraint. The DON said if LVN D had called the physician it's possible the physician might have ordered a soft restraint to keep him from trying to pull out the port. The DON said LVN D was protecting Resident #1 from bleeding to death; however, he did not follow the facility's policy and procedure for notifications and restraints. During an interview on 03/04/25 at 1:17 PM, Registered Nurse (RN E) said after Resident #1 returned to the facility on [DATE], he displayed the behavior of trying to pull out his port. This behavior was addressed through frequent monitoring redirection, redirection, and covering the port with a dressing several times, because he was able to remove the dressing. RN E indicated if Resident #1 had pulled out his port, this could have cause him to bleed to death. RN E said LVN D was trying to protect Resident #1; however, he failed to follow the policy and procedure for notification and restraints. During an interview on 03/04/25 at 2:48 PM, Member F (M F) indicated Resident #1 was discharged from the hospital with altered mental status, and to her knowledge, he was not trying to take out his dialysis port at the hospital. M F said she understood how dangerous it could have been if Resident #1 had pulled out his port. During an interview on 03/04/25 at 3:04 PM, the Minimum Data Set Coordinator (MDS G) indicated she had not incorporated a restraint into Resident #1's Care Plan, nor has she incorporated a restraint into any of the residents' Care Plans, because this is against the facility's policy and procedures. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 3:48 PM, LVN A said she started her shift on 02/18/25 at 6:18 AM and was unaware Resident #1's hand was tied to the bed frame. LVN A said she received shift report from LVN D that included Resident #1 was pulling at his port since returning from the hospital on 02/16/24; however, he did not inform her Resident #1s hand was restraint. After the morning meal, LVN A said she requested an order to send Resident #1 to the hospital because he was very confused. LVN A said she knew it was not inappropriate to restrain a resident, instead the physician, DON, and RP should be notified when there is a change of condition. During an interview on 03/04/25 at 4:26 PM, LVN D said he received report on 02/17/25 at approximately 6 PM from the outgoing LVN A, who said Resident #1 was confused and trying to take out his port. LVN D said Resident #1 slept on 02/16/25 from approximately 6 PM until 10 PM. That's when Resident #1 displayed the behavior of taking off his clothes. LVN D said he monitored Resident #1 every 15 minutes and applied a dressing over his port and two t-shirts; however, he would remove his shirts and dressing so he could pull his port. LVN D said at approximately 4 AM on 02/18/25 Resident #1 pulled off his gown and shirt, and he tried to put them back on but he resisted. Afterwards, LVN D said he wrapped a small blanket around Resident #1's hand and tied the other end of this blanket to the bed frame, so he could continue administering residents' medications. LVN D said Resident #1 did not struggle or tried to remove this restraint. LVN D said he monitored Resident #1 by parking his medication cart approximately 6 feet away from Resident #1's doorway to his room and going into Resident #1's room as he administered medications. LVN D said he knew he was not supposed to restraint a resident, but for his safety, he thought this would better than letting Resident #1 pull out the port and bleed to death. LVN D said he did not call the physician, RP, or DON, because the restraint would just be for a brief time until he could finish the residents' medication pass. LVN D said he was not trying to hurt Resident #1; he was trying to keep him from dying. LVN D said he was suspended and terminated due to using a restraint on Resident #1. During an interview on 03/04/25 at 6:58 PM, CNA H said she received report on 02/17/25 at approximately 7:15 PM from LVN D, who said Resident #1, who returned from the hospital, had been tugging at his port on the previous shift (6 AM to 6 PM). CNA H said she entered Resident #1's room on 02/17/25 at approximately 7:30 AM and put a t-shirt on him to keep him from pulling at his port. CNA H said on 02/17/25 at 10 PM she checked on Resident #1, who was asleep, did not have his hand tied to the bed. CNA H said on 02/18/25 at approximately 1 AM she checked on Resident #1, who was asleep, and had his right hand tied to the bed frame with a mini colorful blanket. CNA H said Resident #1 could move his arm; however, he could not reach his port. CNA H said she saw smeared blood on the skin surrounding the skin around Resident #1's port. CNA H said she immediately reported this to LVN D, because she feared being blamed for the restraint, which she knew was against the facility's policy. CNA H said she informed LVN D Resident #1's hand was tied to the bed, and this facility was a no restraint facility. CNA H said LVN D informed her he had tied his hand to keep him safe from pulling his port because he could die. CNA D said she reported Resident #1's restraint to CNA I, who agreed a restraint is not allowed in this facility unless a doctor order it, and maybe that's why LVN D said he took care of it. CNA H said she checked on Resident #1 on 02/28/25 at 2 AM, 4 AM and 5 AM, before she left at 6 AM. CNA H said she was not asked to check on Resident #1 sooner than every two hours; however, she witnessed LVN D administered residents' medications from the cart near Resident #1's room. CNA H said she witnessed LVN D enter Resident #1's room several times during the night, and he remained at this cart throughout most of the night. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 7:34 PM, CNA I said on 02/18/25 at approximately 1 AM CNA H informed her that she saw Resident #1's hand was tied to the bed frame, and she informed LVN D. LVN D told her he had to restrain him for his safety or else he could bleed to death if he pull out the port. CNA I said she informed CNA H that a resident can be restraint if a doctor orders it. Observation on 03/05/25 at 10:30 AM of the facility's video camera recording dated 02/18/25 indicated LVN D entered Resident #1's room at 12:16 AM, 12:19 AM, 12:24 AM, 1:12 AM, 2:19 AM, 2:39 AM, 3:18 AM, 3:24 AM, 4:11 AM, 4:35 AM, 4:50 AM, and 5:32 AM. During an interview on 03/05/25 at 11:25 AM, LVN A indicated she worked on 02/17/25 from 6 AM to 6 PM and filled out an SBAR because Resident #1 was displaying behavior trying to pull out his port. LVN A said she notified the NP, who gave orders for Hydroxyzine every 6 hours, which she administered to Resident #1 at 8:16 AM. LVN A said she placed a bandage over Resident #1's dialysis port; however, he pulled of the bandage and continued to pull at his port. LVN A said she had to bandage this port 5 times on her 6 AM to 6 PM shift. If he had pulled out the port this would have cause him to bleed to death. LVN A said she did not have to call the NP or his physician because after she administered Hydroxyzine at 1 PM, Resident #1 calmed down. LVN A said during shift report she informed LVN D that she had called the NP, who gave the order for Resident #1 to be administered Hydroxyzine, applying a bandage on the port, and a gown and t-shirt to prevent him from pulling the port: however, he was able to pull off the gown and t-shirt. During an interview on 03/05/25 at 11:45 AM, CNA K said she witnessed Resident #1 trying to pull his port after he returned to the facility from the hospital on 02/16/25. CNA K said she would grab his hand and ask him to stop, and he would comply for a short while then try again. Afterwards, CNA K reported this to LVN A, who entered Resident 1's room and was seen talking to him. During an interview on 03/05/25 at 12:06 PM, the Administrator confirmed LVN D did not follow the facility's policy and procedure for notification and restraint. Since this incident, the Administrator had all nurses and CNAs, who were provided the Administrator's phone number, were in-serviced to report directly to her if a resident is discovered in a restraint. The Administrator said LVN D was suspended after the incident but before returning to work After the investigation was completed, LVN D was terminated. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure for Restraints dated 02/1/07 reflected it is the policy of this facility to maintain an environment that prohibits the use of restraint for discipline or convenience. Restraint usage shall be limited to circumstances in which the resident has medical symptoms that warrant the use of restraints. A restraint Assessment Committee will evaluate and establish the need for restraint use or restraint reduction, for residents in our facility. The facility is committed to nurturing the autonomy and independence of our residents by attempting to provide a restraint-free environment. A physical restraint was defined as any manual method or physical/mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot move easily, which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to leg restraints, arm restraints, hand mitt, soft tie or vest, wheelchair safety bars, Geri-chairs, lap cushions and trays that the resident cannot remove. Restraints will only be applied after it has been determined that a medical symptom requiring restraint usage exist, and only after other alternatives have been tried unsuccessfully. A physician's order shall be necessary to begin a restraint assessment/evaluation for the resident. The Restraint Assessment Committee shall meet to assess the necessity of restraints for a resident by completing a Pre-Restraining Assessment. Restraints will only be used with informed consent from the resident and/or the resident's representative or responsible party and the resident's physician. Physical restraints for behavior control shall only be used in an emergency, which threatens to bring immediate injury to the resident or others. In such an emergency an order may be received by telephone and shall be signed by the physician withing 45 hours. Full documentation of the episode leading to the use of the physical restraint, the type of the physical restraint use, and the length of effectiveness of the restraint time, and the name of the individual applying such measures shall be entered into the resident's medical record. Every effort shall be made to calm the resident; however, personal safety must be considered. There shall be no PRN (as needed) orders for behavioral restraints.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033 Based on observations, interviews and record review, the facility failed to ensure a resident received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan for 1 of 3 residents (Resident #1) reviewed for quality of care. 1. The LVN D failed to notify Resident #1's physician and Member F of Resident #1's change of condition. 2. LVN D failed to obtain an order from the physician to restrain Resident #1's arm to prevent him from pulling out his dialysis port (a medical device used to provide access to a patient's bloodstream for hemodialysis treatment, which is a procedure that removes waste products and excess fluid from the blood when the kidneys are unable to do so). 3. LVN D failed to notify the DON or LVN A, who was the oncoming charge nurse, of the restraint left on Resident #1's arm prior to leaving his shift. These failures could result in decreased quality of care for residents. Findings include: Record review of Resident #1's Face Sheet, dated 03/04/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included metabolic encephalopathy (brain function is impaired.), sepsis (a life-threatening complication of an infection.), acute posthemorrhagic anemia (occurs when someone rapidly loses a large amount of blood, resulting in a low red blood cell count of hemoglobin levels.), myocardial infarction (occurs when blood flow to the heart muscle is blocked, causing damage of death of heart tissue.), atrial fibrillation (an irregular, often rapid heart rate that commonly cause poor blood flow.), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should.), and acute kidney failure with tubular necrosis (a type of kidney injury characterized by damage to the kidney tubules, which are responsible for filtering waste products from the blood. Record review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated, he had a Brief Interview for Mental Status (BIMS) score of 12 (moderately impaired). This MDS indicated his Self-Care assessment required substantial/maximal assistance for toileting, lower body dressing, putting on/taking off footwear, and was dependent for a shower/bath. This MDS indicated Resident #1 required substantial/maximal assistance to rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff to transfer from chair/bed-to-chair. Record review of Resident #1's Order Summary Report with Order Date Range from 02/01/25 to 02/28/25 did not include applying a restraint on Resident #1. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan Report, dated 01/14/25, addressed the need for dialysis that was initiated on 12/11/24. This plan was edited on 03/04/25 to reflect Resident #1's behavior of pulling his dialysis port after he returned from the hospital on 02/16/25. The steps included allowing resident to make decisions about his treatment, education, wrapping with ace bandage, double shirts, and adhesive dressings, and if resident resist with ADLs, leave and return 5 minutes later and try again. Record review of Resident #1's Nursing Note dated 02/16/25 indicated he was readmitted to the facility from the hospital via post fall. Resident #1's decisis non making was poor, required reminders, cues, and supervision in planning, organizing, and correcting daily routines. Resident #1 was not oriented to person, place, time, nor situation, and his Activities of Daily Living (ADL) assistance needs were bed mobility and transfers with 2 persons assist, and eating, toileting, dressing/hygiene, and bathing with 1 person assist. Review of Resident #1's SBAR 3.0 - V4 report dated 02/17/25 at 1:45 PM with admitted [DATE], indicated he was having a behavior change that started on 02/17/25 due to being a danger to self or others. The treatment initiated at 8:16 AM was to administer Tramadol, because he might be agitated due to pain, and to place a bandage over the dialysis port. This condition, symptom, or sign had not occurred before. Resident took bandage off and continued to pull his port. The MD or NP were notified on 02/17/25 at 1:41 pm. The new order was for hydroxyzine 50 mg (milligrams) PRN (as needed) every 6 hours. This report included date and time of notification as 02/17/25 at 6 pm, and LVN A signed this report on 02/18/25. Record review of CNA H's written Witness Statement dated 02/18/25 revealed I was doing round when I noticed pt (Resident #1) hand restraint to the bed. Notified the charge nurse (LVN D) and charge nurse confirmed that it was in protection of pt. and everything was taken care of. During an interview on 03/04/25 at 10:39 AM, Physician J (P J) indicated Resident 1's restrain on 02/18/25 was unfortunate. If LVN D had called him or his nurse practitioner and informed them that Resident #1 was making attempts to remove his dialysis port, he would have discussed the situation and tried other avenues instead of a restraint. P J said if Resident #1 had removed his port, which was deep into his veins, he could have suffered uncontrolled bleeding that would have required putting pressure on the wound and calling 911. In addition, pulling on this port could have resulted on a piece breaking off inside his body leading to a serious outcome. During an interview on 03/04/25 at 11:25 AM, Resident #1, who was sitting in his wheelchair and had a port attached to the upper right chest area, and he did not respond to questions asked of him. Observation on 03/04/25 at 11:30 am indicated Resident #1's bed had a metal frame that was under and around his mattress. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 12:57 AM, the Director of Nurses (DON) indicated on 02/18/25 at 7 AM he discovered Resident #1's hand was tied to a blanket and to the bed frame. The DON questioned Licensed Vocational Nurse (LVN A), and Certified Nurse Aide (CNA B and C), who said they were unaware of Resident #1's restraint. The DON assessed Resident #1, who had no injuries or bruises noted, and asked him if he was hurting; however, he responded by mumbling but did not answer questions asked of him. Afterwards, The DON said he interviewed LVN D, who cared for Resident #1 from 6 PM on 02/17/25 to 6 AM on 02/18/25, and he confirmed he had tied Resident #1's hand to protect him from pulling out his dialysis port. The DON said LVN D confirmed he failed to notify Resident #1's physician, responsible party, and the DON, before applying this restraint. The DON said if LVN D had called the physician it's possible the physician might have ordered a soft restraint to keep him from trying to pull out the port. The DON said LVN D was protecting Resident #1 from bleeding to death; however, he did not follow the facility's policy and procedure for notifications and restraints. During an interview on 03/04/25 at 1:17 PM, Registered Nurse (RN E) said after Resident #1 returned to the facility on [DATE], he displayed the behavior of trying to pull out his port. Resident #1's behavior was addressed through frequent monitoring, redirection, and having to cover his port with a dressing several times, because he was able to remove the dressing. RN E indicated if Resident #1 had pulled out his port, this could have cause him to bleed to death. RN E said LVN D was trying to protect Resident #1; however, he failed to follow the policy and procedure for notification and restraints. During an interview on 03/04/25 at 2:48 PM, Member F (M F) indicated Resident #1 was discharged from the hospital with altered mental status, and to her knowledge, he was not trying to take out his dialysis port at the hospital. M F said she understood how dangerous it could have been if Resident #1 had pulled out his port. During an interview on 03/04/25 at 3:48 PM, LVN A said she started her shift on 02/18/25 at 6:18 AM and was unaware Resident #1's hand was tied to the bed frame. LVN A said she received shift report from LVN D on 02/18/25 that included Resident #1 was pulling at his port since returning from the hospital on 02/16/24; however, he did not inform her Resident #1s hand was restraint. After the morning meal, LVN A said she requested an order to send Resident #1 to the hospital because he was very confused. LVN A said she knew it was inappropriate to restrain a resident, instead the physician, DON, and RP should be notified when there is a change of condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455942	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Health Care Center	4120 22nd Pl Lubbock, TX 79410

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 4:26 PM, LVN D said he received report on 02/17/25 at approximately 6 PM from the outgoing nurse, who said Resident #1 was confused and trying to take out his port out. LVN D said Resident #1 slept on 02/17/25 from approximately 6 PM until 10 PM. That's when Resident #1 displayed the behavior of taking off his clothes. LVN D said he monitored Resident #1 every 15 minutes and applied a dressing over his port and two t-shirts; however, he would remove his shirts and dressing so he could pull his port. LVN D said at approximately 4 AM on 02/18/25 Resident #1 pulled off his gown and shirt, and he tried to put them back on Resident #1 but he resisted. Afterwards, LVN D said he wrapped a small blanket around Resident #1's hand and tied the other end of this blanket to the bed frame. LVN D said he monitored Resident #1 by parking his medication cart approximately 6 feet away from Resident #1's doorway to his room and going into Resident #1's room as he administered medications. LVN D said he knew he was not supposed to restraint a resident, but for his safety, he thought this would better than letting Resident #1 pull out the port and bleed to death. LVN D said he did not call the physician, RP, or DON, because the restraint would just be for a brief time until he could finish the residents' medication pass. LVN D said he was not trying to hurt Resident #1; he was trying to keep him from dying. During an interview on 03/04/25 at 6:58 PM, CNA H said she received report on 02/17/25 at approximately 7:15 PM from LVN D, who said Resident #1, who returned from the hospital, had been tugging at his port on the previous shift (6 AM to 6 PM). CNA H said she entered Resident #1's room on 02/17/25 at approximately 7:30 AM and put a t-shirt on him to keep him from pulling at his port. CNA H said on 02/17/25 at 10 PM she checked on Resident #1, who was asleep, did not have his hand tied to the bed. CNA H said on 02/18/25 at approximately 1 AM she checked on Resident #1, who was asleep, and he had his right hand tied to the bed frame with a mini colorful blanket. CNA H said Resident #1 could move his arm; however, he could not reach his port. CNA H said she saw smeared blood on the skin surrounding the skin around Resident #1's port. CNA H said she immediately reported this to LVN D, because she feared being blamed for the restraint, which she knew was against the facility's policy. CNA H said she told LVN D Resident #1's hand was tied to the bed, and this facility was a no restraint facility. CNA H said LVN D replied he had tied his hand to keep him safe from pulling his port because he could die. During an interview on 03/05/25 at 11:25 AM, LVN A indicated she worked on 02/17/25 from 6 AM to 6 PM and filled out an SBAR because Resident #1 was trying to pull out his port. LVN A said she notified the NP, who gave orders for Hydroxyzine every 6 hours, which she administered to Resident #1 at 8:16 AM. LVN A said she placed a bandage over Resident #1's dialysis port; however, he pulled of the bandage and continued to pull at his port. LVN A said she had to bandage this port 5 times on her 6 AM to 6 PM shift. If he had pulled out the port this would have cause him to bleed to death. LVN A said she did not have to call the NP or his physician because after she administered Hydroxyzine at 1 PM, Resident #1 calmed down. LVN A said during shift report she informed LVN D that she had called the NP, who gave the order for the Hydroxyzine, a bandage on the port, and to put a gown and t-shirt on Resident #1; however, he was able to pull off the gown and t-shirt. During an interview on 03/05/25 at 11:45 AM, CNA K said she witnessed Resident #1 trying to pull his port after he returned to the facility from the hospital on 02/16/25. CNA K said she would grab his hand and ask him to stop, and he would comply for a short while then try again. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/25 at 12:06 PM, the Administrator confirmed LVN D did not follow the facility's policy and procedure for notification and restrain. Since this incident, the Administrator had all nurses and CNAs, who were provided the Administrator's phone number, were in-serviced to report directly to her if a resident is discovered in a restraint. Record review of facility's policy and procedure for Notifying the Physician of Change in Status dated 03/11/13 indicated The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention. This facility utilizes the INTERACT to, Change in Condition - When to Notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires immediate notification of the physician or non-immediate/Report on Next Workday notification of the physician. The nurse will notify the physician immediately with significant change I status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record. The resident's family member or legal guardian should be notified of significant change in resident's status unless the resident has specified otherwise.