

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Lbj Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Haley Rd. Johnson City, TX 78636	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269</p> <p>Based on interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed for accidents and hazards.</p> <p>NA A failed to have another staff assist while providing care for Resident #1 in the bed on 12/29/2024. Resident #1 rolled out of the bed, fell to the floor face down, was transferred to the ER and was diagnosed with laceration on left forehead, a subdural hematoma (collection of blood outside the brain that can be life threatening), a subarachnoid hemorrhage(bleeding in the space below the arachnoid layer of the brain) and possible C6/T1 fractures (C6 is the 6th cervical vertebrae that is in your neck, supports the head, protect the spinal cord and allow head motion; T1 is the 1st Thoracic vertebrae, connect the neck to the upper back) . Resident #1 was hospitalized .</p> <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 12/30/24 at 4:18 pm and an IJ template was given. While the IJ was removed on 12/31/24 at 1:47 pm, the facility remained out of compliance at a level of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This deficient practice could place residents at risk for falls, injuries, hospitalization , and death.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Vascular dementia, Cognitive communication deficit, Unspecified sequelae of cerebral infarction (a condition that may occur at any time after causal condition. Cerebral infraction is process that result in an area of necrotic tissue in the brain) .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS(is a mandatory tool used to screen and identify the cognitive condition of residents) could not be conducted , and staff interview indicated Resident #1 had both short and long-term memory problems. Section GG (Functional abilities) reflected impairment on one side of both upper and lower extremities. It was also reflected in section GG Resident #1 was dependent to roll left and right - the ability to roll from lying on back to left and right side and return to lying on the back on the bed (Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.).</p> <p>Review of Resident #1's care plan dated 10/29/2024 reflected Resident #1 had ADL Functional Status/Rehabilitation Potential and Bed Mobility amount of assist: x 2. The resident was at risk for falling related to Hemiplegia (characterized by total or complete paralysis on one side of the body), Impaired mobility, Poor sitting trunk control, and was NWB. The care plan reflected the resident was dependent transfers with a mechanical lift (often referred to as Hoyer lifts, are devices designed to help caregivers move a person from a sitting to standing position and from one place to another within a room or house). The resident was limited in the ability to dress/undress self, related to hemiplegia with contractures.</p> <p>Review of Resident #1's POC (carefully prepared outline of nursing care showing all of the patient's needs and the ways of meeting them) or CNAs reflected Resident #1 requires x2 assist with bed mobility.</p> <p>Review of Resident #1's progress note from 12/29/24 reflected written by LVN C</p> <p>CNA reported resident rolled off bed when she was changing brief. Supervisor RN here and advised. Resident face down on floor. Called EMS. EMS transporting resident to [city name]. Gash noted on forehead. Called (family) No answer. Unable to leave vm Left VM (DON) notified by nurse supervisor. family returned call. Advised resident will be transported to .ER.</p> <p>Review of Resident #1's hospital records from 12/29/24 reflected:</p> <p>Patient had a left forehead laceration that was repaired. She was also found to have subdural hematoma, subarachnoid hemorrhage and possible C6/T1 fractures. placed in C-collar. Will admit to Trauma Service for further care.</p> <p>During an interview on 12/30/2024 at 10:21 am NA B stated he knew not work alone with any Resident. NA B stated if the other CNAs were busy, he would call the nurse for assistance to provide care for a Resident. NA B stated he was in-serviced by the Weekend Supervisor on fall risk, bed safety and safe lifting. NA B stated he was trained on where and how to find the residents care plan in matrix. Later at about 1:30 pm, NA B demonstrated to the state surveyor on how to locate residents POC in matrix to provide care for resident. NA B stated is was important to know how to locate the residents POC to know how much assistance was needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 12/30/2024 at 11:17 am the Weekend supervisor stated on the morning of 12/29/2024 a little before 5:00 am, she heard the NA called out for help and she went to the room and found Resident #1 on the floor between the bed and the wall, by the window, face down with blood coming from her face. The Weekend Supervisor stated the NA was in the room by herself, and no other staff was in the room assisting the NA to provide care for Resident #1. The Weekend Supervisor stated she protected Resident #1's head because she was bleeding from the left eyebrow area, and moaning, while LVN C called EMS. She stated Resident #1 was immediately transferred to the ER due to concerns for injuries. The Weekend Supervisor said she notified the DON of the incident and initiated in-services on 12/29/2024 regarding fall preventions, safe lifting and bed safety. The Weekend Supervisor stated Resident #1 required 2-persons physical assist to roll over in bed due to her contractures from a stroke. She stated the CNAs/NAs were trained on how to check the residents POC for ADL assistance.</p> <p>During a phone interview on 12/29/2024 at 12:31 pm LVN C stated she was the nurse on duty when Resident #1 fell out of bed. LVN C stated she heard NA A called for help and stated Resident #1 had fallen from the bed. LVN C stated when she and the Weekend Supervisor got to the room, NA A was in the room without another staff, Resident#1 was face down on the floor between the wall and the bed with blood. LVN C stated they were not sure where the blood was coming from, so the Weekend Supervisor tried to protect Resident#1's head while went to call EMS. LVN C stated they did not want to move Resident #1 due to a possible head injury, so the Weekend Supervisor was on the floor with the Resident #1 until EMS got to the facility. LVN C stated EMS got to the facility, repositioned Resident #1 and they noted a big gash on her forehead and Resident #1 was transported to the local hospital ER. LVN C stated she completed an incident report, the Weekend Supervisor started in-services on safe transfers, bed safety and fall prevention. LVN C stated Resident #1 required 2-persons for bed mobility due to history stroke.</p> <p>During a phone interview on 12/30/2024 at 12:54 pm NA A stated on the morning of 12/29/2024 while she was getting Resident #1 ready for a Hoyer transfer , she rolled Resident #1 to the right side, and she fell out of bed, and landed between the bed and the window. NA A stated she notified LNV C and the Weekend Supervisor, and the resident was transferred to the ER. NA A stated she was going to call for help after prepping Resident #1 for the transfer. NA A stated she knew Resident #1 was 2-person assist with Hoyer transfers and she now found out that Resident #1 was 2-persons with bed mobility. NA A stated she was trained on how to check the matrix (the system used by the facility for electronic documentation) to access the residents POC to provide care and on how to position and transfer a resident. NA A said she was called by the Administrator and told she was suspended pending the investigation of the incident.</p> <p>During an interview on 12/30/2024 at 2:26 pm the Sr. VP of Clinical Operation stated NA A was not a CNA, she was an NA, and she knew not to provide care for residents unless there was a licensed nurse or another CNA present. She also stated the NA A knew Resident #1 was a 2-person assist with bed mobility and NA A knew how to check the POC for residents to know how to provide care.</p> <p>During an interview on 12/31/2024 at 10:51 am, the HR/BOM staff stated she was responsible to ensure all new hires knew their job descriptions. She stated NA A went over her job description. She Stated NA A was not yet certified so she could not do any direct care for a resident except if a CNA or a licensed nurse was present.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Multiple telephone calls were attempted on 12/30/2024 at 11:16 am, 11:17 am, 3:25 pm through 12/31/2024 at 10:16 am to reach NA A regarding her job description and not providing direct care for a resident unless there was another CNA or a licensed nurse present but was unsuccessful. A returned call was not received prior to exit.</p> <p>Review of NA A's competency check-off dated 10/30/2024 reflected she was check-off on turns, repositioning residents timely/correctly, and transfers (1-person assist, 2-person assist and Hoyer lift).</p> <p>Review of the facility's in-services reflected the facility-initiated in-services on 12/29/2024 on safe lifting, bed safety and fall preventions for nursing staff (Nurses, CNAs and NAs).</p> <p>Review of NAs job description for the facility reflected:</p> <p>Position Title: NURSE AIDE</p> <p>Reports To Position: DIRECTOR OF NURSING</p> <p>JOB SUMMARY-- Under the supervision of the Charge Nurse, the Helping Hands Aide performs non-professional, non-direct resident care duties and assists in maintaining a positive physical and psychosocial environment for the resident.</p> <p>Review of facility's policy titled Accidents and incidents-Investigating and Reporting dated November 2021 reflected:</p> <p>Policy Statement</p> <p>All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.</p> <p>Review of facility's policy titled Required Training, Certification and Continuing Education of Nurse Aides, undated, reflected:</p> <p>It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides.</p> <p>2. This facility will employ nurse aides in the following circumstances:</p> <p>a. Those who have successfully completed a State approved nurse aide training or competency evaluation program (NATCEP) and are awaiting certification results. They may be employed as full-time and permanent but must provide documentation of certification within 4 months of their hire date. Facility will verify certification through the appropriate state's nurse aide registry.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Sr. VP for Clinical and ADON were notified on 12/30/24 at 4:18 pm that an IJ had been identified and an IJ template was provided.</p> <p>The following Plan of Removal submitted by the facility was accepted on 12/31/2024 @ 10:57 AM.</p> <p>Plan of Removal:</p> <p>F689 - The facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>NA failed to have another staff assist while providing care with Resident #1 in the bed. [Resident #1] rolled out of the bed, fell to the floor face down, was transferred to the ER and was diagnosed with laceration on left forehead and fracture of C6 and T1 vertebrae.</p> <p>1. Immediate Actions Taken for Those Residents Identified:</p> <p>Action: [Resident #1] was assessed following fall, transferred to the ER, and subsequently admitted to the hospital for further evaluation and treatment.</p> <p>Person(s) Responsible: Charge Nurse/Weekend Supervisor</p> <p>Date: 12-29-2024, 5:30 a.m.</p> <p>2. How the Facility Identified Other Possibly Affected Residents:</p> <p>Action: All residents' orders, care plans, resident profile and MDSs reviewed to ensure the methods of transfer match. Any discrepancies will be discussed with the IDT , to include clinical leadership, therapy, and certified nurse aides and licensed nursing staff, as needed, to verify the proper method of transfer is occurring. After any discrepancies have been identified and corrected, resident orders, care plans, resident profile and MDS will be compared no less than quarterly when MDS assessments are completed to ensure everything matches. When changes are made related to change of condition, all noted changes will be verified in the order, care plan, resident profile, and any significant change MDS assessment, if applicable.</p> <p>Person(s) Responsible: Director of Nursing, MDS Nurse, Regional MDS, and/or Designee</p> <p>Date: 12-30-2024</p> <p>3. Measures Put into Place/System Changes to remove the immediacy, and what date these actions occurred:</p> <p>Action: Educate Director of Nursing and Assistant Director of Nursing on required new hire orientation with Certified Nurse Aides/Nurse Aides and licensed nurses to include return demonstration for where to find resident profile information in MatrixCare POC (transfer ability, bed mobility, self-care, toileting, eating, and the number of staff required to complete these activities of daily living to ensure resident safety).</p> <p>Person(s) Responsible: Sr. VP of Clinical Operations or designee</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Date: 12-30-2024</p> <p>Action: Licensed Nurses and Certified Nursing Aides/Nurse Aides educated on Safe Lifting and Movement of Residents and checking resident profile to ensure appropriate number of staff used for all activities of daily living (i.e., transfers, bed mobility, toileting, eating, and self-care). Staff to be educated includes facility staff and temporary staff- agency and/or PRN staff (licensed nurses and nurse aides) that may transfer a resident or assist with activities of daily living. Unlicensed Nurse Aides will be educated that they are not authorized to transfer any resident without a Certified Nurse Aide or licensed nurse present.</p> <p>Licensed Nurses and Certified Nursing Aides/Nurse Aides will be educated prior to working their next shift.</p> <p>Person(s) Responsible: Director of Nursing and/or Designee</p> <p>Date: 12-30-2024</p> <p>Action: Despite having documented education on Matrix POC and resident profiles as well as her own admission that she knew where to find transfer ability and mobility assistance requirements for each resident, by her own admission, the NA stated that she made the decision not to follow established policies and procedure which resulted in injury to [Resident #1]. The NA was suspended immediately pending outcome of the investigation. The NA's employment will be terminated effective immediately.</p> <p>Person(s) Responsible: Director of Nursing and/or Designee</p> <p>Date: 12-31-2024</p> <p>4. How the Corrective Actions Will be Monitored, by whom and for how long:</p> <p>Action: Director of Nursing and/or Designee will observe 3 transfers/resident ADL activities per week x4 weeks to ensure staff (licensed nurses/CNAs/NAs) check the resident profile and perform the appropriate transfer or ADL care based on the resident plan of care which designates the number of staff required. Monitoring will continue for 4 weeks or until compliance is achieved. At no time will NAs be allowed to transfer residents without direct supervision.</p> <p>Person(s) Responsible: Director of Nursing and/or Designee</p> <p>Date: 12-30-2024</p> <p>Action: Ad hoc QAPI performed with Medical Director to review the Immediate Jeopardy Template and the facility's plan to remove the immediacy.</p> <p>Person(s) Responsible: Administrator</p> <p>Date: 12-30-2024, 5:30 PM</p> <p>The Surveyor monitored the POR on 12/31/24 as followed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of facility's in-services reflected the following:</p> <p>12/29/2024 the following in-services were initiated by the weekend supervisor for all direct care staff after the incident:</p> <p>Safe Lifting, fall prevention and bed safety.</p> <p>12/30/2024 the DON and ADON were educated by the Sr. VP of Clinical Operation on new hire orientation. LVN/RN/CNA/NA must do return demonstration on how to find Resident's profile info in matrix.</p> <p>12/30/2024 All direct care staff were in-serviced on POC training and abuse and neglect, initiated by the ADON.</p> <p>During interviews on 12/31/2024 from 11:10 am - 1:20 pm, two CNAs, one RN, and one LVN stated there were trained on abuse and neglect, safe lifting, fall prevention and bed safety, POC training prior to starting their shifts. They all stated they knew how to find the residents mobility status in the POC in matrix. They stated they had to do return demonstration on how to access a resident's POC. They all stated 2-person bed mobility meant 2-persons assist while working with a resident in the bed. Staff stated it was important to follow the resident's POC to prevent injuries. They all stated an NA was not to provide direct care for a resident independently except there is a licensed nurse or another CNA.</p> <p>Review of facility's POR document dated 12 /30/2024 @ 5:30 pm,reflected QAPI was held with the Medical Director, the ADON and the Administrator via phone to discuss the Immediate Jeopardy template.</p> <p>Review of NA A's personnel file reflected the staff was terminated as of 12/31/2024.</p> <p>The ADM, ADON and Sr, VP of clinical Operation were notified on 12/31/24 at 1:47 pm that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm that is not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		