STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676486	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lbj Medical Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, 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 #2) of three residents reviewed for accidents and hazards. The facility failed to have consistent documentation for Resident #2's transfer status and failed to ensure she was properly transferred on 10/27/24. Her left leg foot caught on the wheelchair while being transferred by one person assistance to her bed which resulted in multiple fractures to her tibia and fibula (spiral fractures). This failure resulted in an identification of an Immediate Jeopardy (IJ) on 10/29/24 at 3:56 PM and an IJ template was given. While the IJ was removed on 10/30/24 at 3:00 PM, the facility remained out of compliance at a level of no actual harm at a scope of isolated with a potential for more than minimal harm, that was not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for falls, injuries, and hospitalization . Findings included: Review of Resident #2's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that causes memory loss, thinking problems, and behavior changes), repeated history of falls, lack of coordination, and muscle wasting and atrophy (wasting away). Review of Resident #2's quarterly MDS assessment, dated 10/08/24, reflected a BIMS could not be conducted due to rarely/never being understood. Section G (Functional Status) reflected she required extensive assistance with 2+ assistance for transferring and bed mobility. Review of Resident #2's quarterly care plan, revised 10/29/24, reflected she had impaired balance during transfers R/T OA and limited ROM to bilateral shoulders. She was a 1-2 person transfer but can use mechanical lift depending on her capabilities with an intervention of providing 1 person assistance for transferring. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Physical Therapy order, dated 05/01/24, reflected Resident #2 may be transferred using the mechanical lift for safe transfers. Review of a progress note in Resident #2's EMR, dated 10/27/24 at 11:03 PM and documented by LVN E, reflected the following: [CNA F] informed this nurse as he was pickins [sic] [Resident #2] from wheelchair to lay her in bed when he heard [Resident #1]'s left ankle pop. [CNA F] believes her foot got caught on wheelchair. Fibula is swollen and bruised. [Resident #2] is stating it hurts . Call made for STAT x-ray . Review of a progress note in Resident #2's EMR, dated 10/28/24 at 5:41 AM and documented by LVN E, reflected the following: 911 called for pickup . [Resident #2] complaining of pain. Left lower leg has gotten more swollen and bruised. Reapplied ice . (x-ray company) has not made it here yet. Review of a progress note in Resident #2's EMR, dated 10/28/24 at 8:45 AM and documented by LVN B, reflected the following: Recvd [sic] verbal report from (hospital ER) for [Resident #2] return . Verbal Report: Multiple fractures to tibia and fibula (spiral fractures) . Left leg placed in long splint from hip to mid-thigh. To be bedbound upon return to facility. Review of Resident #2's ER discharge paperwork, dated 10/28/24, reflected the following: Visit Diagnoses: Closed fracture of proximal end of left fibula (primary), closed nondisplaced spiral fracture of shaft of left tibia. Medical Decision Making: [Resident #2] was found to have left fibula and spiral tibia fracture . I did ask the charge nurse to file an APS report given reportedly low mechanism injury and injury pattern. Observation on 10/29/24 at 10:22 AM revealed Resident #2 asleep in her room. Her bed was in a low position, fall mat in place, and call light was within reach. During an interview on 10/29/24 at 10:33 AM, the PTA stated Resident #2 had not been on therapy's caseload since 2023. She stated it was up the staff member's preference on how to transfer Resident #2. She stated there were some aides who did not have the correct stand-and-pivot technique or did not feel comfortable transferring her alone. She stated Resident #2's physical abilities could fluctuate often. She stated in her opinion, to transfer her safely, there should be two staff members assisting. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 10/29/24 at 12:38 PM, LVN E stated she was working the night shift when the incident with Resident #2 happened (10/27/24). She stated CNA F informed her he believed her foot got stuck in the wheelchair when he heard a popping sound. She stated the fractures she acquired were consistent with the twisting motion of her leg getting stuck in the wheelchair. She stated Resident #2 was a 1-2 person assist and it normally depended on the aide. She stated CNA F transferred her on his own before with no issues. She stated he was a big guy and used a gait belt and did not have any problems. During an interview on 10/29/24 at 1:03 PM, the DON stated staff knew residents' transfer status by their care plans, in the POC (EMR), and it was communicated to them. She stated the POC, MDS, and care plans should typically match. She stated Resident #2 could be a 1-2 person transfer or a mechanical lift could be utilized when needed. She stated Resident #2's physical ability fluctuated during the day - sometimes she was more tired at different times of the day. She stated the mechanical lift could be used for safety but it was not very typical that it was used for her. She stated CNA F told her when he was transferring Resident #2 from her wheelchair to her bed (on 10/27/24) he heard a pop and believed her leg was caught by the wheelchair. She stated upon hire, they conducted trainings and competencies regarding transferring but no in-servicing or trainings were conducted since the incident with Resident #2. Attempted interviews with CNA F On 10/29/24 were unsuccessful. Multiple telephone calls were attempted to reach CNA F. A returned call was not received prior to exit. Review of CNA F's competency check-off, dated 08/29/24, reflected he had been observed and checked off for transfers. review of the facility's Safe Lifting and Movement of Residents Policy, revised 03/31/23, reflected the following: Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. . 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. The ADM and DON were notified on 10/29/24 at 3:56 PM that an IJ had been identified and an IJ template was provided. The following Plan of Removal submitted by the facility was accepted on 10/30/24 at 12:44 PM: Plan of Removal: F689 - The facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure Resident #2 was properly transferred. Her foot got caught in the wheelchair when being transferred to the bed. She was diagnosed with multiple fractures to her tibia and fibula (spiral fracture). The facility failed to have consistent documentation for Resident #2's transfer status. 1. Immediate Actions Taken for Those Residents Identified: Action: Resident #2 was assessed by the LVN on duty post-accident, MD notified, MD ordered x-rays, Resident was sent to the hospital. Resident returned to facility. Resident discharge orders included remain non weight bearing and follow up with the orthopedic surgeon. This appointment was scheduled for 10/31/24. The Licensed Nurses and the CNAs were educated on the these orders, Person(s) Responsible: Charge Nurse Date: 10/30/2024 continue to monitor 2. How the Facility Identified Other Possibly Affected Residents: Action: All residents' orders, care plans, resident profile and MDSs reviewed by the Regional MDS Nurse to ensure the methods of transfer match. Any discrepancies were reviewed with the IDT on 10/30/24, to include clinical leadership, therapy, and certified nurse aides and licensed nursing staff. The method of transfer determined by IDT such as gait belt, one/two person or mechanical lift will be updated in the Orders, care plan, resident profile and the MDS. Resident #2 was reviewed upon return, and it was determined by the IDT that she was now a mechanical lift 2 person transfer. The orders, care plan and resident profile were updated. Person(s) Responsible: Director of Nursing, MDS Nurse, Regional MDS, and/or Designee Date: 10/30/2024 by 9AM 3. Measures Put into Place/System Changes to remove the immediacy, and what date these actions occurred: Action: Educate Administrator, Director of Nursing, Assistant Director of Nursing, and MDS Coordinator on residents' orders (if resident requires a mechanical lift), care plans, resident profile and MDSs accurately reflect residents' transfer status. Person(s) Responsible: Clinical Resource Nurse Date: 10/30/2024 by 1PM Action: The CNA that transferred Resident #2 when they received the fracture was educated on Safe Lifting and Movement of Residents on 10/28/24 and return demonstration was completed at this time. Licensed Nurses and Certified Nursing Aides educated on Safe Lifting and Movement of Residents and checking resident profile to ensure that they are aware of the correct transfer method for that resident. Lift and Transfer competencies will be performed on licensed Nurse and Certified Nurse Aides. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed Nurses and Certified Nursing Aides will be educated prior to working their next shift. There will be safe transfer training and how to access resident profile to ensure proper transfer is being used. The facility is not using agency personal, but all PRN and New hires will be trained prior to working their first shift Person(s) Responsible: Director of Nursing and/or Designee Date: 10/29/2024 by 10PM 4. How the Corrective Actions Will be Monitored, by whom and for how long: Action: MDS Coordinator to complete MDSs to include the transfer status in the look back period, prior to the RN signature, Director of Nursing will review the transfer coding on the MDS and will ensure orders (if mechanical lift), care plans, and resident profile match to have consistent documentation in place for all residents for next 4 weeks . Person(s) Responsible: Director of Nursing and/or Designee Date: 10/29/2024 by 10PM Action: Director of Nursing and/or Designee will observe 3 transfer a week, including any current, PRN or newly hired staff for x4 weeks and then monthly thereafter to ensue staff check resident profile and perform the appropriate transfer per the resident profile and procedure. The facility does not currently use agency staff. Person(s) Responsible: Director of Nursing and/or Designee Date: 10/29/2024 by 10PM QAPI: Action: Ad hoc QAPI performed with Medical Director to review the Immediate Jeopardy Template and the facility's plan to remove the immediacy. Person(s) Responsible: Administrator Date: 10/29/2024 by 10PM The Surveyor monitored the POR on 10/30/24 as followed: During an observation and interview on 10/30/24 at 1:10 PM revealed CNA D finding a resident's transfer status on their profile in their POC. Before the transfer, she locked the resident's wheelchair, ensured his feet were flat on the ground in front of him, explained to him what they were about to do, and appropriately utilized the gait belt to transfer him from his wheelchair to his bed. She stated she was in-serviced before her shift on safe transfers and locating residents' transfer status. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 10/30/24 from 1:42 PM - 2:50 PM, two RNs and three CNAs from both shifts stated they were in-serviced on safe transfers before working their shift. All stated they were able to find resident transfer statuses on their face sheet in the POC or in their care plans. They all stated gate belts should always be used for safety. The staff stated if it was a transfer from the wheelchair to the bed, you would ensure the wheelchair was locked, the resident's feet were flat on the floor and facing the bed, they were stable, and at a safe distance to the bed. They all stated limited assistance meant close supervision and residents should never transfer alone unless they were independent. The staff stated safe transfers were important to avoid injuries. Review of QAPI documentation, dated 10/29/24, reflected the DON and ADM met with the MD via telephone to discuss the Immediate Jeopardy template. Review of the audit conducted by the RMDSN to ensure all residents' care plans, orders, MDS, and profiles matched for transfers, dated 10/29/24, reflected 19 residents requiring 1 person assistance, five residents requiring 2-person assistance, two residents that were independent, and seven residents who required a hoyer (mechanical) lift. Review of an in-service, dated 10/29/24 and conducted by the CRN, reflected the DON, ADON, and MDSC were educated on the following: Ensure that all care plans, each residents' profiles, and the MDS match and line up per resident and that the proper transfer status is listed adequately in each place. Please ensure that if the resident is a mechanical lift that the orders are in place aligning with the care plan and MDS. Review of three residents' EMRs, on 10/30/24, reflected their transfer status consistent throughout their charts. Review of an in-serviced, dated 10/29/24 - 10/30/24 and conducted by the Administration staff, reflected all direct care staff were educated on safe transferring and finding resident transfer status in their POC profiles. Review of a document, dated 10/29/24 and documented by the DON, reflected the following: CNA F was re-educated on safe transfers and mobility post-incident and demo/re-demo skills were verified by nurse and DON. The ADM and DON were notified on 10/30/24 at 3:00 PM that the IJ had been removed. While the IJ was removed, The facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of four residents reviewed for pain. The facility failed to provide effective pain management or investigate the reason for the increased pain for Resident #1 when he complained of pain to his lower abdomen/groin area from 09/01/24 - 09/03/24. He was sent to theER on [DATE] and diagnosed with a UTI, sepsis, and a blood clot in his bladder. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 10/29/24 at 3:56 PM and an IJ template was given. While the IJ was removed on 10/30/24 at 3:00 PM, the facility remained out of compliance at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for prolonged and unnecessary pain and suffering and a decreased quality of life. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including acute kidney failure, disorder of urinary system, diabetes , and a history of UTIs and sepsis (a serious condition in which the body responds improperly to an infection). Review of Resident #1's quarterly MDS assessment, dated 08/20/24, reflected a BIMS score of 15, indicating he had no cognitive impairment. Section H (Bladder and Bowel) reflected he had an indwelling catheter. Review of Resident #1's quarterly care plan, dated 08/01/24, reflected he required a suprapubic catheter related to obstructive uropathy (a blockage in the urinary tract that makes it hard to urinate) with an intervention of frequent and as needed incontinence checks to ensure catheter was not leaking. It further reflected he was at risk for increased pain related to DM, PVD , and generalized weakness with an intervention of monitoring pain every shift. Review of Resident #1's progress note, dated 08/31/24 at 11:31 AM and documented by LVN F, reflected the following: [Resident #1] C/O lower abdominal pain. Distention noted. Has blood coming out around meatus/catheter and bloody urine. Denies any trauma. Cath appears intact . Called EMS for transport . Review of Resident #1's progress note, dated 08/31/24 at 7:41 PM and documented by LVN E, reflected the following: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[Resident #1] returned by ambulance from (hospital) . [Resident #1] had suprapubic catheter reinserted 16F. Spoke with (nurse) from hospital who stated [Resident #1]'s urine is wine in color . Review of Resident #1's ER documentation, dated 08/31/24, reflected the following: . [Resident #1] is more altered than normal and pulled out his suprapubic cath and is now having blood and blood clots out of his cath. Final diagnosis: Suprapubic catheter dysfunction Review of Resident #1's progress note, dated 09/01/24 at 9:28 PM and documented by RN A, reflected the following: [Resident #1] c/o penile pain. PRN Tylenol given as ordered and [Resident #1] stated that it is not effective and requesting for a more effective pain pill . Nurse to notify PCP. Review of Resident #1's progress note, dated 09/01/24 at 10:50 PM and documented by RN A, reflected the following: (Physician) called and gave the ff T.O: Tramadol 50mg Q6hrs PRN x 10 days for pain - placed to MAR Review of Resident #1's progress note, dated 09/02/24 at 8:40 AM and documented by LVN B, reflected the following: [Resident #1] complaints of pain at penis . Tylenol given per PRN order on file . Review of Resident #1's progress note, dated 09/03/24 at 7:31 AM and documented by LVN B, reflected the following: Tramadol given for pain per PRN order on file. Review of Resident #1's progress note, dated 09/03/24 at 11:40 AM and documented by LVN B, reflected the following: [Resident #1]'s suprapubic catheter drainage tube not draining properly; repositioned tubing to gravity, currently flowing. [Resident #1] complains of pain; Tylenol given per PRN order on file. Review of Resident #1's progress note, dated 09/03/24 at 8:38 PM and documented by RN A, reflected the following: [Resident #1] complaining of penile pain. Tramadol still not due until 10:46PM. Tylenol PRN given as ordered. [Resident #1] stated that he wants to go to the ER and having a pain scale of 10 . Called 911 . Review of Resident #1's September 2024 MAR reflected the following documented for pain: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	09/01/24: Day 8/10; Night 6/10 09/02/24: Day 2/10; Night 2/10 09/03/24: Day 2/10; Night 4/10 Review of Resident #1's physician order, dated 09/20/23, reflected acetaminophen capsule; 500 mg; 2 tabs ; every 6 hours - PRN. Review of Resident #1's September 2024 MAR reflected acetaminophen was administered the following times: 09/01/24: 7:33 AM (Somewhat effective) 09/01/24: 8:15 PM (Not effective) 09/02/24 8:37 AM (Somewhat effective) 09/02/24 2:39 PM (Effective) 09/02/24 8:39 PM (Effective) 09/03/24 11:37 AM (Not effective) 09/03/24 8:32 PM (Not effective) Review of Resident #1's physician order, dated 09/01/24, reflected tramadol; 50 mg; 1 tab; every 6 hours - PRN. Review of Resident #1's September 2024 MAR reflected tramadol was administered the following times: 09/01/24 11:09 PM - (Somewhat effective) 09/03/24 7:31 AM (Effective) 09/03/24 4:46 PM (Not effective) Review of Resident #1's hospital discharge paperwork, dated 09/17/24, reflected the following: admitted : 09/03/24 Service Date: 09/04/24 HPI: [Resident #1] . who presents with sepsis 2/2 SP tube infection . [Resident #1] presents from (facility) c/o severe pain to penis and lower abdomen. [Resident #1] has suprapubic catheter and noticed blood in catheter x4days . (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Brief Hospital Course: [Resident #1] transferred to our emergency room with complaining of severe lower abdominal pain and blood around the suprapubic catheter. [Resident #1] found to have hypoglycemia , acute renal failure and UTI and admitted to IMCU . underwent cystoscopy and evacuation of large clot . His urine culture grew multiple bacteria and treated with IV Zosyn more than 10-day course. [Resident #1] presented with an elevated creatinine and went up to 7.4 and subsequently down to 3.3. His acute kidney injury most likely related to large blood clot in the bladder neck obstructing the ureter. During a telephone interview on 10/21/24 at 11:15 AM, Resident #1's FM C stated before he (Resident #1) was sent to the hospital on 09/03/24, he had been complaining of pain to his penis for several days. She stated when she visited him before he was sent out, he was doubled over crying in pain and crying out, I just wish they would get this fixed! She stated it was heart-breaking and he should have been sent to the hospital sooner . During a telephone interview on 10/21/24 at 12:38 PM, Resident #1's NP stated when a resident was in pain, she would want to try all interventions first before sending them to the ER. She stated if the tramadol had not been effective for Resident #1 (from (09/01/24 - 09/03/24) she would have thought the staff would have reached out to her for other possible interventions such as a medication or dosage change. During a telephone interview on 10/21/24 at 12:54 PM, RN A stated the PRN medication (tramadol and Tylenol) had not helped to alleviate Resident #1's pain (from 09/01/24 - 09/03/24). She stated she could not remember how much pain he was in on 09/01/24, but believed it was a lot. She stated on 09/03/24, he was yelling/moaning/groaning in pain and the CNA told her he had been like that and he was getting worse. She stated whenever she thought he needed hospitalization in the past he would always refuse, but that day (09/03/24), he was in so much pain he kept telling her to send him. During an interview on 10/21/24 at 1:14 PM, LVN B stated she could not remember if the tramadol was effective for Resident #1 (at the beginning of September 2024). She stated he had always been very vocal about his pain levels. During an interview on 10/21/24 at 1:30 PM, CNA D stated she remembered Resident #1 being in a lot of pain, way much more than normal from 09/01/24 - 09/03/24. She stated there was something really, really wrong. She stated urine and blood was coming out of his penis. She stated he kept saying, it hurts, it hurts. She stated he believed he should have been sent to the hospital sooner but Resident #1 had a history of saying, Why? They do not do anything for me anyways. She stated on 09/03/24 he could not take the pain anymore and requested to go to the hospital. During an interview on 10/21/24 at 3:14 PM, the DON stated she remembered Resident #1 complaining of pain (at the beginning of September 2024) but could not remember if it was an increase in pain any more than normal. She stated she was not made aware that his pain medications were not effective. She stated her expectations would be for the nursing staff to notify the NP if they were not effective to ensure they could alleviate his pain in a timely manner . (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 10/29/24 at 11:40 AM, LVN B stated if she knew blood and urine was coming out of Resident 1's penis, it would be in her progress notes. She stated he had bouts where that would happen when there was over-flow and because of his end-stage kidney disease. She stated when it would happen, they would send him to the ER and they would send him back same day with no new orders. During a telephone interview on 10/29/24 at 12:38 PM, LVN E stated she remembered Resident #1 having pain at the beginning of September (2024) to his groin/stomach area. She stated she could not remember if the pain medications were effective. She stated she did not know about urine or blood coming out of his penis. She stated if she had, she would have notified the NP . During a telephone interview on 10/29/24 at 1:12 PM, Resident #1's NP stated if a resident was in pain and the current pain regiment was not effective and all interventions had been tried and the pain was still uncontrolled and unmanaged, she would expect for the nurses to use their nursing judgement regarding when to send a resident out to the ER. She stated she could not answer if Resident #1 had been sent out sooner (than 09/03/24) if it would have prevented the blood clot. Review of the facility's Pain Assessment and Management Policy, revised July of 2022, reflected the following: General Guidelines: 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. . 5. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassess as indicated until relief is obtained. . Reporting: Report the following information to the physician or practitioner: 1. Significant changes in the level of the resident's pain ; . 3. Prolonged, unrelieved pain despite care plan interventions. The ADM and DON were notified on 10/29/24 at 3:56 PM that an IJ had been identified and an IJ template was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676486	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lbj Medical Center	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.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following POR was approved on 10/30/24 at 12:44 PM: Plan of Removal: F697 - The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility failed to provide effective pain interventions for Resident #1 when he was complaining of pain to his lower abdomen/groin area. The facility failed to investigate the reason for Resident #1`s pain. 1. Immediate Actions Taken for Those Residents Identified: Resident #1 no longer resides at [the facility]. 2. How the Facility Identified Other Possibly Effected Residents: Action: All residents' pain monitoring on the residents' Medication Administration Record MAR was reviewed by DCO for the month of October. Director of Nursing and/or Designee will communicate with Medical Director all residents that triggered for pain and any new orders will be implemented by the Director of Nurses Person(s) Responsible: Director of Clinical Operations, Director of Nursing, and/or Designee Date: 10/30/2024 by 10AM 3. Measures Put into Place/System Changes to remove the immediacy, and what date these actions occurred: Action: Director of Nurses educated Assessing pain, treating pain (as ordered), monitoring for effectiveness, and notifying physician for any residents whose pain medication is not effective or new onset or increase/change in pain. Person(s) Responsible: Clinical Resource Nurse Date: 10/29/2024 by 10PM Action: Licensed Nurses and Certified Nursing Aides educated over pain & reporting pain. Licensed Nurses: Assessing pain, treating pain (as ordered), monitoring for effectiveness, and notifying physician for any residents whose pain medication is not effective or new onset or increase/change in pain. Licensed Nurses and Certified Nursing Aides will be educated prior to working their next shift The Facility is not currently using agency personal, but PRN and new hires will be educated before working their first shift. (continued on next page)

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	676486	A. Building B. Wing	10/30/2024

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Person(s) Responsible: Director of Nursing and/or Designee Date: 10/29/2024 by 10PM 4. How the Corrective Actions Will be Monitored, by whom and for how long: Action: Review pain assessments for prior day(s) during clinical meeting for 4 weeks and will be ongoing for any residents that have expressed or demonstrated pain to ensure effective intervention/investigation/notification for residents complaining of pain. Person(s) Responsible: Director of Nursing and/or Designee Date: 10/29/2024 continue ongoing QAPI: Action: Ad hoc QAPI performed with Medical Director to review the Immediate Jeopardy Template and the facility's plan to remove the immediacy. Person(s) Responsible: Administrator Date: 10/29/2024 by 10PM The Surveyor monitored the POR on 10/30/24 as followed: During interviews on 10/30/24 from 1:42 PM - 2:50 PM, two RNs and three CNAs from both shifts stated they were in-serviced on pain management before working their shift. The CNAs stated any time a resident was in pain a nurse should be notified immediately. All stated some non-verbal signs of pain would be grimacing, moaning, crying, or increased blood pressure. The nurses stated after administering pain medication, the effectiveness needed to be checked within the hour, and if it was not effective, the NP needed to be notified . All staff stated the importance of pain management was to ensure residents were comfortable, vital signs were controlled, and to ensure a good quality of life. During interviews on 10/30/24 from 12:38 PM - 12:59 PM with three residents , all reported they were not currently in pain and when they were, they told their nurse and would receive pain medication. Review of QAPI documentation, dated 10/29/24, reflected the DON and ADM met with the MD via telephone to discuss the Immediate Jeopardy template. Review of an in-serviced, dated 10/29/24 - 10/30/24 and conducted by the Administration staff, reflected all direct care staff were educated on pain management and reporting pain. Review of an in-service, dated 10/29/24 and conducted by the CRN, reflected the DON was in-serviced on assessing pain, treating pain (as ordered), monitoring the effectiveness, and notifying the MD. Review of a Daily Pain Audit, dated 10/30/24 and completed by the CRN, reflected all residents were audited for pain and only one had a pain score over 4 (from 1-10). He was administered his pain medication and it was effective. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM and DON were notified on 10/30/24 at 3:00 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.