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	06/01/2022

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

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 - Actual harm 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** 27430 Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accident hazards/supervision. The facility failed to use a two-person mechanical lift transfer from the wheelchair to the bed causing Resident #1's foot to get caught between the bed and the Hoyer lift, resulting in an acute nondisplaced fracture of her left distal tibia (ankle). The noncompliance was identified as PNC. The noncompliance started on 05/21/2022 and ended on 05/22/2022. The facility had corrected the noncomplaince before the survey began. This failure could result in residents experiencing accidents, injuries and/or a diminished quality of life. The findings include: Record review of Resident #1's facesheet revealed a [AGE] year-old female admitted to the facility on [DATE], with a readmitted [DATE]. Her diagnoses included: history of right hip fracture, chronic pain syndrome, weakness and paralysis following a stroke affecting left non-dominate side, type 2 diabetes mellitus with hyperglycemia, protein-calorie malnutrition, seizures, major depressive disorder, insomnia, and hypertension. Record review of Resident #1's annual MDS assessment dated [DATE], revealed a BIMS score of 15 (normal cognition). Resident #1 required extensive assistance with two-person physical assistance with bed mobility, dressing, and toileting. Resident #1 required total assistance with two-person physical assistance with transfers. The MDS reflected Resident #1's range of motion was impaired on one side to the upper and lower extremity. She utilized a wheelchair. Record review of Resident #1's Care Plan last reviewed 04/08/2022 revealed: Problem: ADL self-care deficit related to effects of CVA (cerebrovascular accident) with left hemiparesis. Prefers staff to assist/complete ADLS for her. Needs encouragement to participant in ADL care. Intervention included: Requires a lift for all transfers with two assist and/or may stand and pivot with two assist. (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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NAME OF PROVIDER OR SUPPLIER Lubbock Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4120 22nd Pl Lubbock, TX 79410	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Problem: Uses Hoyer lift for transfers. Intervention reflected, Use at least two people for transfers with Hoyer lift. Problem: Risk of falls related to impaired mobility due to CVA, impaired gait/balance/debility, use of psych med, incontinence, impaired cognition, diabetes mellitus, use of cardiac medications and use of narcotic pain medications as needed. History of falls. Intervention included: Mechanical lift with two staff members to assist with transfers. Review of Resident #1's Bedside Kardex (gives brief overview of resident) dated as of 05/31/2022 for Transferring listed: *Mechanical lift with staff x 2 to assist with transfers *Resident #1 requires a lift for all transfers with 2 assist and/or may stand and pivot with 2 assist. *TRANSFER: The resident requires total assistance with transfers- Hoyer lift transfer. Record review of Nurse's Note dated 05/22/2022 at 10:15 a.m. revealed that when LVN B was administering Resident #1's morning medications, the resident immediately began to complain of pain to her left ankle. Upon assessment of the site there was obvious swelling and bruising noted. The resident stated it may have been caught on something during a transfer. Nurse Practioner was contacted and new order for x-rays obtained, foot elevated, and pain medication was administered. Record review of Event Nurse's Note 12 hour-Bruise dated 05/22/2022 at 10:13 a.m. revealed Event: Resident complained of pain when LVN B administered topical medication. Resident #1 reported her ankle was hurting. The site was assessed with obvious swelling noted. The resident reported her foot got caught on something when she was being transferred to bed the day before. The Nurse Practioner was notified with a new order for x-rays received. Bruise: left ankle and left big toe. Size: 1 inch Color: blue/purple. Physician notified on 05/22/2022 at 9:00 a.m. Responsible party notified 05/22/2022 at 10:58 a.m. Record review of SBAR (situation, background, assessment, and recommendation - communication between nurses and providers) dated 05/23/2022 at 9:15 a.m. documented possible left ankle fracture, symptoms first appeared on 05/21/2022, x-ray obtained. Nurse Practioner notified on 05/23/2022 at 9:10 a.m., and notified responsible party on 05/23/2022 at 9:10 a.m. Order received to transfer Resident #1 to the hospital for further evaluation. Record review of Nurse's Note dated 05/23/2022 at 9:15 a.m. indicated that Resident #1 was transferred to the hospital related to possible left ankle fracture. Needs a CT scan. (diagnostic imaging) Record review of Nurse's Note dated 05/23/2022 at 3:04 p.m. revealed Resident #1 returned from the hospital. She had a splint noted to left lower extremity. Resident complained of pain at a 6 on a scale of 1 to 10. Will medicate per PRN orders. Family notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the Provider Investigation Report dated 05/27/2022 revealed the investigation determined that Resident #1's ankle was fractured on 05/21/2022 due to NA not using the Hoyer lift with the proper amount of staff to assist. The NA tried to complete the two-person lift by herself resulting in Resident #1's foot being caught between the lift and the bed causing an acute nondisplaced fracture to the left tibia. Following the investigation the facility was continuing to in-service on safe transfers, and perform competency checks. The NA was terminated for not following the plan of care. Resident Satisfaction Surveys and witness statements from Resident #1 and Resident #6 included in the report. Record Review of Resident #1's x-ray report dated 05/22/2022 at 11:00 a.m. revealed findings of decreased bone mineralization. An acute non-displaced fracture of Resident #1's left distal tibia noted. Interview with the Administrator on 06/01/2022 at 1:50 p.m. revealed he was at the facility on Sunday, 05/22/2022, and was told by nursing about the incident involving Resident #1. He stated the NA was suspended immediately pending the investigation. The Administrator stated when he brought her back in to talk to her on 05/24/2022, she did not think she had done anything wrong. The NA was terminated on 05/27/2022 over the incident involving Resident #1. The NA was a certified nurse aid in another state. The Administrator stated they had reviewed the incident at the QAPI meeting, and had been in-servicing to reiterate two-person assistance with Hoyer lifts. He also stated that PT had conducted an in-service on safe transfers. Interview with the DON on 06/01/2022 revealed the NA had only been employed at the facility for about 6 weeks. The DON stated the NA was certified in another state, so she was hired at the facility as a nurse aide. The DON stated she had reports from other residents the NA could be a little rough with them. The DON stated it was ultimately the charge nurse's responsibility to make sure their staff was performing Hoyer lifts correctly. Observation made on 06/01/2022 at 2:50 p.m. of CNA A and the ADON revealed they were performing a Hoyer transfer with Resident #3 without incident. Interview with ADON on 06/01/2022 at 3:00 p.m. revealed that he thought everyone knew that there is supposed to be two staff with a Hoyer lift. All new staff are oriented and have competency checkoffs before working on the floor. He reported that since the incident they have been pounding it in to staff with in-services and competency check-offs. He is making rounds and assisting staff as needed. Interview with CNA B on 06/01/2022 at 3:08 p.m. revealed that she always has a second person with her for a Hoyer lift. Stated they had been in-serviced a lot since the incident. Interview with LVN C on 06/01/2022 at 3:15 p.m. revealed that they had been in-serviced on proper use of the Hoyer lift. Stated that she will help her staff as needed. Interview with CNA C on 06/01/2022 revealed that she always asks for help when there is a Hoyer lift transfer. She stated that if no one was available at that time, she would wait till someone could help her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Phone interview with the NA on 06/01/2022 at 5:32 p.m. revealed that on Saturday, 05/21/2022, around 11:45 a.m., she assisted another staff member with a Hoyer transfer for Resident #1 from the bed to the wheelchair without incident. The NA stated later that day when the CNA's started making their final rounds of the shift, she checked on Resident #1 around 4:30 p.m., who stated she was ready to get back into bed. The NA stated she let her know that she would be back after they completed rounds. The NA stated after about 10 minutes Resident #1's call light was on. The NA stated the resident was getting a little agitated and wanted to lie down, stating the resident told her, I want to lay down now; you can do it. The NA stated she told her to wait just a few more minutes till they finished up their rounds and she had some help. The NA stated approximately 10 minutes after that, Resident #1 turned on her call light again. The NA stated when she entered Resident #1's room, the resident said, You are going to lay me down now! The NA stated she told the resident she would get the Hoyer lift and be right back. The NA stated she asked the roommate to move to the hall, so she could get the Hoyer lift in the room. The NA stated she strapped up the Hoyer to the sling, and moved Resident #1 so she would be over the bed. The NA stated they had been having problems with the lifts stopping in the middle of the transfer, so she wanted to make sure she had the resident over the bed. The NA stated the resident likes to lay close to the wall, so she gave Resident #1 the lift control, so resident could lower herself to the bed, as she guided her into position on the bed. The NA stated following the transfer she repositioned resident with pillows and made sure she was comfortable. She stated she asked the resident if she was okay and if she needed anything. Resident #1 assured her she was okay. The NA denied the resident getting her foot caught or her complaining of pain. When asked about training, the NA stated she had not been trained on how to use the Hoyer lift at the facility. When asked if she had ever been trained or used a Hoyer lift, NA verbalized it had been about a year ago, but she was familiar with it. The NA stated when she came to work on Sunday, 05/22/2022, LVN B asked her if she laid Resident #1 down the evening before. The NA told her she had, and then LVN B told her, You broke her leg. The NA asked LVN B if she could help her understand because the resident was fine when she left her. The NA stated she was fired, and the Administrator had told her it was neglectful for performing the transfer by herself. The NA stated she did not understand because she transferred another resident, Resident #5, by herself all the time with no problem. Interview with the DON on 06/01/2022 at 5:50 p.m. revealed all new hires went through a three-day orientation. The DON stated the first day they shadowed a CNA; the second day the new hire did a little more with assistance; and the third day they are doing total care with supervision. The DON stated the orientation included competency checkoffs and included Hoyer lift transfers. The DON stated that she had two CNA's that had been with the facility for a long while and knew what to do, so she would put the new hires with them. Interview with LVN A on 06/01/2022 at 6:05 p.m. revealed that she did not work the day when the incident happened, but when she came in on Monday 05/23/2022, she had heard about the incident involving Resident #1. LVN A stated that the x-ray results had not been received yet, so she called radiology and got the report sent over. LVN A stated when the results were received reflecting a fracture, LVN A notified the physician and sent Resident #1 to the emergency department. LVN A stated Resident # 1 returned later the same day with a splint to the left lower leg. Interview with Resident #5 on 06/01/2022 at 6:10 p.m. revealed two staff members used the Hoyer lift when transferring him. Resident #5 was asked about NA performing the lift by herself and Resident #5 stated no, there was always someone else to help. Resident #5 stated the NA was the only one that could get him positioned up in his chair right with the lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with CNA A on 06/01/2022 at 6:15 p.m. revealed she had worked with the NA and verified she had been trained with the Hoyer lift. CNA stated that NA worked with another CNA for two days, and she worked with her on the third day. DON showed the schedule of the days NA trained with the two experienced CNA's. Interview with CNA D on 06/01/2022 at 6:20 p.m. revealed she had been a CNA for [AGE] years, and that she always has another staff member to help her with a Hoyer lift transfer. She stated, Will never in my life do it by myself. Interview with Resident #1 on 06/01/2022 at 6:25 p.m. revealed that she was ready to go to bed on Saturday 05/21/2022 and the NA transferred her via Hoyer lift from the wheelchair to the bed. Resident #1 stated when the NA lifted her up out of the wheelchair, her left foot got caught and she was yelling, My ankle, my ankle! Resident #1 stated the NA did not stop and just kept moving her to the bed. Resident #1 stated her ankle was okay once she was in bed, and it did not really start hurting till later that night. Resident #1 stated there should be 2 staff performing the transfer. She denied ever being transferred by one staff member prior to this incident. Resident #1 had a splint to her lower left leg. Resident #1 stated she had an upcoming doctor appointment, and did not know if she was going to have to have surgery. Interview with Resident #1's roommate, Resident #6, on 06/01/2022 at 6:30 p.m. revealed that she saw what happened regarding the NA and Resident #1. Resident #6 stated that the NA asked her to leave the room so she could get the lift into the room. Resident #6 stated there were two lifts in the room. Resident #6 reported that when Resident #1 was being lifted, she saw her foot get caught between the two main bars of both lifts, and heard Resident #1 yell out. She also stated the NA was on the phone as well. Phone interview with LVN B on 06/02/2022 at 11:00 a.m. revealed Resident #1 had no complaints of pain on Saturday 05/21/2022. LVN B stated she always rubbed cream on Resident #1's legs in the mornings, but Saturday was her shower day, so she did not put the cream on till that afternoon. LVN B stated there was no bruising or discoloration that day. LVN B stated on Sunday, 05/22/2022, she went in to Resident #1's room that morning to put cream on her legs, and as she entered the room Resident #1 was complaining of pain to her left ankle. LVN B stated when she pulled the covers back to assess the area, the resident's ankle was bruised with swelling noted. LVN B stated she asked Resident #1 what happened, and that was when she found out that NA had transferred the resident to the bed by herself and the resident's foot got caught. LVN B stated she went back to the station to make notifications to the physician and family. She stated she received orders for an x-ray. LVN B stated she did not think she had to worry about staff doing the right thing, as they were all good CNA's. LVN B stated she told her staff to notify her if they needed assistance. Record review of employee file of the NA revealed: Date of hire was 04/18/2022. Date of termination was 05/27/2022. Completed Abuse/Neglect, Preventing Slips, Trips, and Falls, Accident Prevention post tests on 04/19/2022. Employee comments from the Employee Disciplinary Report dated 05/24/2022 reflected, I told [Resident #1] that I would lay her down. I went back three different times before I finally laid her down. There was nobody to help me and I told her that. She still insisted I lay her down. I still do not understand why it took so long for her to say this happened. If it happened then why did she not say something right away. I feel like I did nothing wrong. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's Quality Assurance and Performance Improvement plan dated 05/23/2022 reflected Quality Area: Staff performing Hoyer lift without two persons assist and not following the care plan. Performance Improvement Goal: Staff will be in-serviced on Hoyer lift transfers/Staff will be retrained by therapy on proper Hoyer lift techniques/Staff will be in-serviced on neglect/Staff will have Hoyer lift competency checked off. Record review of in-services included: Safe Transfers Techniques dated 05/03/2022 and 05/23/2022 over proper transfer training provided to promote maximum safety for residents and staff. Neglect and Unknown Injury dated 03/22/2022 that included handouts on how to use the Kardex in Point Click Care. Record review of the facility's Checklist for Mechanical Lift, undated, reflected, .Step 5 Pull the Hoyer lift slowly away from the bed. With the other aide guiding the resident, move the lift to where it is needed Record review of the facility's Safe Patient Handling policy, dated 12/30/2005, reflected, The facility has a program to promote and assure safe patient handling for both the resident and the employee. The policy includes identification, assessment, and interventions to provide a comfortable safe transfer, repositioning, and resident movement