STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455959	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Trails Nursing and Rehabilitation	3001 Westward Dr Nacogdoches, TX 75964

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** Based on observations, interviews, and records review, the facility failed to ensure the resident environment was free of hazards for 1 of 4 residents reviewed for accidents. (Resident #81). The facility failed to ensure the safety and well-being of Resident #81 by not following procedures for exiting residents from the van using the wheelchair lift. The noncompliance was identified as PNC (past noncompliance). The IJ began on 05/28/2025 and ended on 05/28/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for potential accidents, injuries, harm, or death. Findings included: Record review of a face sheet on 06/23/2025 indicated Resident #81 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included end stage renal disease (final stage of chronic kidney disease and requires kidney dialysis or transplant), diabetes mellitus, heart failure, and mild cognitive impairment. Record review of an admission MDS dated [DATE] indicated Resident #81 had clear speech, usually understood others and was usually understood. She had a BIMS score of 14 indicating her cognition was intact. The MDS indicated she received dialysis treatments and was mobile via wheelchair. Record review of physician orders records dated 06/24/2025 indicated Resident #81 had a physician's order for dialysis treatments every Monday, Wednesday, and Friday at 11:30 AM at a local dialysis center. Record review of a facility reported incident dated 05/28/2025 indicated Resident #81 was transported to the dialysis center on 05/28/2028 via the facility's van. Van Driver A lowered the wheelchair lift to the ground, re-entered the van, and proceeded to back the resident in her wheelchair out the back door of the van. The lift's platform was not flush with the van's floor and both Resident #81 and Van Driver A fell to the ground landing on the lift's platform positioned on the ground. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #81's Progress Notes in the electronic record dated 05/28/2025 at 12:22 PM indicated the dialysis center notified the facility that resident had a fall out of the back of the van. Informed them our diver had notified us but we thanked them for the call. They reviewed with us what occurred and stated that Resident #81 did decline to go to the ER. Review of Resident #81's Progress Notes in the electronic record dated 05/28/2025 at 01:34 PM indicated the DON went to the dialysis center to check on the resident and noted a scratch to the left second finger and Resident #81 complained of a headache. The progress notes also indicated the dialysis center gave Resident #81 some Tylenol for the headache and offered to send Resident #81 to the ER for further evaluation and she refused. Review of Progress Notes dated 05/28/2025 at 02:09 PM indicated Resident #81, in an interview with the DON, said I really don't remember much. She got in the van, and we started backwards and I heard a click and we fell. She caught me though. I landed on her. I think my head hit her face. The note further indicated the MD, NP, and Resident #81's responsible party were notified of the incident. Further review of Progress Notes dated 05/28/2025 at 02:09 PM indicated the following: Transporter (Van Driver A) had arrived at dialysis center and parked, and got out of driver's side door and went to the back and opened the back doors and had began letting the lift down when she noticed a bag a resident had left and unknowingly let the lift all the way down to the ground. She grabbed the bag and went through the side door of the van, closed it behind her and unlatched the resident and began walking backwards with the resident in the wheelchair to load onto the lift. She did not know the lift was all the way down and both transporter and resident fell out of the transport van. Record review of Progress Notes dated 05/28/2025 at 02:23 PM indicated the DON offered to send Resident #81 to the hospital upon her return to the facility. The documentation indicated Resident #81 had a fall out of the back of the van, hit her head on Van Driver A's face, and scraped her finger and knee and was at risk for brain bleed, worsening health conditions, fractures, hospitalizations, and/or death. Resident declined to go to the hospital but agreed to having x-rays done at the facility. Record review of Van Driver A's written statement dated 05/28/2025 indicated she was letting the wheelchair lift down when she noticed a bag belonging to another resident on the ground. She said in her statement she reached for the bag and unknowingly let the lift all the way down to ground level. Her statement further indicated she walked to the front of the bus, entered the bus, and proceeded to back Resident #81 out of the bus and onto the lift. She said she did not notice the lift was not positioned flush with the van floor and stepped backwards, falling to the ground and landing on the floor of the lift. The statement further indicated Van Driver A caught Resident #81 as she fell backwards in her wheelchair and both the resident and wheelchair landed on top of the van driver. Record review of the maintenance director's inspection of the vehicle and lift dated 05/28/2025 indicated the van and lift were operating correctly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation and interview of Resident #81 on 05/23/2025 at 10:10 AM, she said she fell out of the back of the van about a week ago. She said she was sitting in her wheelchair and the driver was pulling her backwards out of the van. She said she heard something click and the next thing she knew, she and her wheelchair were falling backwards out of the van. She said she landed on top of the driver. She pointed to an area on her left second finger and said she got a scratch. There was no remaining evidence of an injury. She said she was not hurt and was not afraid to go to dialysis on the facility's van. She said the person who currently takes her to dialysis made sure the lift was in place before loading or unloading her. During observations and interviews on 06/23/2025 at 1:15 PM, the current van driver (Van Driver B) demonstrated the use of the van's wheelchair lift to load and unload a resident. Van Driver B opened the doors at the back of the bus, unlocked and lowered the lift floor, secured the safety strap at the front of the lift, and manually lowered the lift to the ground by pushing a button on the lift. The maintenance director, who was present during the demonstration, explained and demonstrated that the lift could not be lowered or raised without physically placing a finger on the button. When asked about the clicking sound Resident #81 heard, the maintenance director pointed to a metal pressure-activated sensor mat and demonstrated how when it was stepped on, a clicking sound was made, an alarm sounded, and a red flashing light was activated signaling that the lift was not flush with the van floor. The maintenance director said the lift could not have been lowered to the ground without Van Driver A manually pressing the button that lowered it. The distance from the floor of the van to the ground was 28 inches. The distance from the floor of the van to the floor of the lift at ground level was 26.5 inches. During an interview with the DON on 06/23/2025 at 10:25 AM, she said Van Driver A called the facility from the dialysis center and notified her of the incident involving the wheelchair lift and Resident #81. The DON said she went to the dialysis center and assessed the resident. She said the dialysis center had offered to send Resident #81 to the ER but she refused. The DON said she assessed Resident #81 and found no evidence of a major injury but encouraged Resident #81 to go to the ER but she refused. She said Resident #81 completed her dialysis treatment and returned to the facility where she was assessed again, neuro checks were initiated, and x-rays of Resident #81's skull, left arm, left hand, left hip, and left leg were done. She said the x-rays were negative for any injury. During an interview with the Administrator on 06/23/2025 at 11:05 AM, he said Van Driver A transported Resident #81 to the dialysis center on 05/28/2025 for the Resident's scheduled dialysis treatment at 11:30 AM. He said on 05/28/2025, Van Driver A was re-trained on neglect and the van's wheelchair lift use, screened for drug use, and suspended and sent home pending the facility's investigation of the incident and the results of the drug screen. The Administrator said the maintenance director performed a vehicle and lift inspection on 05/28/2025 and noted no issues. He said beginning 05/28/2025, the facility used city transportation for residents until they were able to train a new van driver. He said the facility immediately began abuse and neglect training of its employees after the incident. The Administrator said Van Driver A was terminated for failing to use the van's lift in a safe and accurate manner and for a negative drug screen test. He said the incident was reported to the QAPI team. A review of Resident #81's x-ray reports dated 05/28/2025 indicated she had no injuries of the skull, left arm, left hand, left hip, and left leg. A review of neuro checks completed on 05/28/2025 for Resident #81 indicated no abnormal findings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Van Driver A's personnel record indicated the following: *Van Driver A applied for employment on 01/19/2024 and began work on 01/22/2024. *The latest annual nurse aide registry check, misconduct registry check, and criminal history check were completed on 02/08/2025 with no negative findings noted. *Training on abuse and neglect were completed on hire and multiple times throughout the year. *Van Driver A was trained and checked by return demonstration on the operation of the van and lift use on 02/06/25, on 03/25/25 and on again on 05/26/25. *Van Driver A was re-trained on the operation of the van and wheelchair lift on 05/28/2025. *Van Driver A was suspended on 05/28/2025 pending the investigation of the incident and results of the drug screen performed on 05/28/2025. *Van Driver A was terminated 06/05/2025 after the facility received the failed drug screen results. Record review of drug screen results for the van driver collected on 05/28/2025 at 01:35 PM indicated Van Driver A tested positive for THC (tetrahydrocannabinol, primary psychoactive compound in marijuana). A review of the facility's Van Incident Monitoring tool indicated Van Driver B received training and was checked off by return demonstration on the use and operation of the facility van and lift on 06/13/2025. Follow-up checks by return demonstration by Van Driver b were noted completed on 06/16/2025, 06/17/2025, 06/18/2025, 06/19/2025, 06/20/2025, and 06/23/2025 with no issues noted. A review of the facility's policy on the use of the facility van and wheelchair lifts undated and titled Employee Auto Training Handbook indicated the following: Serious violations include but are not limited to: Driving under the influence of alcohol or drugs . Lift Operation Procedures and Checklist: Wheelchair lifts make it possible to load wheelchairs of all weights in and efficient and safe manner. However, lifts are potentially hazardous equipment. They must be maintained and operated properly. Considerable caution and awareness is needed when operating a lift. No one but the vehicle operator should operate the vehicle wheelchair lift. Lifts may differ slightly in structure and function, Therefore, each vehicle operator should be familiar with all the lifts likely to be used Unloading: . 3.Staff will operate lift from to up position to assure the lift is in correct position, flush with van floor and ensure front safety barrier is locked before loading the resident onto the lift . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's policy undated policy titled Transportation of a Resident indicated the following: 3. Residents must be physically assisted in and out of the vehicle by a trained employee using appropriate transfer techniques. A review of the facility's undated policy titled Employee Drug Free Workplace Policy indicated the following: It is the policy of this facility to maintain a safe, drug-free working environment through the use of education and for cause drug testing. All staff employee by the company is prohibited, during wok time, from using, distributing or being under the influence of prohibited drugs, alcohol,or abusing prescription drugs, whether on the company's premises or elsewhere. The noncompliance was identified as PNC (past noncompliance). The IJ began on 05/28/2025 and ended on 05/28/2025. The facility had corrected the noncompliance before the survey began.