

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Rosenberg Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1419 Mahlman St Rosenberg, TX 77471	

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 - Actual harm</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** 44241</p> <p>Based on observation, interview, and record review the facility failed to ensure the resident's environment remained as free as possible of accident hazards and each resident received adequate supervision to prevent accident for 1 (CR #1) of 4 residents reviewed for adequate supervision.</p> <p>The facility failed to provide adequate supervision and training of the staff when they incorrectly used Hoyer lift while transferring CR#1 from a shower chair to her bed on 05/02/2024.</p> <p>This failure placed residents living in the facility at risk of harm due to avoidable accidents by staff not properly using equipment when transferring residents from shower chair.</p> <p>Findings included:</p> <p>Record review of CR #1's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses include cerebral infarction with aphasia, contracture unspecified joint, cognitive communication deficit, Type 2 Diabetes Mellitus with Hyperglycemia.</p> <p>Review of CR #1's MDS (Minimum Data Set) dated January 24, 2024, section C revealed a BIMS (Brief Interview for Mental Status) score of 13. Section G regarding resident's Activities of Daily Living (ADL) Assistance revealed resident needs supervision and two persons assisting with bed mobility, transferring and toilet use. It also revealed resident requires, two-person assistance with dressing, and personal hygiene.</p> <p>Record review of CR #1's care plan dated 09/04/2023 revealed:</p> <p>Focus: I have an ADL Self Care Performance Deficit and is at risk for not having my needs met in a timely manner. Performance deficit is related to generalized weakness/impaired mobility.</p> <p>Goal number 1: I will maintain a sense of dignity by being clean, dry, odor free, and well groomed.</p> <p>Goal number 2: I will participate to the best of my ability and maintain current level of functioning with activities of daily living (ADL)</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Goal number 3: I will improve current level of function in bed mobility, Transfer, Dressing, Toilet use, and Personal Hygiene.</p> <p>-Interventions:</p> <ol style="list-style-type: none"> 1. Bed mobility assist 1 person. 2. Transfer per Hoyer 2 person assist. 3. Eating supervision and setup. 4. Toileting assist 1 person. <p>Record review of CR #1's progress notes dated 5/02/24 revealed LVN A recorded CR#1 was being transferred from her shower chair via Hoyer with two staff present, and CR#1 slipped out of the Hoyer and fell to the floor and sustained a laceration to her right upper eye.</p> <p>Record review of facility's grievance log from February 2024 to April 2024 revealed no concerns regarding Hoyer transfers from CR #1 or family members.</p> <p>Record review of facility maintenance director statement dated 5/02/24 revealed that the Hoyer Lift that was used during the incident with CR#1 had been repaired on 3/21/24. The repair was the replacement of the left rear caster. Therefore, the Hoyer lift was in good working order when it was used during the incident involving CR#1 on 5/02/2024.</p> <p>Record review of ADON-B's statement dated 5/03/24 revealed that she stated I ADON on 5/02/24 did apprehend the Hoyer Sling that was being used by CNA x2 during the transfer day of accident. In my professional opinion, The Hoyer Sling loops upon my inspection, did not seem to be torn or ripped. All three loops were intact, and color for each loop x3 was visible. The Hoyer Sling that was used was Large/blue.</p> <p>Record review of CNA A's statement dated 5/02/24 revealed she and CNA B were getting CR#1 out of the shower chair with the Hoyer lift and the legs of the lift were wide open and the straps were secure. CR#1 was wiggling, CNA B was on the left side, and I was moving the lift. I stopped the lift to try and catch but she fell . CNA B dropped to her knees and told me to go get help and bring her some towels.</p> <p>Record review of CNA B's statement dated 5/02/24 revealed she a CNA A went to put the resident in bed with the Hoyer lift. CR#1 was in the Hoyer lift the legs were wide open I was on the right side and CNA A was on the left side. Resident started moving CNA A asked her to stop and that when the resident fell , and I tried to catch her. I feel to my knees trying to catch the resident. I told CNA A to go get help and bring me some towels because the resident was bleeding from her head.</p> <p>Interview with CNA C on 5/03/24 at 12:30pm, she stated she does know CR#1 and that she has never had a problem with tCR#1 moving while CR#1 was being transferred. CNA C also said that even if the CR#1 was moving that CR#1 should not have fallen fall. CNA C said that CR#1 should not fallen if the Hoyer lift was being used correctly and that staff must know which Slings to use and staff must know how to secure the straps to the Hoyer lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with CNA-A on 5/03/24 at 1:25pm she stated that the none of the straps from the Hoyer lift came undone during the incident.</p> <p>Interview with CNA D on 5/03/24 at 1:34pm, she stated she does know CR#1 and that she has never had a problem with tCR#1 moving or anything of that nature when CR#1 was being transferred. CNA D went on to say that there was no reason for CR#1 to have fallen when the</p> <p>Hoyer lift was being used and that the only way CR#1 would have fallen was if the Hoyer Slings are not secured properly to the Hoyer lift.</p> <p>Interview with ADON A on 5/03/24 at 2:02pm, he stated that safety was the most important reason why the Hoyer lift was used when transferring a resident. He stated that the Hoyer lift was designed to prevent injury to residents and staff when the resident must be transferred and that the only way that a resident should fall out of a Hoyer was if there was a malfunction with the lift or sling, but if there isn't a malfunction the resident should not fall.</p> <p>Interview with ADON B on 5/03/24 at 2:21pm, she stated that there was nothing wrong with Sling during here preliminary investigation of CR#1 falling out of a Hoyer lift The sling did not have any rips, or tears. She stated the Hoyer lift itself was working properly. She stated that the Sling had multiple colors to show staff how to secure the sling to the Hoyer lift. She stated that it was extremely difficult for a resident to fall out of a Hoyer lift.</p> <p>Interview with Administrator on 5/03/24 at 2:42pm, she stated that to my knowledge it is impossible for a resident to fall out of a Hoyer lift if it is working properly. She stated that if the Sling is secured properly and that the Hoyer Lift itself is not malfunctioning the resident should not fall. She went on to state that the Hoyer Lift was designed for the safety of the resident and staff.</p> <p>Interview with Resident#1 on 5/07/24 at 10:20 am, she stated that she does not remember what happened the day of her accident. She stated that she does not remember falling. She stated that she remembers being in the Hospital and that she had a cut on her eye and that her head hurts sometimes.</p> <p>Observation on 5/07/24 at 11:50am, CNA D and CNA B performed a Hoyer lift transfer from bed to wheelchair. The CNA s performed the transfer without any problems. They explained to Resident#1 hat they were going to do, provided privacy for the resident, secured the Sling to the Hoyer lift, and placed the resident into a wheelchair.</p> <p>Record review of facility's Mechanical Lift policy dated February 2022 revealed the guideline on facility response to moving obese or immobile residents:</p> <ol style="list-style-type: none"> 1. Verify Physician orders. 2. Introduce self, explain procedure, and provide privacy. 3. Raise bed to highest point possible making sure wheels are locked. 4. Second employee to assist by standing on the opposite side of bed and roll resident toward second employee. <p>(continued on next page)</p>		

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