

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/07/2024
NAME OF PROVIDER OR SUPPLIER Yorktown Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 670 W Fourth St Yorktown, TX 78164	

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** 26481</p> <p>Based on interviews, observation, and record reviews the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 3 residents reviewed for accidents.</p> <p>The facility failed to ensure Resident #1 received 2-person assistance when CNA A transferred the resident from the wheelchair to the bed independently with a mechanical lift with the wrong sized sling.</p> <p>This failure could place residents at risk of injuries, falls, and a decline in quality of life.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 08/25/2024 and ended on 08/27/2024. The facility had corrected the noncompliance before the survey began.</p> <p>The findings included:</p> <p>Record review of Resident #1's Transfer/Discharge Report (face sheet) dated 09/06/2024 revealed she was admitted to the facility on [DATE] and Family Member F was the Responsible Party.</p> <p>Record review of Resident #1's Physician History & Physical, dated 05/27/2024 revealed diagnoses of osteoporosis (deterioration of the bone which causes an increased risk for fractures), high blood pressure, dementia (decline of cognitive abilities that affects an individual's ability to perform everyday tasks), and congestive heart failure (failure of the heart to adequately pump blood resulting in fluid building up around the heart).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE], revealed her cognitive skills for daily decision making were severely impaired, and she was dependent on staff for chair/bed-to-chair transfers.</p> <p>Record review of Resident #1's Care Plan for the focus area of ADL's, revealed under interventions was Transfers = total lift with medium pad [sling] with help of 2 aides, initiated on 04/19/2023.</p> <p>Record review of Resident #1's Care Plan for the focus area of Transfers, revealed under interventions was Total lift Medium (Yellow) Sling, initiated on 05/26/2023.</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>Record review of Resident #1's Care Plan for the focus area of Falls, revealed under interventions was use Mechanical lift with medium pad [sling] with 2 aides, initiated 05/30/2023.</p> <p>Record review of Resident #1's Physician Order summary Report, dated 08/27/2024, revealed Resident #1 was admitted to Hospice B on 05/12/2023.</p> <p>Record review of Resident #1's Lift Transfer Evaluation, dated 05/26/2024, revealed a total mechanical lift was required with use of a medium (yellow) sling and required 2 team members.</p> <p>Record review of Resident #1's Lift Transfer Evaluation, dated 08/26/2024, revealed a total mechanical lift was require with use of a medium (yellow) sling and required 2 team members.</p> <p>Record review of Resident #1's Nurse's Notes, dated 08/25/2024 at 19:10 (7:10 PM) by LVN D revealed I was called to resident's room by other nurse where I observed resident lying on the floor on her right side (sic) CNA was holding her head up off of the foot of the mechanical lift. Side of her head, right temporal area was bleeding. Resident was unable to say what had happened. CNA reported that resident was up in the mechanical lift .and resident fell hitting her head. RN E was notified at 7:21 PM. I called Hospice Nurse .at 7:33. Hospice Nurse would come to assess resident and call MD with her findings. [Hospice Nurse] Asked me to please call the family and after her assessment she would also call and report to family. At 7:43 PM and 7:55 PM I called and left message for Family Member F to please return my call. Family Member F called [back] approx. [approximately] 8:30 [PM] and I reported what had happened. Instructed that hospice nurse would be calling with her findings.</p> <p>Record review of Resident #1's Nurse's Notes, dated 08/25/2024 at 22:00 (10:00 PM) by LVN D revealed Resident #1 was transferred to Hospital G's ER.</p> <p>Record review of Resident #1's Nurse's Notes, dated 08/26/2024 at 04:45 (4:45 AM) by LVN D revealed Resident #1 returned from Hospital G, RN E was notified.</p> <p>Record review of Resident #1's Hospital G's ER report, dated 08/25/2024, revealed the resident was diagnosed with a zygomatic fracture (break in the cheek bone).</p> <p>Record review of Resident #1's Nurse's Notes, dated 08/26/2024 at 04:46 (4:46 AM) by LVN D revealed Resident #1 returned from Hospital G . in stable condition. Imaging shows fracture to right cheek area, . Resident received sutures to laceration to right temporal region . Called and reported to RN E on call.</p> <p>Record review of Resident #1's Nurse's Notes, dated 08/26/2024 by LVN C revealed Resident on f/u [follow-up] for fall. Nuero [sic] checks are continued. Resident has sutures to below right eye. No drainage noted from sutures. No nonverbal signs/symptoms of pain observed. Asked resident if she were in pain and she shook her head no.</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>Record review of Resident #1's Fall Incident Report, dated 08/25/2024, revealed LVN D was called into the resident's room by another nurse, observed Resident lying on the floor on her right side. The CNA was holding her head up off the foot of the mechanical lift, the right side of Resident #1's head was bleeding. CNA reported the resident was up in the mechanical lift over her bed, and the resident fell to the floor hitting her head. Resident was assessed on the floor, vital signs were within normal limits, and neuro checks were within normal limits. The mechanical lift was used to safely place the resident back in bed. The open area to the right temple was cleaned with normal saline and gauze. An ice pack was placed to the side of her face to help with any swelling that may occur. RN E was called at 7:21 PM and informed of the resident's status. Then the hospice nurse was called at 7:33 PM. Resident #1's Family Member F was called at 7:43 PM.</p> <p>Record review of Resident #1's Rehabilitation Fall Screen, dated 08/26/2024, revealed resident had a fall on 08/25/2024, [the] resident fell out of mechanical lift with CNA.</p> <p>Record review of the facility's Provider Investigation Report, for intake #527624, dated 08/29/2024, revealed on 08/25/2024 at 7:09 PM, when CNA A was transferred the resident with the mechanical lift, the resident's bottom bumped the bed, caused the lift to jolt during the transfer, and caused the resident to transfer to the floor. The CNA was suspended during the investigation. All CNAs and nurses were retrained regarding safe transfers and competencies were completed. Lift/transfer evaluations were completed on all residents. A QAPI meeting was held with staff and the medical director.</p> <p>Observation on 09/06/2024 at 11:51 a.m. revealed Resident #1 was sitting in a specialized wheelchair with both of her legs elevated with pillows under her feet in the dining room. Resident #1 had a wound on her right cheek with no signs of bruising to the cheek and there were no sutures in the wound.</p> <p>In an interview on 09/06/2024 from 3:06 PM to 3:25 PM, CNA A stated on 08/25/2024 she was transferring Resident #1 from her wheelchair to the bed by herself with the mechanical lift, used the sling that was under the resident [a large sling instead of a medium size sling], and connected the sling correctly to the lift. CNA A said when she moved Resident #1 from her wheelchair over to the bed, the bed was too high. This caused Resident #1 to bump into it, caused the lift bar to tilt, and Resident #1 slid out of the sling and hit her head when she went down. The CNA said the resident's feet were still in the sling and all the sling loops were connected to the lift bar. The CNA stated she unfastened half of the sling loops after the resident was on the floor and was doing this transfer by myself. CNA A said she called the nurses to come help her and they assisted the CNA with putting the resident back into her bed with the mechanical lift. CNA A said she was the only aide on the floor so she transferred Resident #1 by herself, and she should have asked the nurse to help her. CNA A stated it was recommended to transfer Resident #1 with the mechanical lift using the yellow sling and 2 staff members. CNA A said she could look in the Kardex system or ask the nurse to determine how a resident was transferred and what size of sling was to be used. CNA A said the harm that could result by transferring a resident with a mechanical lift by 1 person was it could cause the resident to slip or fall and hit their head. CNA A stated she had training prior to the incident on how to use the lift. After the incident, she and all the other CNAs were trained on the use of the mechanical lifts with a return practice demonstration.</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>In an interview on 09/06/2024 from 5:46 PM to 6:06 PM, LVN L stated she was in a resident's room when she heard CNA A yell for LVN D. LVN L stated she entered Resident #1's room, found the resident still connected to the lift with 1 side of the sling connected, the resident was all the way down on the floor and her head must have hit the floor or the base of the lift because there was blood on the floor and base of the lift. LVN L said she put a washcloth to the laceration to stop the bleeding and had CNA A hold the washcloth while she got LVN D to assist. LVN L said she did a head-to-toe assessment the best that she could when the resident was on the floor, LVN D, LVN L and CNA A lifted Resident #1 back into her bed with the mechanical lift to further assess the resident. LVN L stated she monitored Resident #1 while LVN D called hospice, the on-call RN and the family. Then LVN D came back into the room and informed LVN L she could leave the room and go back to her duties. LVN L stated CNA A was usually good at waiting for another staff member or nurse to assist her with the transfer and LVN L did not know why CNA A did not seek assistance that day. LVN L stated the harm that could result if a resident was transferred with a mechanical lift by 1 person instead of 2 as required could result in a lot of things, fall, fractures, skin tears, it would depend on the resident.</p> <p>In an interview on 09/06/2024 from 6:07 PM to 6:15 PM, LVN D stated she was in a resident's room and as she came out of the resident's room, LVN L told her they had a fall. When LVN D entered Resident #1's room, CNA A was holding the resident's head off the base of the mechanical lift and had a laceration to her head. LVN D said she tried to assess the resident who was on her right side before they lifted the resident with the mechanical lift and placed her in the bed for a further in-depth assessment. LVN D said she called the on-call nurse RN E who informed her to contact hospice. LVN D called Hospice Nurse N who told her she would come to the facility to assess the resident, she would call the hospice MD after she had assessed the resident, and asked LVN D to contact Resident #1's family. Hospice Nurse N would later contact the family after Resident #1 was assessed by Hospice Nurse N. LVN D stated she called Resident #1's Family Member F twice leaving a message both times. LVN D said she checked Resident #1's vital signs every 15 minutes which were within normal limits. LVN D stated the harm of 1 staff member transferring a resident with a mechanical lift instead of 2 could result in the resident falling, or their legs could hit the lift bar.</p> <p>In an interview on 09/07/2024 from 10:28 AM to 10:43 AM, RN E stated she was the on-call nurse on 08/25/2024 and received a call from LVN D who informed her CNA A had transferred Resident #1 and the resident had fallen during the transfer. RN E advised LVN D to assess Resident #1 and to contact hospice. RN E said she wanted to see the resident herself so when she arrived at the facility, Hospice Nurse N was in the facility evaluating the resident who had a laceration to her right cheek. RN E stated Hospice Nurse N contacted the hospice physician and the decision was made to send the resident to the hospital for evaluation. RN E stated the harm of 1 staff member transferring a resident with a mechanical lift instead of 2 could result in numerous things that could happen to the resident.</p> <p>In an interview on 09/07/2024 at 10:57 AM, Hospice Nurse LVN N stated she was not available at this time, but she would call the state surveyor back at the phone number provided. No return call was provided by Hospice Nurse LVN N before the state surveyor exited the facility.</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>In an interview on 09/06/2024 at 4:27 PM the Interim DON stated the facility's investigation of the incident with Resident #1 revealed the lift sling under Resident #1 was a large size (blue) sling instead of the medium size (yellow) sling that was needed to transfer Resident #1. It caused the resident to slide out of the sling when the resident's bottom hit the bed as CNA A transferred the resident from the wheelchair to the bed by herself. The Interim DON stated after the incident, the Maintenance Director looked at the lift to make sure it was operating correctly, all the slings were checked to make sure they were not torn, and nursing staff were in-serviced on the size of slings to use. The Interim DON stated if a resident required 2 staff to transfer and there was only 1 CNA in the building, the CNA should ask the nurse to assist them with the transfer.</p> <p>In an interview on 09/06/2024 at 4:16 PM, the Interim DON stated a POC was initiated for the lift incident with Resident #1 and handed the state surveyor a blue binder with the facility's POC. The Interim DON stated the nursing staff were instructed on using the right colored lift sling, received a competency checkoff on how to use the mechanical lift, all residents who required transfer assistance had Lift Transfer Evaluations, residents who were transferred with mechanical lift had their care plans updated, and a sheet was created for the nursing staff with how the resident was to be transferred, what sling size to use, and was placed at the nurse's station.</p> <p>In a further interview on 09/07/2024 from 1:58 PM to 2:21 PM, the Interim DON stated inside the blue POC binder, the first sheet was a QAPI form provided by corporate which she and RN E completed to develop a plan and to start assessing other residents as soon as possible. The Interim DON said an ad hoc QAPI meeting was held with the medical director via phone and their signatures were on the back side of the QAPI form. The Interim DON stated the second tab in the blue POC binder had Resident #1's hospital record and facility record which included the neuro check sheet, Kardex printout, and her care plan for transfers. The Interim DON stated the third tab in the blue POC binder had the Lifter Sheet that was created and kept at the nurse's station for staff to access, all the Lift/Transfer Evaluations that were done on all the residents in the facility, and a list of residents who were going to be evaluated by OT. The Interim DON said the fourth tab in the blue POC binder had the Lift/Transfer Evaluations for the 2 residents who were admitted after 08/26/2024. The Interim DON stated the fifth tab had the in-service sign-in sheets for the Abuse and Neglect in-service. The Interim DON said all the skills checkoffs for the nurses and the CNAs use of the mechanical lift were in a yellow binder.</p> <p>Record review of the documents in the blue POC binder revealed there was a QAPI Identification Tool, a tab labeled Resident Actions, a tab labeled Identification of Others, a tab labeled New Admit Lift Audits and an unlabeled tab that had an email from the Interim DON to corporate and a sling audit tool.</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>Record review of the undated QAPI Identification Tool in the facility's POC blue binder, revealed immediate actions taken for the resident identified revealed Resident #1 was taken to the ER for an evaluation and returned to the facility with sutures to a laceration on her head and a zygomatic fracture to her cheekbone. The lift and sling were taken out of service, the resident's care plan/Kardex was reviewed for appropriate lift and sling. The CNA A was in-serviced on 08/26/2024 on the use of the sling with return demonstration. Immediate actions that were taken to identify all residents potentially affected included conducting lift/transfer assessments on all current residents; residents care plans were updated as needed, all slings were assessed for any disrepair, and lift competencies were done with all nursing staff. System changes that were made or modified included in-service to 100% of the nursing staff on the lift/transfer program with return demonstration. Lift evaluations would be completed on all new admissions. The DON was to review the completed daily clinical meeting lift assessments, and the DON would do audits of lift assessments twice a week for 8 weeks then biweekly for 2 months. An Ad Hoc QAPI meeting was held with the Medical Director regarding the POC on 8/27/24 and results of the monitoring audits would be presented at QAPI for the next three months. The QAPI Identification Tool sheet was signed by the Administrator, Interim DON, and Medical Director.</p> <p>Record review of the documents under the first tab titled Resident Actions in the facility's POC blue binder, revealed Resident #1's ER hospital record for 8/25/24, the Neurological Evaluation Flow Sheet that was started 8/25/24 at 7:20 PM, and her Kardex which indicated the resident required to be transferred by 2 aides with a mechanical lift and a yellow sling. Resident #1's care plan for Transfers was included and she required a mechanical lift with a yellow sling for transfers.</p> <p>Record review of the documents under the second tab titled Identification of Others in the facility's POC blue binder, revealed the first sheet showed 11 residents listed who were transferred with a mechanical lift, and listed the color of sling used for the transfer. The second sheet was a Care Plan Item/Task Listing report for the 11 residents who required a mechanical lift transfer. Copies of the Lift Transfer Evaluations, dated 8/26/24 for all the residents who were in the facility on that day and 9/3/24 for the residents admitted after 8/26/24 were included along with a list of residents who were identified to be evaluated and treated by OT.</p> <p>Record review of the documents under the third tab titled Competencies in the facility's POC blue binder, revealed all 32 employees had been in-serviced on Abuse and Neglect.</p> <p>Record review of the documents under the fourth tab titled New Admit Lift Audits in the facility's POC blue binder, revealed Lift Transfer Evaluations were done on 2 newly admitted residents.</p> <p>Record review of the documents under the fifth untitled tab in the facility's POC blue binder, revealed a weekly sling inventory audit tool.</p> <p>Record review of the facility's Yellow Binder revealed the following:</p> <p>1. Record review of Team Member Acknowledgment of the Facility's Lift Program Policy and Procedures sign-off sheet revealed This program has been implemented in an effort to provide a safe environment for the patients/residents in our care, and our team members. Our patients/residents will be evaluated upon admission to determine what type of assistive transfer equipment, if any, is needed based on the assessment criteria .failure to follow the lift program .may result in termination.</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>2. Record review of the Team Member Acknowledgement of the Facility's Lift Program Policy and Procedures sign-off sheets revealed 25 nursing staff (11 CNAs and 14 nurses) had signed the acknowledgement form on 08/26/2024 and on 08/27/2024.</p> <p>3. Record review of the Mechanical Lift Skills Checklist revealed 25 nursing staff (11 CNAs and 14 nurses) had completed the skills checklist on 08/26/2024.</p> <p>4. Record review of the Mechanical Lift Skills Checklist revealed CNA A had completed the skills checklist on 05/29/2024 and on 06/20/2024 in addition to training on 08/26/2024.</p> <p>5. Record review of an Inservice Training Report Sign-In sheet, dated 08/25/2024, revealed 25 nursing staff (11 CNAs and 14 nurses) were trained on how to use the mechanical lift, falls prevention, and provided guidance/education with assisting residents to safely reposition or transfer the resident. CNA A had signed the in-service training sheet.</p> <p>Record review of an untitled, undated sheet with employee names and titles revealed the facility had 11 CNAs and 14 nurses (25 total nursing staff) and total of 32 employees.</p> <p>In an interview on 09/06/2024 at 1:06 PM, CNA H and CNA I stated a paper was kept at the nurse's station with information on what type of lift was required to transfer a resident and the size of the sling.</p> <p>Record review of the undated Lifter List kept in a binder at the nurse's station revealed the resident's name, type of lift required (if mechanical lift), and the lift sling size required. The sheet indicated Resident #1 required a mechanical lift with a medium (yellow) sized sling.</p> <p>In an interview on 09/06/2024 at 3:43 PM, LVN J stated she worked from 6 AM to 6 PM and recently received several trainings on how to use the mechanical lift which included skills check off and to use the correct color/size of lift sling.</p> <p>In a further interview on 09/06/2024 at 3:50 PM, CNA I stated she worked from 6 AM to 6 PM she had recently been trained on how to use the mechanical lift which included skills check off and to make sure the correct size of lift sling was used for the resident being transferred.</p> <p>In an interview on 09/06/2024 at 4:36 PM, LVN K stated she worked from 6 AM to 6 PM and she recently received several trainings on how to use the mechanical lift which included skills check off and to use the correct color/size of lift sling.</p> <p>In an interview on 09/06/2024 at 4:42 PM, the Maintenance Director stated after the incident he checked the lift to make sure it was functioning correctly and found no problems with the lift and the lift slings were checked to make sure they were not torn.</p> <p>In an interview on 09/06/2024 from 5:46 PM to 6:06 PM, LVN L stated she worked from 6 PM to 6 AM and recently received several trainings on how to use the mechanical lift which included skills check off and to use the correct color/size of lift sling.</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>In an interview on 09/06/2024 from 6:07 PM to 6:15 PM, LVN D stated she worked from 6 PM to 6 AM and recently received several trainings on how to use the mechanical lift which included skills check off and to use the correct color/size of lift sling.</p> <p>In an interview on 09/06/2024 from 6:36 PM to 6:43 PM, CNA M stated she worked from 6 PM to 6 AM and recently received several trainings on how to use the mechanical lift which included skills check off and to use the correct color/size of lift sling.</p> <p>In a further interview on 09/07/2024 from 1:58 PM to 2:21 PM, the Interim DON stated the harm of 1 staff member transferring a resident with a mechanical lift instead of 2 could result in bruises, skin tears, fractures, or other injuries to the resident. The Interim DON said CNA A told her the other CNA who was scheduled to work was running late and CNA A did not ask for help from the nurses when she transferred Resident #1.</p> <p>In an interview on 09/07/2024 from 2:37 PM to 2:48 PM, the Administrator stated the harm that could happen to a resident if they had 1 person transferred the resident with a mechanical lift instead of the required 2 persons, could result in the resident sliding out of the sling. The Administrator said he thought CNA A thought she was capable of transferring Resident #1 by herself. The Administrator stated after the incident with Resident #1, the lift was taken out of service until it was evaluated and determined it was safe. The residents' care plans were reviewed, all CNAs and nurses were trained on how to do a mechanical lift, therapy evaluated residents, all slings were inspected, and none were found to be defective, and all residents had a Lift/Transfer Assessment completed. The Administrator said the medical records employee made sure the Lift/Transfer Assessment would popup to be completed in the electronic clinical record for new residents as part of their admission assessment. The Administrator stated monitoring would be done at the daily meetings by reviewing the Lift Assessments and completed audits would be presented at the QAPI meetings for the next three months.</p> <p>Record review of the Lift 4 care - Safe 4 All lifting policy, dated February 2023, revealed the purpose was To provide team members guidance with assisting residents to safely reposition or transfer .7. In order to maintain resident's' safety, residents should be lifted or transferred by the lift and sling which is deemed appropriate after the lift evaluation is completed, there should be no interchanging of lifts and slings.</p>		