

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Hallettsville Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 825 W Fairwinds Hallettsville, TX 77964	

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** 48753</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents reviewed for accidents (Resident #1).</p> <p>CNA A failed to use a gait belt while performing a sliding board transfer for Resident #1 resulting in Resident #1 being improperly lowered to the ground and receiving a fracture of the proximal tibia and fibula (a fracture or break in the shinbone just below the knee).</p> <p>This deficient practice could affect residents at the facility who required a gait belt while receiving sliding board transfers by contributing to injury.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet revealed Resident #1 was an [AGE] year-old female who admitted to the facility on [DATE] and had diagnoses of anxiety, type 2 diabetes mellitus, depression, chronic kidney disease and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease).</p> <p>Record review of Resident #1's quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS of 11, indicating mild cognitive impairment. The MDS revealed Resident #1 had impairment on one side of the lower extremity (hip, knee, ankle, foot) and used a wheelchair for mobility. In addition, the MDS revealed Resident #1 required substantial assistance with bed to chair transfers.</p> <p>Record review of Resident #1's care plan, dated 07/20/2023, revised 06/24/2024, revealed Resident #1 was a fall risk and Resident #1 required assistance with ADL self-care performance related to paralysis from the waist down.</p> <p>Record review of Resident #1's fall risk evaluation, dated 05/13/2024, revealed Resident #1 was categorized as low fall risk and revealed Resident #1 had a balance problem while standing/walking.</p> <p>Record review of Resident #1's fall risk evaluation, dated 06/24/2024, revealed Resident #1 was categorized as high fall risk and revealed Resident #1 had 1-2 falls in the past 3 months.</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 incident report completed by LVN B, dated 06/24/2024, revealed LVN B was notified of a witnessed fall by CNA A on 06/24/2024 around 2:30p.m. The incident report revealed LVN B entered Resident #1's room and observed the resident lying on her back on the floor with her feet under the bed and the wheelchair brakes locked, room well-lit and uncluttered. The report revealed CNA A stated resident pushed hard against the wheelchair and caused the wheelchair to move away from the sliding board. She started to lean so I lowered her to the floor. The report said Resident #1 was hollering call the EMS and complained of pain to lower back and hips bilaterally. The incident report revealed 911, Resident#1's physician and Resident #1's responsible party were notified.</p> <p>Record review of Resident #1's hospital diagnostic results revealed an x-ray was completed of the right knee, 06/24/2024 at 5:27pm. The results of the x-ray revealed a subtle fracture proximal tibia and fibula.</p> <p>Record review of hospital physician progress note, dated 06/25/2024 at 11:28am, stated patient was evaluated by ortho and it is recommended to remain non weight bearing to her right LE and wear a knee immobilizer for 6 weeks. Xrays are to be repeated at 6 weeks to verify healing.</p> <p>Record review of facility investigation document, undated, provided by the Administrator, revealed under the investigation/conclusion summary, CNA A also mentioned that the resident was beginning to fall forward and turned the resident around so that she could assist her to the floor on her buttocks. The resident's legs were twisted upon her being turned around and this potentially caused the fractures.</p> <p>During an interview with Resident #1's family member, 06/26/2024, the family member stated she was notified on 06/24/2024 that Resident #1 was lowered to the ground during a sliding board transfer, was complaining of pain and was being sent to the hospital. She said she was notified by the hospital on 06/26/24 that Resident #1 sustained fractures to Resident #1's tibia and fibula. Resident #1's family member stated she was aware that Resident #1 was using a sliding board for transfers and said Resident #1 told her the wheelchair was not locked and it moved away from the sliding board.</p> <p>Record review of a handwritten statement signed by CNA A, dated 06/24/2024, stated while setting up for the slide board transfer, check points were made to ensure the safety of the resident and employee. The wheelchair in use was locked and placed directly next to the bed, and the proper clothing and tennis shoes were being worn by both the employee and resident. After the sliding board was properly placed under the resident, they attempted to place more of their body on the board and grabbed the arm of the wheelchair for assistance and stability. This caused an imbalance leading to the resident pushing the wheelchair away from the bed. Resident started to slide down slowly; employee the lowered resident to the floor; landing them softy on their back.</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>During an interview on 06/27/2024 at 12:10p.m., CNA A stated she received training from another CNA on using the sliding board for transfers for Resident #1 to and from the bed to the wheelchair. CNA A said on 6/24/2024, she set up the sliding board between the wheelchair and the bed and locked the wheelchair brakes. CNA A said Resident #1 was sitting on the board and CNA A bent down to move Resident #1's feet so she could slide down the board onto the wheelchair. CNA A said Resident #1 became anxious and pushed on the wheelchair causing it to move and Resident #1 begun falling forward. CNA A said she was trying to prevent Resident #1 from falling on her face so, in a quick reaction, turned Resident #1's upper torso thinking she would be able to sit her down on her buttocks. CNA A said Resident #1's legs got tangled up under the wheelchair because Resident #1 was unable to move her legs. CNA A said she realized, after the fact, that she should not have tried to turn Resident #1 while lowering her to the floor. CNA A was asked if she was using a gait belt for the transfer and she said, I'm not going to lie, no I didn't. CNA A said she was trained to use a gait belt during orientation and was aware that the facility required all staff to use a gait belt during resident transfers.</p> <p>During an interview on 06/27/2024 at 12:42p.m., LVN B said on 06/26/2024, she was returning from break and CNA A called her and told her Resident #1 had a fall and was on the ground in her room. LVN B said when she entered the room, Resident #1 was lying on the ground on her back, the wheelchair was next to the bed, and she observed the wheelchair wheels in the locked position. LVN B said Resident #1 was complaining of pain in her lower back and hips, so LVN B reported it to the physician and called 911. LVN B said she called and notified Resident #1's family member of the fall and pending transport to the hospital. LVN B said CNA A told her that CNA A was using the sliding board and Resident #1 had her hand on the wheelchair and Resident #1 pushed on it and it caused her to launch forward and fall.</p> <p>During an interview on 06/27/2024 at 1:49p.m., the PT stated Resident #1 was on therapy services in March 2024, April 2024 and again on 06/17/2024. The PT stated Resident #1 was able to safely perform a sliding board transfer with one person assist. The PT stated Resident #1 was taught to use the sliding board transfer with one person when she was on therapy services from 03/16/24 through 05/15/2024. The PT stated therapy provided training to staff on using the sliding board transfer. The PT stated she would not have turned Resident #1 while lowering her to the ground and would have tried to counter the motion of Resident #1 falling forward and would lower her to the ground in the direction Resident #1 was falling.</p> <p>During an interview with the DON, 06/27/2024 at 2:35p.m., the DON stated Resident #1 was a one person transfer with a sliding board. The DON stated CNA A received training on using a gait belt during orientation and completed competency skills check on completing transfers with a gait belt. The DON stated the expectation was all transfers are completed with the use of a gait belt. The DON said residents are at risk for injuries if staff do not use a gait belt and stated, if the CNA was wearing her gait belt, it would have been easier for her to lower Resident #1 to the ground. The DON also stated CNA A should not have twisted Resident #1 around when she was lowering her to the floor. The DON said, the proper way to lower a person to the ground includes a gait belt and lowering the person down in the direction they are falling. The DON stated no other residents in the facility use a sliding board as a device for transfers.</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>During an interview with the Administrator and DON, 06/28/2024 at 9:18a.m., the DON stated the facility-initiated in-services on fall prevention and completed return demonstration with direct care staff regarding the use of gait belts for transfers and how to properly lower residents to the floor during an assisted fall. The Administrator and DON stated no direct care employees would work the floor until they had received the training and performed return demonstration.</p> <p>Record review of facility document titled, One on One Inservice and dated 06/25/2024, revealed sliding board reenactment, sliding board reeducation with return demonstration with therapy. The return demonstration outcome stated, staff member able to properly demonstrate sliding board transfer. The document was signed by CNA A, DON, and PTA.</p> <p>Record review of facility document revealed CNA A completed an online training certificate of completion for a course titled, Falls, Assessment and Prevention, completed on 05/06/2024.</p> <p>Record review of facility document titled, C.N.A. Competency Skills Check List, revealed CNA A received a competency check off on transfer (gait belt use) on 05/08/2024.</p> <p>Record review of a document titled, Inservice Training Report, dated 06/25/2024, revealed staff received education on fall management and abuse and neglect and was signed by 28 employees.</p> <p>Record review of a document titled, Inservice Training Report, dated 06/27/2024, stated the summary of the training was resident safety during transfers and properly lowering a resident to the floor and resident safety during transfers utilizing a gait belt. The undated or titled document attached to the in-service training listed the steps for lowering a patient to the floor as 1. If a patient starts to fall and you are close by, move behind the patient and take one step back. Look and be attentive to cues if a patient is feeling dizzy or weak. 2. Support the patient around the waist or hip area or grab the gait belt. Bend your leg and place it in between the patient's legs. Hand placement allows for a solid grip on the patient to guide the fall. 3. Slowly slide the patient down your leg, lowering yourself at the same time. Always protect the headfirst. Lowering yourself with the patient prevents back injury and allows you to protect the patient's head from hitting the floor or hard objects. 4. Once the patient is on the floor, assess the patient for injuries prior to moving. Assesses patient's ability, or need for additional help, to get off the floor. 5. Provide reassurance and seek assistance if required. If required, stay with the patient, and call out for help. The in-service was signed by 52 employees.</p> <p>Record review of a document labeled, direct care staff and undated, had 53 employee names listed.</p>		