STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675462	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interview and record review, the facility failed to ensure to address, resolve and have a prompt resolution of all grievances in accordance with facility policy for 1 of 9 (Resident #4) residents, in that: The facility failed to ensure that Resident #4's grievance from February 2024-April 2024 was investigated and that the decisions included the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed, any corrective action or to be taken by the facility as a result of the grievance, and the date when the decision was issued for Resident #4's grievances regarding specifically CNA D not offering hydration, leaving Resident #4 hall unattended, using the wrong lifting technique on Resident #4 roommate and changing Resident #4 preferential shower time. This failure had the potential to cause residents feelings of helplessness, diminished quality of life and at risk for grievances not being addressed or resolved promptly. Findings included: Record review of Resident #4's face sheet, undated, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnosis to include major depressive disorder (constant feeling of sadness) and anxiety (increased worry). Record review of Resident #4's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 15, which indicated the resident's cognition was cognitively intact. Section I revealed Resident #4 had the following active diagnosis: depression (constant feeling of sadness). Review of a Screenshot of Resident #4's text message sent to HHSC 04/15/24 at 1:16 PM revealed that Resident #4 had texted the ADM about Resident #4 hall being left unattended by CNA D, CNA D not using the proper lift on Resident #4's roommate, and CNA D not allowing Resident #4 to switch Resident #4's shower time. Resident #4 stated in the text messages that staff makes it hard living at the facility, and they (staff) suck the joy and pleasure out of life. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's grievance log dated 01/13/24-04/13/24 did not reveal any concerns from Resident #4. An interview on 04/15/24 at 12:56 PM Resident #4 stated Resident #4 was unsure of the exact date but about three weeks ago (March 2024) when Resident #4 came out of the restroom. Resident #4 said Resident #4's shower time was moved to the evening because it was Resident #4's preference. Resident #4 said that Resident #4 liked to feel fresh before bed. Resident #4 said CNA D told Resident #4 that this (evening showers) was not going to work. Resident #4 said that Resident #4 did not feel abused but that Resident #4 felt neglected. Resident#4 said Resident #4 had told the ADM multiple times about different things in the facility. Resident #4 said Resident #4 had texted the ADM some of Resident #4 concerns and verbally told the ADM about other concerns. Resident#4 said Resident #4 had told the ADM about staff specifically CNA D taking a smoke break every hour. Resident #4 said the staff were able to smoke more in 8 hours than they (residents) were in 24 hours. Resident#4 said the ADM was aware of Resident #4 concerns; that Resident #4's roommate was supposed to be transferred using the Hoyer lift and the staff were not transferring Resident #4 roommate that way. Resident #4 said Resident #4 had complained about CNA D leaving the hall unattended. Resident #4 said Resident #4 could defend Resident #4 and speak up for Resident #4, but Resident #4 roommate and others could not. Resident#4 said that Resident #4 had reported to the ADM about CNA D but should not have to because the other staff have heard how CNA D speaks with Resident #4 and others. Resident #4 said Resident #4 heard CNA D talk about another resident, how difficult other residents was to work with, and that the resident was a pain. Resident 4 said no one ever followed up with Resident #4 when Resident #4 made complaints. Resident #4 said Resident #4 had never received anything in writing. Resident #4 said CNA D would seem to get better but then would return to being mean. Resident #4 said Resident #4 was unaware if the ADM had talked to CNA D. Resident #4 said Resident #4 had met with the ADM and discussed some of Resident #4 concerns but was never told how Resident #4 concerns were resolved. Resident #4 said CNA D had never been moved off Resident #4's hall because CNA D did not mind letting people know that hall 300 was CNA D's hall. An interview on 04/15/24 at 1:44 PM CNA D stated that CNA D does not know much about the shower time change with Resident #4. CNA D said the change occurred when CNA D was off. CNA D said Resident #4 preferred Resident #4's shower before bed, so Resident #4 was not sweaty. CNA D said CNA D did not know the exact date of the incident but there was a day where Resident #4 became upset and did not want another staff to shower Resident #4. CNA D said that as a result, CNA D was the staff that had to shower Resident #4. CNA D said regarding providing hydration for Resident #4 CNA D was unaware of an issue because CNA D offered what Resident #4 ask for whether it was tea or water. CNA D said CNA D had not been addressed or spoken to about any incidents with Resident #4. They said the ADM did inquire about using the wrong transfer on Resident #4's roommate but that no slings were clean and that was why they did not use the Hoyer that particular time. CNA D said CNA D had been on the 300 hall for 2 years and had never received a complaint. CNA D said that CNA D had been told by other staff that Resident #4 did not like CNA D. CNA D did not specify dates or times for the incident regarding Resident #4's shower. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Parkview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3200 Parkway Big Spring, TX 79720	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview on 04/15/24 at 3:58 PM the ADM stated that the ADM did not consider any of the allegations that Resident #4 texted was abuse. The ADM said the ADM did not consider them allegations of abuse. The ADM said Resident #4 had a lot of concerns and that it was impossible to remember everything that Resident #4 said. The ADM said the ADM had offered Resident #4 to have other aides care for Resident #4, but Resident #4 refused. The ADM said Resident #4 and CNA D have a personality conflict. The ADM said Resident #4 would get upset with CNA D a lot. The ADM said Resident #4 was upset about Resident #4's shower the other night (no specific date provided) but was unsure if it involved CNA D. The ADM said Resident #4 texted the ADM so much that the ADM tried to make bullet points of Resident #4's concerns when the ADM talked to Resident #4. The ADM said the ADM had not had a chance to talk to Resident #4 about the shower incident. The ADM said the ADM expected grievances to be handled by whomever received the grievance and if it could not be managed, they would tell the charge nurse on duty. If still unresolved then facility administration should be informed. The ADM said the ADM did not do the formal grievance process because the ADM felt the ADM had a relationship with Resident #4. The ADM said the purpose of a grievance was for staff, family members, and residents to be able to express concerns and reach resolve. The ADM could not give a potential negative outcome to the residents because the ADM said it would depend on the exact scenario. The ADM said the ADM was unsure what the facility policy said about grievances. The ADM said the ADM usually does not provide closed grievances in writing because the ADM tried to be more personal. The ADM said when the ADM was told by the nurses as required then the ADM investigated and tried to resolve all concerns. The ADM said there was grievances form but the staff do not have to fill it out. The ADM said it was impossible to write all concerns down on the form. The ADM said the ADM was responsible at the end of ensuring concerns were resolved but it could involve other people for example the person who initially takes the grievance. The ADM said any grievance that gets to the ADM will be taken care of, whether big or small. The ADM said they used no scale to gauge whether a grievance was big or small. An interview on 04/16/24 at 10:23 AM the DON stated that the DON had not heard any concerns from Resident #4. The DON stated the DON had not heard any concerns about CNA D outside of CNA D being too bossy. The DON said the DON had not received any resident complaints. The DON said a grievance was a complaint or concern from a resident, family or employee. The DON said all grievances should be reported as soon as possible. The DON said they train the staff to report to a charge nurse, but as soon as the DON received a grievance, the DON obtained witness statements, interviews people, and follows up on what was reported. The DON said they ultimately end up with the ADM. A confidential interview revealed they were present when the Resident #4 shower incident occurred. They said that when Resident #4 was admitted to the facility, Resident #4 shower was in the evening but changed it to the morning for unknown reasons. The time it was changed was not specified. They said when it was changed to the evening again CNA D was upset and made a big deal about it. They said one day (date not specified) after Resident #4 was taken to the toilet CNA D pointed out that Resident #4 shower was at the same time as their break and that it was not going to work. Resident #4 said the morning shift can figure it out, and so can the evening shift. They said in response CNA D said CNA D would take CNA D break at 8 that night and told Resident #4 it was figured out. They said they reported this to the MDS Coordinator and was told that they would ensure that Resident #4 received Resident #4 shower at 8. They said they reported this incident to the ADM and was told that it would be looked into. They stated this incident may have happened a couple of weeks prior to the interview. Record review of the facility policy, Investigating Grievance/Complaints (undated), revealed: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Policy Statement: Our facility investigates all grievances and complaints filed with the facility. Policy Interpretation and Implementation Upon the receipt of a grievance and complaint report, the administrator or designee will begin an investigation into the allegations. The department director of the involved employee will be notified of the nature of the complaint and that an investigation is underway. The investigation and report will include, as each may apply: The date and time of alleged incident The circumstances surrounding the alleged incident The location of the alleged incident. The names of any witnesses and their account of the alleged incident The resident account of the alleged incident The employee's account of the alleged incident. Recommendations for corrective action If applicable, the resident, or person action on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended as soon as possible after the filing of the grievance or complaint. Record review of the facility policy, Filing Grievances/Complaints (undated), revealed: Policy Our facility assists residents, their representatives (sponsors), other family members, or resident advocates filing grievances or complaints when such request is made. It is the facilities goal to have prompt resolution of all grievances. Policy Interpretation and Implementation: Any resident, his or her representative (sponsor), family member or appointed advocate may file a grievance complaint concerning treatment, medical care behavior of other residents, staff members, theft of property, etc. without fear or reprisal in any form. Grievances may be submitted orally or in writing. Grievances may also be submitted anonymously. Written complaints or grievances should be signed by the resident or the person filing the grievance or complaint on behalf of the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Parkview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Parkway Big Spring, TX 79720	

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	If possible, the facility Grievance form should be used if filing a written grievance, but any form of written grievance will be accepted and handled in the same manner. The administrator will review the findings with the person investigating the complaint (if it is not the administrator him/herself) to determine what corrective actions, if any, need to be taken. After learning of a grievance, immediate action will be taken to prevent further potential violations of any resident right while the alleged violation is being investigated. The resident or person filing the grievance on behalf of the resident will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made by the administrator or his/her designee as soon as possible after the filing of the grievance or complaint. The resident, or person filing the grievance on behalf of the resident, has the right to obtain a written decision regarding his or her grievance. This will be requested of the administrator. All written grievances decisions will include the date the grievance was received, a summary of the resident grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident 's concern, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. Record review of the facility's Resident Rights flyer (undated) revealed: A person living in a nursing home has the same rights as any other resident of Texas and the United States under federal and state laws. These include the right to: Complain without the fear of retaliation.

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NAME OF PROVIDER OR SUPPLIER: Parkview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3200 Parkway Big Spring, TX 79720	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on, interview and record review, the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 9 residents (Residents #1) reviewed for abuse and neglect. 1.A confidential facility staff member willing and knowingly failed to report allegations of abuse regarding Resident #1 to the abuse coordinator after Resident #1 reported CNA D physically and verbally abused Resident #1 (date and time of incident was not specified). 2.The Administrator failed to reassign CNA D to duties that did not involve patient care after she was notified on 04/15/24 by the HHSC worker that CNA D was named in an allegation of abuse by resident #1. This failure could place the residents in the facility at risk of lacking timely reporting of incidents, risk of abuse, neglect, exploitation, or misappropriation of their property by staff members and contribute to further resident abuse. Findings included: Record review of Resident #1's face sheet, 4/13/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnosis to include anxiety (increased worry) and cognitive communication deficit. Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 12, which indicated the resident's cognition was moderately intact. Section I revealed Resident #1 had the following active diagnosis: Anxiety and depression (constant feeling of sadness). An interview on 04/13/24 at 1:17 PM Resident #1 stated that Resident #1 did not want to get anyone in trouble. Resident #1 said CNA D was mean to Resident #1 and would get mad if you don't do what CNA D tells you to do. Resident #1 said CNA D had hit Resident #1 on Resident #1's head with a closed fist. Resident #1 said CNA D hit Resident #1 so hard Resident #1's head fell off. Resident #1 said CNA D did not like Resident #1 and had called Resident #1 a bitch before. Resident #1 said Resident #1 would not respond to CNA D. Resident #1 told one staff before that CNA D was mean to Resident #1. Resident #1 said Resident #1 wanted CNA D to go to court and lose CNA D teaching license. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A confidential interview on date and time revealed that they knew who the abuse preventionist was. They named the administrator as the abuse preventionist. They were able to name 5 types of abuse and explained that they had been trained to report abuse if they witness or suspect abuse. They said the 2-10 pm staff talk poorly to the residents and they have heard it before. They said specifically CNA D had been named to them from Resident #1 for being mean to them. They said CNA D tone of voice upsets Resident #1 and Resident #1 gets sad. They said they have not reported it because they (facility administration) are not going to do a damn thing about it. They said everyone was aware of how CNA D was. They said they had heard CNA D call Resident #1 stupid. They said CNA D did not have a pleasing attitude with the residents. They said they were told three weeks ago by Resident #1 that CNA D was mean to Resident #1. An interview on 04/15/24 at 12:10 PM the ADM revealed that the ADM was the abuse preventionist. The ADM said the ADM expected the ADM's staff to report all suspicions and witnessed abuse. The ADM said the staff were trained to report to their charge nurse, but most staff members had the ADM's number. An interview on 04/15/24 at 1:18 PM, Resident #1 stated that if Resident #1 did not do what CNA D told Resident #1, CNA D would be mean. Resident #1 said Resident #1 was afraid of CNA D and that CNA D made Resident #1 feel like dirt. Resident #1 stated that Resident #1 no longer wanted to talk about CNA D then. An interview on 04/15/24 at 3:58 PM the ADM stated all staff had been trained what to if they witness or suspect abuse and that was to report it immediately. The ADM said the ADM was unaware of any allegations that Resident #1 had made and any allegations regarding CNA D. The ADM said the potential negative outcome was that residents could suffer from further abuse. The ADM said the system to monitor for abuse and neglect was training staff and they were supposed to report it because anyone can report allegations of abuse. The ADM said the ADM was unsure what the facility's abuse policy said specifically about reporting as the ADM had a lot of policies and would have to reference it physically. An interview on 04/16/24 at 10:23 AM the DON stated the DON had not heard any concerns about CNA D outside of CNA D being too bossy. The DON said the DON had not received any resident complaints. The DON said the DON was unaware of any concerns from Resident #1. The DON said they monitor for abuse, neglect and exploitation by conducting written in-services and staff watch a film upon hire and annually. The DON said the DON expected staff to report any allegations of abuse immediately and that if it was not reported that the person not reporting was just as guilty of placing the resident at risk for further abuse. A confidential interview revealed that Resident #1 told them that CNA D was rude and mean to Resident #1 and that Resident #1 did not like CNA D. They said they reported this to a Hispanic nurse but did not remember the nurse's name and also told an agency nurse. They said when it was an agency nurse, they acted like they did not know what to do. (continued on next page)

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Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview on 04/16/24 at 2:15 PM the ADM stated that the reason CNA D was allowed to work CNA D's entire shift even after the ADM was made aware of the allegations from Resident #1 at 11:15 AM on 04/15/24 by the HHSC worker was because the DON and the ADM visited with all residents on Hall 300 on 04/15/24 and no issues of concern was reported. ADM said they told CNA D not to be around Resident #1. The ADM said CNA D was able to provide care to the remainder of the resident's on CNA D's hall. The ADM stated that the ADM did not have CNA D come to work on 04/16/24 because the ADM needed time to review the ADM's notes. The ADM stated that it was nerve wrecking with HHSC workers in the facility and not having CNA D in the facility on 04/16/24 was one less thing for the ADM to think about. ADM stated the ADM stayed in the facility until 9:00 AM and the DON was there until 10:00 PM. The ADM stated that the ADM was unaware what the facility abuse policy specifically stated without reading the facility's policy. The ADM stated the ADM would usually suspend but this was different situation. The ADM stated that they would deal with the abuse allegation once HHSC staff left the facility. Record review of CNA D's time sheet for the period ending 04/15/24 revealed that CNA D worked from 1:45 PM until 11:15 PM on 04/15/24. Record review of the facility policy, Reporting Abuse to Facility Management (undated), revealed: Policy Statement It is a responsibility of our employees, facility consultants, attending physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse . Policy Interpretation and Implementation All personnel, residents, family members, visitors are encouraged to report incidents of residents, abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. A person shall not knowingly: Fail to report an incident of mistreatment or other offenses. Record review of the facility policy, Staff Responsible for coordinating/Implementing abuse prevention Program Policies and Procedures (undated), revealed: Policy statement The administrator assumes the responsibility for the overall coordination and implementation of our facilities prevention program policies and procedures. Policy Interpretation and Implementation The administrator has the overall responsibility for the coordination and implementation of our facilities of these provision program policies and procedures. Record review of the facility policy, Abuse Investigation (undated), revealed: Policy statement (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	All reports of resident abuse, neglect and injuries of unknown sources shall be promptly investigated by the facility management. Policy Interpretation and Implementation Employees of this facility, who have been accused of resident abuse may be assigned to another area of the facility, to nonresident care duties, or suspended from duty until the results of the investigation have been reviewed by the administrator period this will be at the discretion of the administrator or her designee. Record review of the facility policy, Protection of Residents During Abuse Investigation (undated), revealed: Policy Statement Our facility will protect residents from harm doing investigations of abuse allegations. Policy Interpretation and Implementation During an investigation, residents will be protected from the harm by the following measures: Employees accused of participating in alleged abuse could be reassigned to duties that do not involve resident contact or could be suspended without pay until the findings of the investigation have been reviewed by the administrator period this will be at the discretion of the administrator or her designee. Record review of the facility's Resident Rights flyer (undated) revealed: A person living in a nursing home has the same rights as any other resident of Texas and the United States under federal and state laws. These include the right to: Be free from abuse, neglect and exploitation.

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(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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 43344 Based on observations, interviews, and record reviews the facility failed to ensure the environment was free of accident hazards and supervision of staff for 2 out of 9 (#2 and #3) residents who required mechanical lift transfers. 1. 3 confidential interviews revealed they transferred residents alone with a mechanical lift which required 2 people for safety. 2. Resident #2 confirmed that staff (unnamed) transferred them with the mechanical lift with one staff on a regular basis. 3. Resident #3 confirmed that staff (unnamed) transferred them with the mechanical lift with one staff and that he had almost fallen out of the mechanical lift 2 months ago because the sling strap was not secured properly. 4. An observation of CNA F and G operating the Hoyer lift revealed that they did not examine the sling prior to operation nor did they lock the wheels at anytime during the duration of the transfer of Resident #3. This deficient practice could affect residents who require transfers with the mechanical lift at risk for injury or death. The findings included: Record review of Resident #2's face sheet, undated, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnosis to include Parkinson's (brain disorder that causes uncontrollable movements), seizure disorder, contractures, muscle spasms. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 15, which indicated the resident's cognition was cognitively intact. Section G revealed that Resident #2 require two + person to physically assist with transfers. Section I revealed Resident #2 active diagnoses were Parkinson's (brain disorder that causes uncontrollable movements) disease and seizure disorder. Record review of Resident #2's, care plan, undated, revealed the following: Problem onset: [DATE] Resident needs assistance with all ADL's due to muscle weakness, physical decline. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Parkview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Parkway Big Spring, TX 79720	

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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The care plan did not address use of the Hoyer lift. Record review of Resident #3's face sheet, undated, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnosis to include Parkinson's (brain disorder that causes uncontrollable movements) and anxiety (increased worry). Record review of Resident #3's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 11, which indicated the resident's cognition was moderately intact. Section G revealed that Resident #3 require two + person to physically assist with transfers. Record review of Resident #3's, care plan, undated, revealed the following: Problem onset: [DATE] Resident requires assistance with all ADL's. Resident is at risk for a decline in ADL's related to Hemiplegia (paralysis of one side of the body), repeated falls, and weakness. The care plan did not address use of the Hoyer lift. An interview on [DATE] at 2:32 PM Resident #2 stated that staff used the Hoyer to get in and out of bed, but they used one staff more often than not. He said 2 months before the interview he nearly fell out of the Hoyer lift and was horrified. He said the staff thought Resident #2 had buckled the sling correctly but was loose. Resident #2 said Resident #2 had to be lowered down immediately. Resident #2 said the staff that almost dropped him no longer worked at the facility. Resident #2 said he had not told anyone about the incident. An interview on [DATE] at 2: 35 PM Resident #3 stated that staff use the Hoyer lift when transferring Resident #3 but sometimes they don't. Resident #3 said sometimes it was one staff and sometimes it was two staff. Resident #3 could not report if it was more often that the staff used one or two staff. Resident #3 said Resident #3 did not want to name anyone because Resident #3 did not want to get anyone in trouble. Resident #3 stated Resident #3 had never reported this to anyone and never had an incident or injury to occur. A confidential interview revealed they had used the Hoyer lift with only one staff member. They said other staff at the facility also use the Hoyer lift with one staff. They said it was common for staff to use the Hoyer lift with one staff. They said there are two workers on the hall and by the time they would get down the hall, residents requiring the Hoyer such as Resident #3 would already be in bed and the other staff would not have asked for help. They said that they were aware of their work partner not using the Hoyer and transferring Resident #3 without the Hoyer and they told their work partner that they needed to use the proper transfer for Resident #3 which was the Hoyer lift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A confidential interview revealed that they use the lift alone. They said they did not have time to go and get another staff and the person they work with was worthless. They said they were supposed to use two staff, but they don't do it. They said they had been trained to use the Hoyer with 2 staff. They said at least two times (date not disclosed) while using the Hoyer lift the sling had almost come off while they were lifting the residents and they now had to look before they lift residents because there are moments when they forget to hook one of the sling loops. They said using the Hoyer lift with one staff, anything could happen with the residents as a result of using it alone. They said they knew that two staff may be faster and safer, but they do not have time to watch the resident being lifted because they all have people to get up. They said they had another staff on their hall but that they did not attempt to ask for help. An interview on [DATE] at 3:58 PM the ADM stated that they ADM was unaware that staff were using the Hoyer with one staff. The ADM said the ADM was not aware that 2 staff are necessarily needed. The ADM said that the ADM reached out to friends at other nursing facilities to see what they were doing regarding the Hoyer lift and the ADM's friends from other nursing facilities stated they were not using two staff and the use of two staff was situational. The ADM said the ADM was unsure what the facility's policy says. The ADM said the ADM would look at the resident's care plan to see what it instructed the staff to do. The ADM said the ADM was unsure whether the five residents using the Hoyer lift required one or two staff. The ADM said the potential negative outcome for not using the Hoyer lift as recommended was an injury could occur. The ADM said the ADM was unaware that Resident #2 had almost fallen out of the Hoyer lift. The ADM said the ADM remembered a case where the battery died and that the ADM had to order an extra battery but was unsure if that was with Resident #2. The ADM said they do competency upon new hire and annually to ensure the staff knew how to operate the lift. The ADM said the ADM could not say if they trained using two staff or one specifically but that the ADM had set through trainings before. The ADM said the ADM expected staff to use two staff if it had been deemed to use two staff. The ADM stated the nurse or therapist was responsible for determining whether to use one staff or two. The ADM said the ADM had seen staff use the Hoyer lift in passing but had no documentation of the ADM's observations. (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

An interview on [DATE] at 10:23 AM the DON said the DON was aware that over the years staff have operated the Hoyer with one staff. The DON said the MDS Coordinator had brought up the concern about using one or two staff and it was decided that it was on an individual basis. When a resident was admitted they use the information from the resident's pasts such as medical records, resident testimony and family testimony to determine which transfer to use with each resident. The admission nurse did the review of the residents past and their records. They stated they will also use the notes from those sessions if they were in therapy. The DON said staff know what transfer to use because it was displayed on the can's computer daily. Specifically, Resident #2 depended on how he felt whether one or two staff were used with the Hoyer. The DON said Resident #2 was verbal and could communicate to staff if he felt bad. The DON said that the CNA does not determine if when using the Hoyer if they would use one staff or two staff. The DON said residents were assessed upon admission and during their MDS review. The DON said there was no tool or documentation to indicate what was being assessed and how the determination was made for one staff or two. The DON said the DON was unaware that Resident #2 had an incident where he almost fell out of the sling. The DON said Resident #2 did have instances where he would hyperventilate from time to time. The DON said the Hoyer lift's purpose was to ensure a safe transfer for the residents. The DON could not provide a potential negative outcome for not using two staff while using the Hoyer lift because the DON said the DON was not going to throw the facility under the bus. The DON said the DON had observed two staff using the Hoyer in the past but observed two staff aides doing all their tasks together. The DON said the DON did audit staff periodically. The DON said staff have to be checked off on there use of the Hoyer lift upon hire, annually and if anything, specific was reported to them that required re-education. The DON said the DON observed during the trainings, and the DON felt that two staff were used because one staff was lifting another staff member. The DON did not specify if during training they had an additional staff to help monitor the resident. The DON said the DON does not think there was a break in their system because no resident has been harmed. The DON said the DON did think it was bad that they were not notified about Resident #2. The DON said if they knew about that situation the DON would have assessed to see if any changes needed to be made with the transfer.

An interview on [DATE] at 12:45 PM the MDS Coordinator stated upon admission that the MDS Coordinator uses information from the charger nurse, aides and medical records to determine the resident transfer. The MDS Coordinator said the nurse aides also come to them and give feedback. The MDS Coordinator said it was a rule of thumb that they use two staff for safety. The MDS Coordinator said in the past the MDS Coordinator brought up the topic of using one staff or two staff with the Hoyer two the ADM and DON and it was decided that two staff would be used for safety reasons. The MDS Coordinator said they did not train the staff about this determination after determining it because they had not gotten around to it. The MDS Coordinator expressed that the more people the better when it came to transfers, the MDS Coordinator said the MDS Coordinator was aware that staff were using one staff. The MDS Coordinator said the MDS Coordinator was unaware of Resident #2's incident where Resident #2 almost fell in the Hoyer lift. The MDS Coordinator said the MDS Coordinator does believe that two staff would prevent accidents but that they also had trained staff that knew how to operate the lift.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A confidential interview revealed that they do not do the lift with one staff. They stated they had been trained to use two staff for safety of the resident. They stated they had [NAME] seen staff use the Hoyer lift with one staff but that Resident #4 had reported it to them that staff use the Hoyer with one staff on Resident #4's roommate. They stated they had never reported this because they had never seen it happen. They stated they would feel uncomfortable using the Hoyer with one staff because things could go wrong. They stated they needed a second staff to help guide the resident in the sling. They stated that the potential negative outcome for not using 2 staff when using the Hoyer was automatic termination, but another outcome could be injury to the resident. They stated the ADM was adamant about making sure there are two staff. They stated during the last few meetings the ADM emphasized that there should be two people at all times when using the Hoyer lift. A confidential interview revealed that they had used the Hoyer lift by themselves once. They said they are short staffed, making it hard to do things by the book. They said they had never told anyone but had used the Hoyer lift once with two residents. They named two of the three residents on the hall as the only ones that use the Hoyer lift. They stated they only used the Hoyer lift on the two named resident excluding Resident #2. They said they had been trained always to use two staff because anything could happen such as the loops on the sling could pop, or residents can slide out if they are too skinny and the sling can break if the resident was too big. They said they are unaware if others were using the Hoyer lift with one staff. An observation conducted on [DATE] at 1:47 PM revealed that CNA F and G operated the Hoyer lift to transfer Resident #3 from the wheelchair to the bed. There was no indication (verbal or physical) that the staff checked the sling before use. Neither staff member locked the wheels of the Hoyer lift when securing the sling to the rotating arm of the Hoyer, and neither staff member locked the wheels of the Hoyer when lowering the resident down in the bed. Record review of the Arjo (Hoyer) manual (undated) indicated that prior to use a clinical assessment should be carried out by a qualified nurse and Therapist before lifting residents. Record review of internet search of Arjo Maxi Move Hoyer lift instruction manual revealed the following (file:///C:/Users/Kjohnson09/Downloads/001.25060.EN%20rev.%2017.pdf) : Page 5-- Note: The need for a second attendant to support the patient must be assessed in each individual case. Page 8-- WARNING: Patients with spasms can be lifted, but great care should be taken to support the patient's legs to prevent fall risk and injuries. Record review of the facility policy, Transfer Technique Guidelines (undated), revealed: PURPOSE: To safely transfer a resident that is unable to safely transfer alone. GUIDELINES: 1) Lock wheelchair brakes. (continued on next page)

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