STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675498	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on interviews and record reviews the facility failed protect a resident's right to be free from misappropriation of resident property and/or exploitation for 2 of 3 residents (Resident #4 and Resident #5) reviewed for Misappropriation of Resident Property. LVN C was found to have left the facility with pain pills belonging to Residents #4 and #5 on the morning of 04/11/2025 as he left his shift at 7:00AM. This failure could cause residents to experience a decreased quality of life, unrelieved pain, and mental anguish. Findings included: The incident report submitted by the facility on 04/11/2025 indicated at or around 7:00AM, RN B witnessed LVN C behaving erratically. LVN C was unable to focus, could not sit or stand still and exhibited repetitive speech. RN B offered to walk LVN C to his car with the thought he was having a medical incident. When they both arrived at LVN C's car, he fumbled for his keys in his pockets and various pills and a syringe of an unknown substance fell to the ground. RN B immediately asked LVN C what the contents of his pocket were, and he admitted to taking narcotics and other pills off of the medication cart on the 200 hallway. RN B checked to ensure LVN C was able to drive himself home and returned to the facility with the drugs. The confiscated drugs were placed in separate containers and locked in the DON's office pending further investigation. An interview with the Administrator on 04/24/2025 at 8:12AM reflected no drug testing was performed on LVN C or on any staff members working with LVN C during his shift from 7:00PM on 04/10/2025 through 7:00AM on 04/11/2025. She stated as the Abuse Coordinator for the facility, LVN C had admitted to taking the pills, so she felt there was no need to test other staff members. She was unable to say if any pills had been passed to other staff members during the shift. The Administrator stated the medication counts were correct after the event, so she assumed all the pills had been retrieved by RN B at the time of the incident. She was unable to answer how the counts were correct if LVN C had left the building with the pills and syringe. She stated she had been told they were correct by the DON. The Administrator stated she left for vacation the morning of the incident and it was not the first thing at the front of her mind at the time. The Administrator stated LVN C had been suspended on 04/11/2025 pending an internal investigation and was terminated on 04/16/2025. A police report was filed with local police outlining the theft of the medications. The police report # was 25-0505104 and was filed on 04/11/2025. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on 04/24/2025 at 8:29AM revealed the narcotic counts in the medication cart had been correct when LVN C took over the shift at 7:00PM on 04/10/2025. The counts were not correct when LVN C handed off the medication cart to RN B at 7:00AM on 04/11/2025. She stated the total amount of controlled substance pills that were missing from the cart was 25, along with 2 syringes of Morphine totaling 5.1ml. The DON and RN B immediately began pain assessment rounds on the residents of the 200 hallway and found that Resident #4 had not received her morning dose of Lorazepam and Resident #5 had not received her morning dose of Tramadol. Resident #4's pain level was 9 out of 10 with all-over radiating pain and Resident #5's pain level was 6 out of 10 with lower back pain. The DON stated during these pain assessment rounds she had also found an empty syringe on the bathroom counter of one resident and had asked her if she had received her morning dose of Morphine. The resident told the DON she had not received the dose and asked for it due to all-over pain and pain in her left breast that was 9 out of 10. An interview on 04/24/2025 at 2:55PM with Resident #4 reflected she had missed the administration of her morning pain medication only one time that she could remember but having pain was something she was used to, so she thought she had probably waited for the next dose. An interview on 04/24/2025 at 4:12PM with Resident #5 reflected she had missed the administration of her pain medication one night before she went to bed. She stated she thought she had fallen asleep, so her pain must not have been too bad, or she would have asked a nurse for a pill. Record review of Resident #4's clinical records revealed Resident #4 was a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Unspecified glaucoma (condition where there's a build-up of fluid in the eye that puts pressure on the optic nerve and retina, potentially leading to vision loss or blindness), Anxiety disorder, unspecified, Insomnia, unspecified (inability to sleep),Pain, unspecified, Gastro-esophageal reflux disease without esophagitis (heart burn without reflux), Unspecified osteoarthritis, unspecified site, Trigger finger, right ring finger, Secondary hyperparathyroidism of renal origin (a condition where the parathyroid glands produce excessive parathyroid hormone (PTH) due to chronic kidney disease (CKD), Unspecified abdominal pain, Syncope and collapse (loss of consciousness with falling),Nondisplaced spiral fracture of shaft of left tibia, initial encounter for closed fracture (a fracture where the broken bones remain aligned), Long term(current) use of insulin, Dependence on supplemental oxygen, Chronic kidney disease, stage 3 unspecified, Other chronic pain, Bipolar disorder, unspecified, Major depressive disorder, recurrent, unspecified, Hypothyroidism, unspecified (a condition where the thyroid gland does not produce enough thyroid hormones), Type 2 diabetes mellitus with diabetic chronic kidney disease, Type 2 diabetes mellitus with hyperglycemia (refers to a situation where someone diagnosed with type 2 diabetes has persistently high blood sugar levels (hyperglycemia)), Chronic respiratory failure with hypoxia (a long-term condition where the lungs are unable to adequately provide oxygen to the body, leading to chronically low blood oxygen levels). Review of Resident #4's MDS dated [DATE] indicated she had a BIMS score of 15 indicating she was cognitively intact. Her care plan dated 03/04/2025 indicated she was at risk for pain related to glaucoma, osteoarthritis, and previous fracture of the left tibia. Her pain would be managed through prescribed medications and exercise, as able. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's orders were as follows: Orders: acetaminophen [OTC] tablet; 500 mg; amt: 1 tab; oral Three Times A Day Ativan (lorazepam) - Schedule IV tablet; 0.5 mg; amt: 1 tab; oral Three Times A Day Behavior Monitoring Every Shift: ANTIANXIETY Drug- Symptoms include restlessness, shortness of breath, agitation. Special Instructions: Behavior: 1. restlessness 2. shortness of breath 3. agitation INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Removal of Stressors J: Other K: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, Every Shift Behavior Monitoring Every Shift: ANTIDEPRESSANT Drug- Symptoms include voicing sad thoughts, social withdrawal, decreased appetite Special Instructions: Behavior:1. voicing sad thoughts 2. social withdrawal 3. decreased appetite INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Other I: No interventions needed OUTCOMES:1. Improved, 2. Unchanged, W. Worsened Every Shift Behavior Monitoring Every Shift: ANTIPSYCHOTIC Drug Use- Symptoms include refusing care, yelling out, delusions. Special Instructions: Behavior: 1. refusal of care 2. yelling out 3. delusions INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Removal of Stressors J: Other K: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, Every Shift EQUIPMENT Oxygen: Change O2 tubing/nasal cannula/mask/humidification system weekly Once a Day on Sun bariatric Bed, Wheelchair, Hoyer lift, air mattress EQUIPMENT: Keep O2 cannula/mask/tubing and/or Nebulizer mask/tubing bagged when not in use Every SHIFT Check resident for level of pain utilizing numeric rating scale 0-10 or verbal descriptor scale(M)Mild, (Mo)Moderate, (S)Severe, (VS)Very Severe Monitor for side effects every shift: ANTIANXIETY. Special Instructions: SIDE EFFECTS: 0. NONE 1. Hypotension 2. Sedation 3. Dizziness 4. Dry Mouth 5. Blurred Vision 6. Urinary Retention 7. Drowsiness, Fatigue 8. Slurred Speech 9. Confusion 10. Nightmares 11. Appetite Changes Every Shift (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitor for side effects every shift: ANTIDEPRESSANTS Special Instructions: SIDE EFFECTS: 0. NONE 1. Dry Mouth 2. Blurred Vision 3. Constipation 4. Urinary Retention 5. Hypotension 6. Appetite Changes 7. Headache 8. Insomnia 9. Dyspepsia 10. Weight Changes 11. Suicidal ideations; Wishes of death; Attempts to harm self Every Shift Monitor for side effects every shift: ANTIPSYCHOTIC DRUG USE Special Instructions: SIDE EFFECT CODES: 0. NONE 1. Neck Stiffness 2. Confusion 3. Muscle Rigidity 4. Involuntary Movements 5. Drooling 6. Tremors 7. Restlessness 8. Sleep Disturbances 9. Dry Mouth 10. Blurred Vision 11. Constipation 12. Sedation Every Shift Quarterly Observations due every three months (Focused Observation, Braden, Elopement, Pain, Fall, B/B, Side Rail) Once A Day on 3rd Fri of Jan, Apr, Jul, Oct Record review of Resident #5's clinical records revealed Resident #5 was an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Unspecified dementia, severe, with other behavioral disturbance, Major depressive disorder, recurrent severe without psychotic features, Generalized anxiety disorder, Other chronic pain, Essential (primary) hypertension, Other idiopathic scoliosis (the most common type of scoliosis, characterized by an abnormal spinal curvature with an unknown cause), site unspecified, Unspecified inflammatory spondylopathy, lumbar region (degenerative condition affecting the lower back (lumbar spine)), Cognitive communication deficit, Pain, unspecified, Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela (a serious medical condition where bleeding occurs in the space between the brain and the dura mater (the outermost layer of tissue surrounding the brain), resulting in pressure buildup and potentially causing loss of consciousness), Presence of neurostimulator (a medical device that delivers electrical stimulation to nerves to modulate their activity, often for pain relief or other therapeutic purposes), Muscle wasting and atrophy, not elsewhere classified, unspecified site, Muscle weakness (generalized), Other osteoporosis without current pathological fracture, Unspecified fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing. Review of Resident #5' MDS dated [DATE] indicated she had a BIMS score of 7 indicating she was moderately, cognitively impaired. Resident #5's care plan dated 04/11/2025 indicated she was at risk for pain related to scoliosis, spondylitis, previous lumbar fracture, and osteoporosis. Her pain would be managed through prescribed medications, neurostimulator and exercise, as able. Resident #5's orders were as follows: Orders: Tramadol - Schedule IV tablet; 50 mg; amt: 1 tab; oral Every 8 Hours - PRN Trazodone tablet; 100 mg; amt: 2 tablets; oral At Bedtime Behavior Monitoring twice daily: ANTIDEPRESSANT Drug ** Note Drug/Condition to be monitored** Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distract C: Redirect D: Validate E: Activity Program F: Quiet Time/Rest G: Inc Observation H: Other I: No interventions needed OUTCOMES:1. Improved, 2. Unchanged, 3. Worsened, twice a Day. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior Monitoring twice daily: HYPNOTIC Drug Use **Note Drug and Behavior/Condition to be monitored**Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distract C: Redirect D: Validate F: Quiet Time/Rest G: Increased Observation H: Removal of Stressors J: Other K: No interventions needed OUTCOME: 1. Improved, 2. Unchanged, 3. Worsened Twice a Day EQUIPMENT: Low Bed, Wheelchair Every SHIFT (2) Check resident for level of pain utilizing numeric rating scale 0-10 or verbal descriptor scale(M)Mild, (Mo)Moderate, (S)Severe, (VS)Very Severe, Every Shift Monitor for side effects twice daily: ANTIDEPRESSANTS Special Instructions: SIDE EFFECTS: 0. NONE 1. Dry Mouth 2. Blurred Vision 3. Constipation 4. Urinary Retention 5. Hypotension 6. Appetite Changes 7. Headache 8. Insomnia 9. Dyspepsia 10. Weight Changes 11. Suicidal ideations; Wishes of death; Attempts to harm self Twice a Day Monitor for side effects twice daily: HYPNOTICS Special Instructions: SIDE EFFECT CODES: 0. NONE 1. Sedation 2. Dizziness 3. Confusion 4. Nightmares 5. Daytime Anxiety 6. Hallucinations 7. Fatigue 8. Headache 9. Sedation Twice a Day Quarterly Observations due every three months (Braden, Elopement, Pain, Fall, B/B) Once a Day on 1st Mon of Every 3rd Month Record review of medication count records from LVN C's shift which started at 7:00PM on 04/10/2025 reflected Resident #4 had 90 Lorazepam 0.5 mg pills and 3 hydrocodone-acetaminophen-5-325 mg pills at the beginning of the shift when the cart was handed off to him. Medication count records from the next morning on 04/11/2025 at 7:00AM reflected Resident #4 had 89 Lorazepam 0.5 mg. pills and 2 hydrocodone-acetaminopen-5-325 pills remaining. The medication administration record revealed that neither medication was charted as administered to Resident #4 by LVN C. Pain assessment rounds performed by RN B the morning on 04/11/2025 when the missing pills were discovered reflected Resident #4 had not received medication the night before and currently had a pain level of 9 out of 10 with all-over body pain. Record review of medication count records from LVN C's shift which started at 7:00PM on 04/10/2025 reflected Resident #5 had 12 Tramadol 50mg pills at the beginning of the shift when the cart was handed off to him. Medication count records from the next morning on 04/11/2025 at 7:00AM reflected Resident #5 had 10 Tramadol pills remaining. The medication administration record from the same time frame revealed no Tramadol had been charted as administered to Resident #5 by LVN C. Pain assessment rounds performed by RN B the morning on 04/11/2025 when the missing pills were discovered reflected Resident #5 had not received medication the night before and currently had a pain level of 6 out of 10 with lower pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RN B on 04/25/2025 at 8:40AM reflected she was on duty the night and early morning of the incident with LVN C. She stated LVN C's behavior was erratic, and he was sweating profusely. She asked if he was he having a medical problem. RN B stated LVN C became angry and could not help her complete med counts. RN B stated all the narcotic counts were off the morning 04/11/2025 and when she asked LVN C about them, he stated he didn't know anything about them, yet there were medication cards lying on top of the med cart and there were 2 vials of Morphine that he could not remember to whom they belonged. LVN C then told RN B that he suddenly remembered and took one vial of Morphine into an unnamed resident's room. She stated she went into the unnamed resident's room a few minutes later and asked the resident if she had gotten her Morphine and she stated she had not. RN B stated she found an empty syringe in the resident's bathroom on the counter. RN B stated she went to find LVN C and stated to him, I'm taking off my RN badge and putting on my friend badge. What's going on with you? RN B stated LVN C became very angry, and she began to try to get him out of the building, but it took some time as he was resistant. When RN B got LVN C to his truck, he reached in the pocket of his pants to try to find his keys and when he could not, he reached into his jacket pocket and pulled the keys out, along with 2 cups of pills and a syringe of what she thought was probably Morphine. RN B stated she took the drugs from LVN C and told him he needed to get some help. RN B offered to drive LVN C home, but he would not let her, so she had the maintenance man go and sit with him in his truck to see if he was even able to drive himself home. RN B stated LVN C had several disciplinary write ups concerning medication administration/medication charting and she knew the Administrator and the DON were aware of those problems. She stated she had no idea why they continued to keep him working when he'd had so many problems with medications. RN B stated everyone who worked with him knew he had a problem. LVN C would sometimes stay until 10:30AM or 11:00AM charting, when his shift ended at 7AM. RN B stated she thought he was falsifying records, but neither she nor the DON had been able to find definitive proof. She stated there was no way to tell exactly how many pills or vials of Morphine he had taken over the time he has been employed. An interview with the DON on 04/25/2025 at 9:16AM reflected LVN C had several disciplinary concerns in his file regarding medication administration and medication charting. She stated he was written up the first time on 04/17/2024 for failure to follow policy when he left his med cart unlocked. He was written up the second time on 12/09/2024 for medication error when he entered all the medications for a new resident under a different resident's name and chart. LVN C's third write up was on 02/07/2025 for administering medication without an order. She stated the pill in question was an Ambien and it was unknown if he had given it to a resident or had taken it himself. LVN C was also written up at the same time for incomplete charting since, You can't chart a med you don't have an order for. The DON stated LVN C was originally suspended on 04/11/2025 pending the investigation for the missing pills and Morphine that were found in his pockets as he left the building around 7:30AM, at the end of his shift. The DON stated on 04/16/2025 LVN C was terminated. She stated he was kept on staff for so long with so many infractions, due to their corporate policy of progressive discipline. She stated the policy was as follows: 1st offense-verbal warning. 2nd offense-documented verbal warning. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3rd offense-written warning. 4th offense-final warning and then termination if another offense occurs. Review of in-service documentation from 04/11/2025 reflected licensed staff were educated on medication administration, documentation, medication discrepancies and reporting of suspected drug diversion. An attempt to speak with LVN C by phone was made on 04/25/2025 at 9:17AM. LVN C was not available for comment and there was no VM to leave a message for a return call. Review of facility policy for Pharmacy Services; Section 2; Subject 2.6 Storage and Reconciliation of Controlled Substances dated April 2024 revealed the following: Policy: 1. The Facility will have systems in place to ensure the safe and secure storage of Controlled Substance Medications. 2. The facility will conduct routine reconciliations of all Controlled Substances to prevent any potential loss or diversion. Procedures: 1. Only authorized staff, licensed nurses and pharmacy personnel will have access to controlled medications. 2. Medications listed in Schedules II, III, IV, and V are dispensed by the pharmacy in readily accountable quantities and containers designed for counting of contents. 3. All controlled medications must be maintained in separately locked, permanently affixed compartments. The access key to controlled medications is not the same key which gives access to other medications. Duplicate keys to all medication storage areas, including those for controlled medications, are kept by the Director of Nursing. A. The authorized staff member will always have the Controlled Substances key(s) in his/her possession while on duty. 4. A scheduled reconciliation (shift change count) of controlled substance inventory should be completed every nursing shift change and documented as required by state regulations. A. At the end of every shift the nurse/authorized staff member reporting on duty and the nurse/authorized staff member reporting off duty meet at the designated medication cart or storage area to count all Controlled Substance drugs. B. The off-going nurse/authorized staff member reads off each controlled substance inventory record sheet on drug at a time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 47159 Based on observation, interview, and record review, the facility failed to ensure the resident received adequate supervision to prevent accidents for 1 of 1 Residents (Resident #1) reviewed for Accidents and Hazards. On 04/05/2025, the facility failed to secure the van lift strap to Resident #1's wheelchair while in use which resulted in Resident #1 rolling off backwards when the lift was suspended in the air and caused Resident #1 to be hospitalized in the Intensive Care Unit with multiple fractures on his spine. The noncompliance was identified as PNC. The IJ began on 04/05/2025 and ended on 04/07/2025. The facility had corrected the noncompliance before the survey began. This deficient practice could place residents at-risk of harm, serious injury, or death. Findings included: Review of the facility's self-reported incident indicated on 04/05/2025 at approximately 1:00PM Resident #1 was leaving the dialysis center after treatment. He was in his wheelchair and ready to be transported back to the facility in the facility's van by CNA A. The incident report simply stated, Resident #1 was on the van lift and was being transferred back to the facility. He fell backwards off the lift, hitting the ground. Resident #1 was transferred by EMS to [local hospital] ER for further evaluation and treatment. There was also a complaint which was made against the facility in this matter. A by-stander who witnessed the incident felt the actions that took place were grave enough to warrant a complaint on behalf of Resident #1, due to the way CNA A attempted to load Resident #1 into the van. A phone interview with the complainant on 04/22/2025 at 5:38PM reflected the following: The complainant stated she was taking her husband to dialysis on Saturday 04/05/2025 when Resident #1 was being loaded into the facility's van after his dialysis treatment. The complainant stated she saw the van driver use the lift on the side of the van to raise Resident #1's wheelchair but thought CNA A had not secured the wheelchair properly before starting the lift. The complainant stated CNA A started the lift and rode to the top, with Resident #1. The complainant stated CNA A stepped inside the open door of the van, leaving Resident #1 unattended on the lift while in the raised position. Resident #1 immediately rolled off the back of the lift and landed on his back, while still in his wheelchair. The complainant stated the day was cold, wet, and snowy. Resident #1 was not dressed for the weather and had landed in a puddle of water when he fell . The complainant immediately called 911 and her granddaughter got a jacket from their truck to warm Resident #1 until EMS arrived. (continued on next page)

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	675498	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's clinical records revealed a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnoses of Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral (a combination of diabetic complications affecting both eyes, leading to vision loss) Cognitive communication deficit, Unspecified lack of coordination, Muscle wasting and atrophy, not elsewhere classified, unspecified site, Muscle weakness (generalized), Other reduced mobility, Encounter for observation for suspected exposure to other biological agents ruled out, Type 2 diabetes mellitus with diabetic nephropathy, Type 2 diabetes mellitus with diabetic chronic kidney disease, Type 2 diabetes mellitus with hypoglycemia without coma, Venous insufficiency (chronic) (peripheral) (a condition where the veins in the legs have difficulty returning blood to the heart. This results in blood pooling in the lower extremities, leading to symptoms like swelling, pain, and skin changes), Benign prostatic hyperplasia with lower urinary tract symptoms (frequent or urgent urination, waking up multiple times at night to urinate (nocturia), difficulty starting urination, a weak urine stream, dribbling at the end of urination, and the feeling of not fully emptying the bladder), Dependence on renal dialysis (refers to a condition when an individual's kidneys are no longer functioning properly and require regular dialysis treatments to filter blood and maintain bodily function). Review of Resident #1's Quarterly MDS dated [DATE] indicated he had a BIMS score of 15, indicating he was cognitively intact. Resident #1 required a 1- to 2-person assist for all ADLs. His means of mobility were a wheelchair and Hoyer lift. His care plan dated 03/18/2025 revealed he was a fall risk related to impaired sight, Diabetes Mellitus, muscle weakness and occasional low blood pressure. Resident #1 was dependent on a wheelchair for ambulation. An interview with the Administrator on 04/24/2025 at 8:12AM revealed she received a call from the DON at approximately 1:30PM on 04/05/2024 which informed her Resident #1 had fallen in his wheelchair from the van and was at the hospital. The DON told the Administrator they did not know what happened, but he had fallen. The Administrator stated it took approximately 1-hour for her to arrive at the facility from her home. The Administrator stated she interviewed CNA A as soon as she arrived at the facility. In that interview, CNA A told the Administrator she locked Resident #1's wheelchair wheels when she pushed him onto the lift. CNA A stated the lift plate at the back of the lift was up, so she did not know how he could have rolled off. CNA A stated Resident #1 was unable to tell her how he rolled off, as well. The Administrator suspended CNA A from her duties at the facility, in lieu of an investigation and she was no longer allowed to drive the facility's van. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A phone interview with Resident #1's RR on 04/24/2025 at 9:46AM reflected stated Resident #1 was not doing well since the fall. The RR stated Resident #1 was still in ICU and was very fragile. He had been in the ICU for almost 2-weeks. Resident #1 broke T4 and T5 in his back and surgery could not be completed due to his fragility. The orthopedic surgeon stated he would not survive the surgery. The RR lived approximately 45 miles out of town, so she called a local friend, who went to the hospital and checked on Resident #1 until she could arrive. The RR stated when the Administrator called her she stated that Resident #1 was not secured when he was lifted with the van lift. The RR was told by the Administrator that EMS had taken Resident #1 to [local hospital] and he had been admitted . The RR was told the van driver had to go back to the facility to meet with HR about the incident, so the facility had sent the maintenance man's son, who was also an employee, to sit with Resident #1 until the RR could arrive. When the RR arrived, no one was with Resident #1. When the RR was able to speak with Resident #1, he told her he was up in the air when he felt himself falling backward. The RR stated Resident #1 was blind, and should have been secured very well, since he had to rely on the help of others for his safety. The RR stated she felt it was incredibly negligent on the part of the facility to let the incident happen. The RR stated she was not sure if Resident #1 lost consciousness and Resident #1 was unable to tell her if he had lost consciousness after the fall. The RR stated the ER took x-rays of Resident #1's head and back and found no injury to his head, but his spine had swelling, and it appeared there were fractures at T4 and T5 in his back. The RR stated Resident #1's quality of life was taken from him, and he would never be the same again. The surgeons had stated he would have chronic back pain and problems with his back, for the rest of his life. The RR stated the Administrator told her the dialysis center had video of the incident. The RR called the dialysis center and made an appointment to view the video, but when she arrived the RR was told the corporate office had told the dialysis center, not to release the video. The RR stated she received a call from the DON a few days after the incident, but the RR was too mad to speak with her because Resident #1 could still die. The RR stated that was the last communication she received from anyone at the facility. She stated up to the time of the incident, Resident #1's care at the facility had been good. He got his medications on time, had no issues with his insulin and seemed to be contented living there. Record review of [local hospital] ER visit notes dated 04/05/2025 reflected Resident #1 presented to the ER at 1:19PM with complaints of back pain after a fall prior to arrival. Resident #1 reported he was leaving his dialysis treatment when the accident occurred. He was being loaded into a van while in his wheelchair on the van lift when he fell back off the lift while still in the wheelchair and hit his head and back. He notes that he was elevated off the ground. Resident #1 denied loss of consciousness. Resident #1 denied the use of supplemental 02 at home. ER triage notes read as followed: Patient arrived from dialysis center due to a fall. Patient had just finished dialysis and was being loaded into van by a wheelchair lift when he was not secured properly and fell backwards. Pt hit head and is on Eliquis (blood thinner). Pt did not have loss of consciousness. Resident #1 was discharged from the ER and admitted to the Surgical Critical Care Unit of the same hospital at 4:48PM with the following diagnostic considerations and differential diagnoses: Intra-cranial hemorrhage, skull fracture, subdural hematoma, subarachnoid hemorrhage, epidural hemorrhage, rib fractures, a thoracic/lumbar/ cervical spine fractures, hip fracture, pelvic injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The plan was as followed: Check general labs electrolytes since the patient did just recently have dialysis. We will also check imaging of the patient's head neck thoracic spine and lumbar spine. The patient does not really appear to have any true cervical spine discomfort with given the mechanism wheel look. The patient was found to have a T4-T5 vertebral fracture with some facet widening along with hemorrhage in that area concerning for significant spinal cord injury. That is said the patient does not have any deficits he is able to move all his extremities without any significant difficulty he has good sensation throughout. The patient's case was discussed with the nurse practitioner for [Neurosurgeon]. She will have him look at the imaging and once they have reviewed the imaging we will adjust any necessary treatment and then proceed. IMAGING CT Head Without Contrast (Results Pending) CT Thoracic Spine Without Contrast (Results Pending) CT Lumbar Spine Without Contrast (Results Pending) The patient's case was discussed with [Neurosurgeon] through Nurse Practitioner; they recommend that we admit the patient from the trauma service to the SICU; the patient has an unstable fracture at T4 and T5 and will require close monitoring. On 04/05/2025 at 6:02PM The CICU Physician charted the following in Resident #1's [local hospital] medical record: CT Thoracic Spine Without Contrast PROCEDURE: CT THORACIC SPINE WITHOUT CONTRAST COMPARISON: None. INDICATIONS: Fall with thoracic spine pain concern for injury, TECHNIQUE: Multi-planar CT images were obtained and created without intravenous contrast. FINDINGS: VERTEBRAE: There was bridging anterior vertebral body osteophytes throughout the thoracic spine compatible with DISH. There is a fracture through the anterior inferior corner of the T4 vertebral body with extension to the disc space and into the superior T5 end plate. There is associated mild widening of the T4-T5 facet joints with mild retrolisthesis of T4 and TS measuring 4 mm, traumatic in etiology. This results in severe bilateral neural foraminal stenosis and mild spinal canal stenosis. There is mild haziness in the spinal canal ventral to the spinal cord which may represent a small amount of epidural hemorrhage without definite mass effect on the thecal sac. PARASPINAL AREA: Large prevertebral edema or hemorrhage at the level of T4-T5. DISC LEVELS: Fracture through the T4-T5 disc space. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	ALIGNMENT: Traumatic retrolisthesis of T4 and TS measuring 4 mm. OTHER: Multilevel degenerative changes throughout the thoracic spine with mild multilevel spinal canal and foraminal stenosis. There is a consolidation in the right lower lung which could represent pneumonia or atelectasis. Mild left lower lobe atelectasis. Cardiac pacer leads are present. Moderate atherosclerosis of the coronary arteries and aorta. CONCLUSION: 1. Acute fractures through the anterior inferior corner of the T4 vertebral body with the fracture extending into the disc space in the superior endplate of T5 in the setting of DISH. There is widening of the bilateral T4-TS facet joints which likely indicates facet capsular injuries and associated traumatic retrolisthesis of T4 and TS measuring 4 mm. This results in severe bilateral neural foraminal stenosis and at least mild spinal canal stenosis. Minimal hyperdense stranding in the anterior epidural space at this level may represent blood products, however there is no definite hematoma or substantial mass effect on the thecal sac identified on this exam. An MRI could be performed to assess for mass effect on the spinal cord if clinically indicated. 2. Moderate hemorrhage or edema anterior to the T4-TS fractures. CT Lumbar Spine Without Contrast PROCEDURE: CT LUMBAR SPINE WO CONTRAST COMPARISON: None. INDICATIONS: Fall with a lower back pain concern for injury, TECHNIQUE: Multi-planar CT images of the lumbar spine were obtained without IV contrast. FINDINGS: BONES: No fractures. Bilateral pars defects at L5. Osteophytes all lumbar levels. Schmorl's nodes superior endplates L1 and L2. A mild bi concave deformities L3, L4 and L5. Hypertrophy of the spinous processes with faceted appearance consistent with Braestrup's disease series 8, image 36. ALIGNMENT: Grade 1 anterolisthesis L5 on S1. PARASPINAL AREA: Arterial calcifications. Atrophy left kidney. Right kidney not well seen. LUMBAR DISC LEVELS: T12-L1: No significant disc/facet abnormality, spinal stenosis, or foraminal stenosis. L1-L2: Calcification within the disc. Mild bilateral facet arthrosis. L2-L3: Facet arthrosis and ligamentum flavum thickening contribute to central canal and foraminal stenosis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	L3-L4: Bilateral facet arthrosis and ligamentum flavum thickening contribute to central canal and foraminal stenosis. L4-L5: Bilateral facet arthrosis and ligamentum flavum thickening contribute to central canal and foraminal narrowing. L5-S1: Disc space narrowing anterolisthesis leads to narrowing of the foramina bilaterally. CONCLUSION: 1. No acute fractures. 2. Bilateral pars defects of at L5 with grade 1 anterolisthesis of L5 on S1. 3. Degenerative changes all lumbar levels. 4. Baastrup's disease. 5. Atherosclerosis. CT Head Without Contrast PROCEDURE: CT HEAD WO CONTRAST COMPARISON: None. INDICATIONS: Fall with head trauma on Eliquis concern for injury. TECHNIQUE: CT images were created without intravenous contrast. FINDINGS: VENTRICLES: The ventricles, sulci and cisterns are mildly enlarged. CEREBRUM: No intracranial hemorrhage. Symmetrically diminished attenuation in the deep white matter consistent with mild leukoaraiosis. , CEREBELLUM: Small high attenuation extra-axial lesion abutting the [NAME] surface measuring 1.3 x 0.7 cm series 7, image 37 and also demonstrated on axial series 5 images 9-10 consistent with a meningioma. BRAINSTEM: Negative. SKULL: No fractures. Small right frontal scalp laceration. SINUSES: Normal. OTHER: Arterial calcifications. CONCLUSION: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. No intracranial hemorrhage. 2. Small meningioma in the right posterior fossa. 3. Mild atrophy and leukoaraiosis. 4. Small right frontal scalp laceration. ASSESSMENT AND PLAN: Patient Active Problem List Diagnosis o Acute kidney injury superimposed on chronic kidney disease o Type 2 diabetes mellitus with hypoglycemia, with long-term current use of insulin (HCC) o Mixed hyperlipidemia o Morbid obesity with BMI of 50.0-59.9, adult (HCC) o Benign prostatic hyperplasia with lower urinary tract symptoms o Paroxysmal atrial fibrillation (HCC) o Microcytic anemia o Coronary artery disease involving native coronary artery of native heart without angina pectoris o Hypervolemia, unspecified hypervolemia type o Chronic kidney disease requiring chronic dialysis (HCC) o ESRD (end stage renal disease) on dialysis (HCC) o Coagulopathy o Fall o Closed unstable burst fracture of fourth thoracic vertebra, initial encounter (HCC) Fall Assessment & Plan (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Patient is status post fall complaining of back pain and suffered an unstable thoracic spine fracture. Patient will be admitted to surgical ICU with strict spine precautions. Tertiary evaluation to be performed in the morning. Coagulopathy Assessment & Plan Patient has history of coronary artery disease along with paroxysmal AFib currently on Eliquis. Last dose was this morning. Patient requires full reversal for Eliquis. Paroxysmal atrial fibrillation (HCC) Assessment & Plan Patient has history of coronary artery disease along with paroxysmal AFib currently on Eliquis. Last dose was this morning. Patient requires full reversal for Eliquis. * Closed unstable burst fracture of fourth thoracic vertebra, initial encounter (HCC) Assessment & Plan Patient is status post fall complaining of back pain and suffered an unstable thoracic spine fracture. Patient will be admitted to surgical ICU with strict spine precautions. [Neurosurgeon] has been consulted who will evaluate the patient. He initially recommended MRI, however, could not be done secondary to presence of pacemaker. Also recommended keeping mean arterial pressure greater than 70, IV Decadron. Appreciate his recommendations. Chronic kidney disease requiring chronic dialysis (HCC) Assessment & Plan Patient has history of chronic kidney disease on hemodialysis through a left upper extremity fistula. Will consult [Nephrologist]. Coronary artery disease involving native coronary artery of native heart without angina pectoris. Assessment & Plan Patient has history of coronary artery disease along with paroxysmal AFib currently on Eliquis. Last dose was this morning. Patient requires full reversal for Eliquis. Morbid obesity with BMI of 50.0-59.9, adult (HCC) Assessment & Plan BMI of 48.6 likely related to excess calories. Supportive care at this point. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Mixed hyperlipidemia Assessment & Plan Chronic diagnosis. Patient takes atorvastatin. Will resume when able. Type 2 diabetes mellitus with hypoglycemia, with long-term current use of insulin (HCC) Assessment & Plan Chronic diagnosis. We will obtain HbA1c in the morning. Start more moderate category sliding scale. Antibiotics: Ancef on-call Nutrition: Keep NPO Analgesia: Tylenol, Robaxin with as-needed fentanyl Sedation: Not indicated Thromboprophylaxis: SCDs only, no chemoprophylaxis Ulcer prophylaxis: Start Protonix Glucose: Will obtain HbA1c in the morning, start sliding scale insulin Plan for today: o Admit to surgical ICU o Start Levophed to keep mean arterial pressure greater than 70 o Reverse Eliquis o Pain control o Strict spine precautions o Add duo nebs o Will obtain CT chest abdomen pelvis without contrast o I have consulted [Hospitalist] to help assist with medical management The patient is extremely critical. I had an extensive discussion with the patient and his RR over the phone. I updated them about his condition, including the potential risks and complications associated with his fall, given his advanced age, multiple comorbidities (OM, pacemaker, OA, HTN), and current anticoagulation therapy with Eliquis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	I also discussed the need for continuous monitoring and potential consultations with orthopedic and neurology specialists. All their questions were answered thoroughly, ensuring they understood the gravity of the situation and the steps being taken. The patient is a full code. ICU RN notes from 04/05/2025 at 6:22PM read as follows: Admitting DX: Burst fracture of 4th thoracic vertebra Current level of care: ICU Current CLS (care level score): 150 Current treatment plan: admitted following a fall for an unstable burst fracture of T4. Nephrology consult for chronic dialysis. Intubated and placed on pressers within 24 hours. Neurosurgery consulted - pt not a good surgical candidate due to multiple factors, recommended palliative care consult. Barriers to discharge: Remains in critical care, not stable to transfer to lower level of care. Resident #1 remained in ICU at [local hospital] until 04/17/2025 at or around 5:00 PM when he was transferred to [local LTAC] for continued care. Resident #1's hospital discharge plan dated 04/17/2025 at 2:36PM read as follows: Spoke with NP regarding discharge plan and patient is able to transfer from ICU to LTAC due to higher level of medical need. Spoke with patient's RR and she has toured [local LTAC] and is agreeable. Patient Care Levels complete. Called and sent referral. Case manager will remain available. Pt has been approved for [local LTAC] and can transfer today at 5:00PM via ambulance. Pt and family informed. Pt scheduled for dialysis today at 2:00PM but will complete dialysis tonight at the LTAC. Nurse given number to call report. No other needs at this time. Primary RN notified this RN patient will be transferring to LTAC at 5:00PM via ambulance. Per Case Manager note, dialysis is to be done tonight at LTAC. Nephrologist notified, no treatment at [local hospital] today. Fax order sheet to dialysis center for LTAC dialysis. Occupational Therapy orders sent to [local LTAC] at 3:43PM read as follows: ROM: patient consulted and evaluated in SICU on 4/9/2025. During evaluation patient demonstrated primary impairments in bed mobility, functional transfers, activity tolerance, sustained grasp, dynamic sitting/standing balance, insufficient spinal precautions, cognition including anxiety and problem solving, visual scanning, and gross weakness/deconditioning impacting safety, participation, and independence with all ADLs. Pt scored 6 out of 24 on the AM-PAC Daily Activity assessment indicating over 100% impairment completing all basic ADLs successfully/independently, meaning patient will require assistance at time of discharge. Therefore, without skilled OT service, patient is at a higher risk for loss of independence with basic necessary ADLs, loss of dignity, and inability to return to the community reducing their quality of life. OTR initiated a Plan of Care to approximate prior level of independence and improve impairments to baseline. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Pertinent Surgical History: No plans for surgical intervention per neuro at this time. Assessment: Pt initially evaluated by occupational therapy on 4/9/2025 by OTR. During patient's plan of care, this patient seen by therapy 3 times and received: -Dynamic therapeutic activities utilized to improve functional performance, activity tolerance, and balance with therapist supervision and grading to ensure maximum patient benefit. -AOL training and functional transfer training with OT practitioners providing graded assistance and cueing to ensure maximum safety and independence. Patient made fair progress towards goals however due to pain and short length of stay, all goals remain active at time of discharge from hospital to SNF. Continued occupational therapy services are recommended. Plan of care, discharge recommendations, AE equipment, and safety education with spinal precaution with TLSO education reviewed with patient and/or family prior to discharge from hospital. Will discontinue acute care OT orders at this time. An interview with the Administrator on 04/24/2025 10:33AM revealed CNA A had returned to work after her internal investigation, because they could not prove she had done anything wrong during the transport of Resident #1. She stated she had called the dialysis center to inquire about video footage but was told the cameras would not have picked up the area where Resident #1 fell . She stated the doctors at the hospital told the RR, Resident #1 was not secured on the lift, not herself or anyone else at the facility. The Administrator stated Resident #1 was very particular about the brakes on his wheelchair due to his blindness and any time there were issues with his wheelchair he called the MD immediately. An interview with the CM of the dialysis center on 04/24/2025 at 1:00PM revealed there was video of the incident involving Resident #1 falling off the lift of the facility's van. Review of the video with the CM clearly showed CNA A push Resident #1 onto the lift and up to the front of the lift platform. It was difficult to see if CNA A or Resident #1 locked the wheelchair wheels, but CNA A activated the lift and rode with Resident #1 to the top, where they were both even with the open entrance to the van. CNA A then stepped inside the van, out of the video frame and Resident #1 was seen rolling backward off the lift and onto the parking lot pavement below. It was approximated from the video footage that the fall height was about 3-3 1/2 feet. Resident #1 was still in his wheelchair at the time of the fall and bystanders came to his aid. At that point, the video stopped. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with CNA A on 04/24/2025 at 2:12PM revealed she pushed Resident #1 out of the dialysis center to the place in the parking lot where the van was waiting. CNA A operated the lift into the down position and then pushed Resident #1 onto the lift platform. CNA A stated she made sure Resident #1's wheels were locked and then took two steps inside the van to try to pull him forward into the back of the van. CNA A stated when she looked back, Resident #1 was not there, and she heard him scream. CNA A stated she ran to him, and he was on his back, on the parking lot pavement, in the wheelchair. CNA A stated she pushed Resident #1 out of the dialysis center, but tried to pull him into the van, because he was too heavy to push over the lip of the van entrance. This investigator told CNA A the security footage from the day of the event was viewed at the dialysis center and she was seen pushing Resident #1 out of the dialysis center in the snow. CNA A had trouble getting Resident #1 off the sidewalk but kept pushing until she got him over a small patch of snow and onto the parking lot and the van's lift. CNA A changed her story and could not remember if she pushed or pulled him onto the ramp of the van. This investigator told her the video footage revealed she pushed him onto the ramp, rode the ramp to the top with Resident #1 and then stepped inside the van, where Resident #1 was left unattended. Resident #1 was then seen rolling off the back of the elevated lift and onto the pavement below. CNA A had no comment. An interview on 04/24/2025 at 2:34PM with Resident #2 revealed she also was a dialysis patient but had never been driven to dialysis by CNA A. Resident #2's RR was in the room at the time of the interview and stated Resident #2 had not had any issues with transportation provided by the facility. Resident #2 stated she felt safe during her travels. An interview on 04/24/2025 at 2:43PM with Resident #3 revealed she also was a dialysis patient but had never been driven to dialysis by CNA A. Resident #3 stated she had not had any issues with the transportation provided by the facility and felt safe during her travels. An interview on 04/24/2025 at 3:07PM with the MD the van had not been used by the facility and had been in the repair shop since the incident. The MD stated the lift on the van held 800 lbs. which was more than ample to lift Resident #1 and his wheelchair. The MD stated the plate at the back of the platform was designed to keep wheelchairs from rolling off the lift should have been in an upright position if the lift was engaged and moving up. He stated there should not have been a way for Resident #1 to roll off the platform. The MD stated he had checked all circuits after the incident, and all were working properly. The MD provided the maintenance work order dated 04/05/2025 which reflected the following: Drove van to facility. Upon arrival I inspected the lift operation. Pushed the unfold button. Lift unfolded 1/4 of way down and stopped. Manually operated lift into van and discontinued van operation. The requested priority was High meaning the lift needed to be evaluated by an outside source within 24-hours. Record review on 4/24/25 of the MD provided policy for Transporting Wheelchair-bound Residents which was used as part of his re-training for van drivers on 04/06/2025 revealed: Safety for Using a Wheelchair Lift: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675498	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. Move the wheelchair, outward facing, all the way onto the lift. If you need a handhold, use one indicated by the lift manufacturer. Set both wheelchair breaks and fasten the lift safety restraint, if applicable. 2. Do no ride on the lift with the passenger but go int the van and meet the lift. 3. Move the patient/resident so they are facing forward in the van. 4. Lock the wheelchair and secure the wheelchair to the van and buckle the patient/resident in. 5. Keep the patient/resident away for any heat source or other hazard that would lead to an injury or irritate the skin. If the passenger has a cane make sure it is secured. If the patient/resident is visually impaired, secure the cane within the passenger's reach. The MD stated CNA A was not trained to load residents onto the platform of the lift, facing the inside of the van; they were to be loaded outward facing. The MD stated CNA A was trained to double-check the breaks on all resident's wheelchairs to ensure safety. The MD stated the van did not have safety restraints on the lift platform. The restraints were used once the resident was loaded inside the van. The MD stated CNA A was not trained to ride on the lift with Resident #1 but had been trained to go up the stairs and meet the resident inside the van. The MD stated CNA A had passed the competency test as a van driver on 02/05/2024 and had attended all in-services given by him, since that time. The MD stated there was not a check list to validate safe van lift use. The MD stated the manufacturer's recommendations were used instead. The MD did not provide a copy of the recommendations. The MD provided the invoice from [Fleet management] after the incident which indicated the van had been inspected by the owner and a technician on 04/08/2025 and reported the following: Inspected the van on-site. Took videos and pictures. Upon inspection it was determined by both parties that the outer barrier (roll stop) had no faults and worked as designed. [Fleet Management] will hold off on the repairs until the State agency looks over the lift. Record review on 4/24/25 of re-training on Transport Accidents on 04/07/2025 to all van drivers regarding any falls or accidents which occurred while on transportation revealed the following: A. Do not move the resident. B. Immediately call 911 to have the resident assessed. C. Notify the DON, Administrator and Maintenance immediately. Record review on 4/24/25 of the QAPI committee met on 04/07/2025 at 12:00PM and was attended by the following committee members: Medical Director, DON, (2) ADONs, Activity Director, MD, Social Services, (2) Nurse Assessment Coordinators and Human Resources. The Administrator was on vacation in Hawaii and did not attend the meeting by phone. (continued on next page)

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	675498	A. Building B. Wing	04/25/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Mitigation Plan was put into effect under F689 Free from Accidents/Hazards/Supervision/Devices and read as follows: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Practice issue: Free of accident/hazards/supervision/devices Resident fell while being lifted on the facility van lift on 04/05/2025. Resident was sent to the ER. The physician and family were notified. The staff member was suspended, and the incident was reported to HHSC. Staff was re-educated beginning on 04/06/2025 and will