STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675532	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uvalde Healthcare and Rehabilitation Center	535 N Park St Uvalde, TX 78801

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on interviews, and record reviews the facility failed to implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 3 residents (Resident #1) reviewed in that: CNA A failed to follow the plan of care which required a 2 person assist to transfer Resident #1 with the Hoyer Lift (a mechanical lift that uses a sling attached to a hoist to transfer a person from a bed to a wheelchair) on 03/23/24. This failure resulted in the identification of Immediate Jeopardy (IJ) on 3/23/24 at 6:53 p.m. While the immediacy was removed on 3/28/24 at 3:42 p.m., the facility remained out of compliance at scope of isolated and a severity with actual harm due to the facility's need to monitor the implementation of the plan of removal. This failure placed residents at the facility who required the mechanical lift for transfers at risk for pain or injuries. Findings included: Record review of Resident #1's undated face sheet revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes (sustained high blood sugar levels and can increase risk of damage to eyes, nerves, heart and cause delayed wound healing), morbid obesity (severe form of excess body weight), contracture of the left knee (gradual shortening of muscles, tendons, and skin that causes the joints to shorten and prevent normal movement), hemiplegia (paralysis of one side of the body) and high blood pressure. Record review of Resident #1's electronic physician's orders revealed an order for ADL - transfer by 2 staff with mechanical lift, with a start date of 09/09/23. Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 11 out of 15 which indicated his cognitive skills for daily decision making were moderately impaired; he had functional limitation in range of motion on 1 side of his upper and lower extremities (legs and arms), used a wheelchair, and was dependent on staff assistance of 2 or more helpers with transfer from chair/bed-to-chair. (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: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER: Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 N Park St Uvalde, TX 78801	

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan for the problem of Alteration in ADL self-performance and mobility related to weakness, left sided hemiparesis, contractures to left upper extremity, revealed under Approaches with a start date of 11/09/22 was Requires assist x 2 staff with Hoyer [mechanical lift] with transfer tasks. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:00 PM by LVN B revealed Called to resident room - upon entry resident sitting up in wheelchair alert awake and active forgetful and anxious - CNA A reports resident had light on and asked to put him up for dining-he asked to move to the chair for dinner - she informed him she would go find someone to help - was unable to find assistance - was then transferring resident to wheelchair using Hoyer [mechanical] lift and while put him in wheelchair the back of the wheelchair . reclined quickly and then CNA C came into the room at about 3:30 PM and saw he was in chair. Resident says he fell on the floor while being transferred to wheelchair - resident says he was put in sling and CNA A went to get some help - came back and was trying to put him in wheelchair when he fell to floor - denies pain or loc [loss of consciousness] at this time. Record review of a handwritten, signed statement from CNA A, dated 3/23/24, revealed Resident #1 hes [sic] call light was on. He asked to put him up for dining he asked to move to the chair for dinner. I told him I was going to go find someone. I couldn't find anyone. I went to move him to the chair, his chair reclined back. He did fall. He was placed in the chair. CNA C walked in about 3:35 PM and saw he was in his chair. Record review of a handwritten, signed statement from CNA C, dated 3/24/24, revealed March 23, 2024 about 3-4 PM I heard CNA A's voice. I went to room check if she needed any help only to find she was attempting to transfer Resident #1 to his chair alone, she already had him over his chair but the back of the chair was reclined to [sic] far. I guided him so he was placed in the chair . In an interview on 03/25/24 at 10:33 AM, Resident #1 stated on 3/23/24, around 4 PM, CNA A came into his room to transfer him from his bed to his wheelchair per the resident's request. Resident #1 said CNA A placed the mechanical lift sling underneath him, then she told Resident #1 that he might have to help her because the other CNAs were working. Resident #1 stated he asked CNA A if she could wait until the other aides finished their work to assist her. Resident #1 said CNA A left the room and came back about five minutes later, said she could not find anyone and moved the mechanical lift over to the bed, attached the lift sling that was under him, grabbed the lift remote control and asked Resident #1 if he was ready. Resident #1 stated he responded, Yes, I'm ready, just don't drop me on the floor. Resident #1 stated when CNA A moved him from his bed to the wheelchair with the mechanical lift by herself, she could not bring him to the chair, and he fell . Resident #1 stated another CNA (CNA C) came into the room, and assisted CNA A. In an interview on 03/25/24 at 2:53 PM, CNA C stated on 3/23/24 when she entered Resident #1's room, the back part of his chair had reclined back all the way, and he was a bit crooked in the chair, holding onto the right arm rest with his right arm and Resident #1 stated he fell . CNA C said she asked CNA A why she was doing it by herself, and CNA A said she could not find anyone to help her. CNA C said she assisted CNA A with positioning Resident #1 in his chair correctly, the sling that was under him was crooked, so they fixed the sling, sat him upright, unhooked the straps of the lift sling from the mechanical lift. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 03/25/24 at 4:38 PM to 4:54 PM, CNA A stated when the mechanical lift was used to move a resident there must be 2 employees present to operate the lift and there could be a lot of damage to the resident if one person transferred a resident by themselves with the lift. CNA A stated she was the shower aide but on 3/23/24 she was working as a CNA and there were 3 other CNAs for a total of 4 CNAs. CNA A stated on 3/23/24 was the first time she cared for Resident #1, but she was aware the aides would use a mechanical lift with the assistance of two staff to move Resident #1. CNA A stated on 3/23/24 Resident #1 insisted on getting out of bed into his chair. CNA A said she told Resident #1 to wait while she went to find assistance. CNA A stated she could not find anyone and came back into Resident #1's room and Resident #1 insisted that he be moved from the bed to his chair. CNA A stated she moved Resident #1 into his wheelchair with the mechanical lift by herself and as she placed him into his wheelchair, the back of the chair reclined, and he got scared. CNA A said Resident #1 stated that he fell but she told him he did not fall, his chair just reclined back. CNA A said then another CNA (CNA C) came into the room, saw Resident #1 in the chair, together they repositioned the resident in his wheelchair. CNA A stated the reason why she did the transfer by herself was because she could not find anyone else to assist her. In an interview on 03/27/24 at 10:50 AM, LVN B stated on 03/23/24 around 4 PM CNA C told her to go see Resident #1. LVN B said when she entered Resident #1's room, he was in his wheelchair and told her he fell when CNA A dropped him to the floor. LVN B stated CNA A then entered the room and said she was getting him ready to take him to the dining room, Resident #1 was in his bed, and she (CNA A) transferred him to his wheelchair with the mechanical lift. CNA A told LVN B the back of Resident #1's wheelchair reclined abruptly, and Resident #1 said his foot hurt; then CNA C walked into the room and assisted CNA A with repositioning Resident #1 into his wheelchair. LVN B said CNA A denied Resident #1 fell to the floor. LVN B stated she expects CNAs to always have 2 people transferring a resident with a mechanical lift and if they cannot find another person, the CNA should wait until they can get assistance. LVN B said a resident could fall, get injured or die because of being transferred with a mechanical lift that was done by only one person. LVN B stated it was important to follow a resident's plan of care because the care plan specifically addressed the resident's needs. In an interview on 03/27/24 at 2:00 PM, RN D stated the DON was on leave, she was the DON Designee in her absence and had worked in the facility for less than one month. RN D stated staff were expected to have 2 CNAs or nurses in the room when they transfer a resident with the mechanical lift, and they should not do the transfer until 2 people are present. RN D stated the harm of transferring a resident with only 1 person operating a mechanical lift instead of 2 people could cause falls, serious injuries, head injuries, broken bones or cause psychological harm. In an interview on 03/25/24 at 6:43 PM, the Assistant Administrator stated the risk of 1 person transferring a resident with a mechanical lift instead of 2 people could result in the resident falling, slipping out of the sling, or a plethora of things could happen. The Assistant Administrator stated CNA A told him she was not able to find anyone right away to assist her, the resident was getting impatient, and she did it right away by herself instead of waiting for assistance. In an interview on 3/25/24 at 3:40 PM, RN D stated an in-service had been completed on use of a mechanical lift in January 2023 and she could not find any other in-service trainings on use of a mechanical lift. Record review of an Employee In-Service Attendance Record, dated 01/15/24, revealed CNA A was in-serviced on mechanical lift transfers. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy Safe Lifting and Movement of Residents, revised July 2017, revealed In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents .1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents .5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. Record review of the facility's policy Care Planning - Interdisciplinary Team, revised September 2013, revealed Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident .2. The care plan is based on the resident's comprehensive assessment and is developed by a care planning/interdisciplinary team . This was determined to be an Immediate Jeopardy (IJ) on 03/25/24 at 6:53 PM. The facility Assistant Administrator was notified. The Assistant Administrator was provided with the IJ template on 03/25/24 at 6:53 PM. On 03/26/24 the facility provided a plan of removal titled: Plan of Removal. The plan of removal was accepted on 03/26/2024 at 7:49 PM. It is documented as follows: Plan of Removal Problem: Failure to prevent accidents allegation Interventions: -CNA A was suspended, and terminated as of 03/26/24 -In the course of investigation, it was reported that CNA A stated Resident #1's foot hit the floor hard. A written statement from CNA A contradicted this, and there was no mention of resident hitting his foot on the floor. -CNA A also admitted that she transferred Resident #1 with no assistance, which is against company policies and procedures -In-service nursing staff on Mechanical Lift Transfer with two staff members at all times, starting on 3/24/24. New in-servicing regarding proper sling placement, and the wear and tear of a sling, as well as the steps to be taken if no other staff members are available at the time of transfer, will begin on 3/26/24. Staff not present on 03/25/24 will be in-serviced prior to attempting to transfer a resident with a mechanical lift. -Abuse and neglect in-service for all staff started on 03/24/24 -Inspection of all lift slings, with removal from service any sling that is frayed or torn, will be conducted on 03/26/24. -Maintenance supervisor to visually inspect both mechanical lifts to ensure that they are in proper working order, and that there is no damage that would prevent the safety of patient transfers (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitoring -The DON and/or Designee will monitor at least 5 lift transfers per week, observing for proper technique and staff assistance, and maintain a running log of said transfers. -The DON/Designee will observe and log that all slings are in good working order at least once a week -The QAPI committee will review findings monthly for no less than 90 days and makes changes as needed The facility's POR Verification was as follows: In an interview on 03/27/24 at 2:30 PM, the Assistant Administrator stated CNA A was terminated from employment on 3/26/24. In an interview on 03/27/24 at 2:00 PM, the DON Designee, RN D, said she had a list of two employees who had not received the education and would not schedule them to work until they received the in-service training. In an interview on 03/27/24 at 3:00 PM, the Assistant Administrator stated the DON Designee had identified employees who had not received education at that time and the employees were not scheduled to work until they have received the education. The Assistant Administrator stated the facility had a QAPI meeting on 03/27/24 and discussed the findings of the deficient practice and the plan of removal. The Administrator said the findings of the audits would be brought to the monthly QAPI meetings and reviewed. He stated the information would be used to determine if the interventions in place were effective or if they need to make changes to their systems. In an interview on 3/27/24 at 3:05 PM, the Maintenance Director stated he inspected both mechanical lifts on 3/26/24 and the lifts were functioning properly. He stated the mechanical lifts were inspected weekly and kept an inspection log in a binder and if there was a concern with a mechanical lift, it would be removed from service and be repaired and notify the DON and the Assistant Administrator. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a group interview on 03/28/24 at 11:15 AM with the Assistant Administrator and the DON Designee, RN D stated an audit log was created to document observations of mechanical lift transfers. RN D stated she or the DON would observe 5 mechanical lift transfers weekly; and two observations were completed on 3/27/24 at 4:45 PM and on 3/28/24 at 8:30 AM. RN D stated there were no concerns with the mechanical lift, technique used by staff or the sling that was used for the transfer. RN D stated she observed the mechanical lift slings used during the transfer and the slings were in good condition. The Administrator stated the log would be reviewed and facility would track the findings and use the information to determine if further education was needed or if staff performed the transfers correctly. The Assistant Administrator stated the audit information would be brought to QAPI meeting monthly and the information would be reviewed to determine effectiveness and if changes needed to be made to the system, policy, or procedure. The Assistant Administrator stated the Housekeeping Supervisor completed a sling audit on 03/27/24 at 4 PM that revealed 9 slings in use were in good working condition. He stated the slings will be observed weekly by the Housekeeping Supervisor and would be recorded on the audit log. He stated any slings with holes, tears or frays would be removed from service. He stated the audit information will be reviewed and used to track the condition of the sling supply and determine when new slings should be purchased. In an interview on 03/28/24 at 1:35 PM, the housekeeping Supervisor stated she completed the sling audit on 03/27/24, there were 9 slings in use, and they were in good condition. She stated if a sling was found with worn, torn, or frayed material she would remove it from service, log the information on the audit log and place an order to replace the sling. Interviews with 23 of 29 direct care staff from different shifts was completed on 03/27/24 and 03/28/24 which consisted of 13 direct care staff from day shift (6 AM-6 PM) and 10 direct care staff from night shift (6 PM-6 AM). All 23 staff members reported there were educated and trained on the use of mechanical lifts. Interviews on 03/27/24 and 03/28/24 with 50 of 66 facility staff from different shifts revealed staff have received education on abuse and neglect. Observations on 03/27/24 and 03/28/24 of resident and staff interactions revealed no signs of abuse or neglect. Observations on 03/26/24 of 5 resident slings and on 03/27/24 of 4 resident slings revealed no holes, tears, or frays on the slings. Record Review of CNA A's termination paperwork dated 3/26/24 revealed she was terminated on 03/26/24 for operating a mechanical lift without 2 people; the document was signed by the Assistant Administrator, and he noted CNA A refused to sign the document. Record review of education sign in sheet, dated 03/24/24, revealed 48 staff received education on proper techniques of a mechanical lift transfer which always included the use of 2 persons for mechanical lift transfers. Record review of education sign in sheet, dated 03/26/24, revealed 66 staff received education on using 2 people to perform a safe mechanical lift transfer. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of education sign in sheet, dated 03/26/24, revealed 66 staff received education on reporting incidents of abuse and neglect immediately to the Assistant Administrator, DON, and Charge Nurse. Record Review of the facility sling audit tool dated 03/27/24 revealed documentation 9 slings were in use and in good condition. Record Review of an inspection check off list completed on 3/26/24 for two facility mechanical lifts showed no concerns with the mechanical lifts. Record review of an audit form reflecting a mechanical lift observation was done on 03/27/2024 at 4:45 PM by CNA G and CNA H, who performed a mechanical lift of a resident revealed no concerns were noted. Record Review of the QAPI meeting Sign-in Sheet revealed a QAPI meeting was held on 03/26/24 at 8:30 AM and in attendance was the Administrator, Medical Director, RN Designee-RN D, Director of Marketing, Director of Rehab and 9 other department managers. On 03/28/24 at 3:42 PM, the Assistant Administrator was notified the immediacy was lifted on 03/28/24 at 3:42 PM but the facility remained out of compliance at scope of isolated and a severity with actual harm due to the facility's need to monitor the implementation and effectiveness of its POR.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 26481 Based on observation, interview and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents, hazards, and supervision in that: CNA A failed to follow Resident #1's physician order and plan of care which required a 2-person assist to transfer Resident #1 with a Mechanical Lift (a mechanical lift with a sling attached to a hoist to transfer a person from a bed to a wheelchair) on 03/23/24, which resulted in the back of Resident #1's wheelchair to recline as he was placed in it and caused an injury to his right foot when his foot hit the floor. Resident #1 was transferred to a local hospital and was diagnosed with a fracture of the right 5th metatarsal bone (break in the little toe). This failure resulted in the identification of Immediate Jeopardy (IJ) on 3/23/24 at 6:53 p.m. While the immediacy was removed on 3/28/24 at 3:42 p.m., the facility remained out of compliance at scope of isolated and a severity with actual harm due to the facility's need to monitor the implementation of the plan of removal. The failure placed residents at the facility who required the mechanical lift for transfers at risk for pain or serious injuries. Findings included: Record review of Resident #1's undated face sheet revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes (sustained high blood sugar levels and can increase risk of damage to eyes, nerves, heart and cause delayed wound healing), morbid obesity (severe form of excess body weight), contracture of the left knee (gradual shortening of muscles, tendons, and skin that causes the joints to shorten and prevent normal movement), hemiplegia (paralysis of one side of the body) and high blood pressure. Record review of Resident #1's electronic physician's orders revealed an order for ADL - transfer by 2 staff with mechanical lift, with a start date of 09/09/23. Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 11 out of 15 which indicated his cognitive skills for daily decision making were moderately impaired; he had functional limitation in range of motion on 1 side of his upper and lower extremities (legs and arms), used a wheelchair, and was dependent on staff assistance of 2 or more helpers with transfer from chair/bed-to-chair. Record review of Resident #1's Care Plan for the problem of Alteration in ADL self-performance and mobility related to weakness, left sided hemiparesis, contractures to left upper extremity, revealed under Approaches with a start date of 11/09/22 was Requires assist x 2 staff with Hoyer (mechanical lift] with transfer tasks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:00 PM by LVN B revealed Called to resident room - upon entry resident sitting up in wheelchair alert awake and active forgetful and anxious - CNA A reports resident had light on and asked to put him up for dining-he asked to move to the chair for dinner - she informed him she would go find someone to help - was unable to find assistance - was then transferring resident to wheelchair using Hoyer [mechanical] lift and while put him in wheelchair the back of the wheelchair . reclined quickly and then CNA C came into the room at about 3:30 PM and saw he was in chair. Resident says he fell on the floor while being transferred to wheelchair - resident says he was put in sling and CNA A went to get some help - came back and was trying to put him in wheelchair when he fell to floor - denies pain or loc [loss of consciousness] at this time. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:10 PM by LVN B revealed Resident now begins to c/o [complain of] pain to outer right foot - small bump to area palpated with c/o pain - no discoloration noted - foot is warm/dry - capillary refill [assessment done to determine blood flow to the toes/fingers] less than three seconds pedal [foot] pulse present - this writer asked if his body hurt in any way and he now begins to c/o some back pain. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:16 PM by LVN B revealed contact made with RN D - informed her of occurrence she and I [LVN B] connect via phone with Assistant Administrator and notified him of the occurrence. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:25 PM by LVN B revealed Resident #1's family member contacted informed her - verbalizes understanding. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:29 PM by LVN B revealed physician made aware, order to send to ER to eval and treat. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:40 PM by LVN B revealed report called to nurse at Hospital E's emergency room , 911 called pending arrival. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 4:42 PM by LVN B revealed neuro checks [special assessment done to determine if there is injury to the brain or nervous system] initiated - Resident #1 remains alert awake and active continues to c/o slight pain to back and to outer right foot - denies loc - no change in neuro status noted pending EMS to arrive. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 5:00 PM by LVN B revealed no change in neuro status is alert awake and active forgetful and confused at times .continues to c/o slight pain to right outer foot and to back will continue to monitor. EMS here - patient report and patient care turned over. Record review of Resident #1's Nurse's Note, dated 3/23/24 at 9:15 PM by LVN F revealed received report from nurse at Hospital E's emergency room , Resident #1 ready to be discharged back to facility .diagnoses: right foot sprain, contusion [bruising] to lower back, fracture of 5th metatarsal [little toe] bone .Assistant Administrator notified, RN D/Weekend Supervisor notified of above. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Nurse's Note, dated 3/23/24 at 9:30 PM by LVN F revealed resident returned to facility via EMS accompanied by 2 EMTs, x3 assist to transfer resident back to bed, and made comfortable - Resident #1 c/o back pain administered, pain medication was administered at ER prior to leaving, discoloration noted to right lower extremity [lower leg], resident wearing post-op shoe, no physical sign of distress noted . Record review of Resident #1's Hospital E's emergency room Patient Visit Information sheet, dated 3/23/24, revealed he was seen for contusion of lower back, right foot sprain, and fracture of right fifth metatarsal bone and discharge instructions were sent for the foot fracture. Record review of Resident #1's Hospital E's emergency room Discharge Instructions for Foot Fracture, dated 3/23/24, revealed A foot fracture is a break in any of the 26 bones in the foot. It may take 3 to 10 weeks to heal . Record review of Resident #1's Event [Incident] Report dated 3/23/24 revealed the resident had a fall in his room, complained of pain to his back and outer right foot, resident was sent to the ER for evaluation and treatment, the physician was notified on 3/23/24 at 4:29 PM and gave order to send to ER to evaluate and treat, Resident #1's family member was notified and would meet Resident #1 at the ER. Record review of a handwritten, signed statement from CNA A, dated 3/23/24, revealed Resident #1 hes [sic] call light was on. He asked to put him up for dining he asked to move to the chair for dinner. I told him I was going to go find someone. I couldn't find anyone. I went to move him to the chair, his chair reclined back. He did fall. He was placed in the chair. CNA C walked in about 3:35 PM and saw he was in his chair. Record review of a handwritten, signed statement from CNA C, dated 3/24/24, revealed March 23, 2024 about 3-4 PM I heard CNA A's voice. I went to room check if she needed any help only to find she was attempting to transfer Resident #1 to his chair alone, she already had him over his chair but the back of the chair was reclined to [sic] far. I guided him so he was placed in the chair but he was not correct. As we adjusted him, he stated to me that 'he fell '. I asked him what he meant, and he stated that he fell to the floor. CNA A said 'no' that as she placed him to the chair, that the back dropped as she lowered him, he got scared but he never fell to the floor. He then stated that his right foot hurt I asked what part? He said the outside his toe's. I asked why? He said he hit something when she was transferring him. I told him not to worry we will figure it out. They both told the story until CNA A left the room. Then I asked again if anything hurt he said just his foot. I asked did you drop to the floor. He said 'yes', he was on the floor. I told him to give me a minute that I had to talk to LVN B about what to do next. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 N Park St Uvalde, TX 78801	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 03/25/24 at 10:33 AM, Resident #1 stated on 3/23/24, around 4 PM, CNA A came into his room to transfer him from his bed to his wheelchair per the resident's request. Resident #1 said CNA A placed the mechanical lift sling underneath him, then she told Resident #1 that he might have to help her because the other CNAs were working. Resident #1 stated he asked CNA A if she could wait until the other aides finished their work to assist her. Resident #1 said CNA A left the room and came back about five minutes later, said she could not find anyone and moved the mechanical lift over to the bed, attached the lift sling that was under him, grabbed the lift remote control and asked Resident #1 if he was ready. Resident #1 stated he responded, Yes, I'm ready, just don't drop me on the floor. Resident #1 stated when CNA A moved him from his bed to the wheelchair with the mechanical lift by herself, she could not bring him to the chair, and he fell . Resident #1 stated another CNA (CNA C) came into the room, asked him if anything hurt and he told her his back and his right foot hurt. Resident #1 stated LVN B came into the room and asked him if he was alright, and he told her his back and his right foot hurt. Resident #1 stated LVN B came back into the room, told him she called his family member to let her know he fell , and his family member was going to meet him at the hospital. Resident #1 stated then the ambulance came and took him to the hospital, and he did not return from the hospital until after 10 PM because the hospital needed the x-ray results. Resident #1 stated he did get out of bed yesterday (3/24/24) and today (3/25/24) he was still a little bit sore, his right foot still hurt, and he received Tylenol for his foot pain which helped. In an interview on 03/25/24 at 2:53 PM, CNA C stated on 3/23/24 when she entered Resident #1's room, the back part of his chair had reclined back all the way, and he was a bit crooked in the chair, holding onto the right arm rest with his right arm and Resident #1 stated he fell . CNA C said she asked CNA A why she was doing it by herself, and CNA A said she could not find anyone to help her. CNA C said she assisted CNA A with positioning Resident #1 in his chair correctly, the sling that was under him was crooked, so they fixed the sling, sat him upright, unhooked the straps of the lift sling from the mechanical lift. CNA C stated when the sling was removed from the lift, Resident #1 stated to her again that he fell . CNA C said she asked Resident #1 what he meant, and the resident said he fell . CNA A told CNA C that Resident #1 did not fall but the back of the chair reclined back and stated again that Resident #1 did not fall. CNA C said Resident #1 told her his foot hurt, so she reassured him, and left the room to notify LVN B of the situation. CNA C stated as LVN B assessed Resident #1 told LVN B the same story of what happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 03/25/24 at 4:38 PM to 4:54 PM, CNA A stated when the mechanical lift was used to move a resident there must be 2 employees present to operate the lift and there could be a lot of damage to the resident if one person transferred a resident by themselves with the lift. CNA A stated she was the shower aide but on 3/23/24 she was working as a CNA and there were 3 other CNAs for a total of 4 CNAs. CNA A stated on 3/23/24 was the first time she cared for Resident #1, but she was aware the aides would use a mechanical lift with the assistance of two staff to move Resident #1. CNA A stated on 3/23/24 Resident #1 insisted on getting out of bed into his chair. CNA A said she told Resident #1 to wait while she went to find assistance. CNA A stated she could not find anyone and came back into Resident #1's room and Resident #1 insisted that he be moved from the bed to his chair. CNA A stated she moved Resident #1 into his wheelchair with the mechanical lift by herself and as she placed him into his wheelchair, the back of the chair reclined, and he got scared. CNA A said Resident #1 stated that he fell but she told him he did not fall, his chair just reclined back. CNA A said then another CNA (CNA C) came into the room, saw Resident #1 in the chair, together they repositioned the resident in his wheelchair and Resident #1 complained that his foot hurt so the nurse was informed who assessed the resident. CNA A stated when the wheelchair back reclined back, Resident #1's foot hit the floor hard. She stated the reason why she did the transfer by herself was because she could not find anyone else to assist her. CNA A stated she received verbal training on how to use the mechanical lift about a month ago and was not in-serviced on 3/23/24 or on 3/24/24 on use of the mechanical lift. In an interview on 03/27/24 at 10:50 AM, LVN B stated on 03/23/24 around 4 PM CNA C told her to go see Resident #1. LVN B said when she entered Resident #1's room, he was in his wheelchair and told her he fell when CNA A dropped him to the floor. LVN B stated CNA A then entered the room and said she was getting him ready to take him to the dining room, Resident #1 was in his bed, and she (CNA A) transferred him to his wheelchair with the mechanical lift. CNA A told LVN B the back of Resident #1's wheelchair reclined abruptly, and the Resident #1 said his foot hurt; then CNA C walked into the room and assisted CNA A with repositioning Resident #1 into his wheelchair. LVN B said CNA A denied Resident #1 fell to the floor. LVN B stated she assessed Resident #1, felt his foot, and felt a bump on his foot which the resident stated he had a lot of pain, and when she assessed his back Resident #1 stated it hurt. LVN B said she notified the RN on duty (RN D), the Assistant Administrator and Resident #1's physician who gave orders to send the resident to the hospital. LVN B stated she expects CNAs to always have 2 people transferring a resident with a mechanical lift and if they cannot find another person, the CNA should wait until they can get assistance. LVN B said a resident could fall, get injured or die because of being transferred with a mechanical lift that was done by only one person. In an interview on 03/27/24 at 2:00 PM, RN D stated the DON was on leave, she was the DON Designee in her absence and had worked in the facility for less than one month. RN D stated staff were expected to have 2 CNAs or nurses in the room when they transfer a resident with the mechanical lift, and they should not do the transfer until 2 people are present. RN D stated the harm of transferring a resident with only 1 person operating a mechanical lift instead of 2 people could cause falls, serious injuries, head injuries, broken bones or cause psychological harm. In an interview on 03/25/24 at 6:43 PM, the Assistant Administrator stated the risk of 1 person transferring a resident with a mechanical lift instead of 2 people could result in the resident falling, slipping out of the sling, or a plethora of things could happen. The Assistant Administrator stated CNA A told him she was not able to find anyone right away to assist her, the resident was getting impatient, and she did it right away by herself instead of waiting for assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 3/25/24 at 3:40 PM, RN D stated an in-service had been completed on use of a mechanical lift in January 2024 and she could not find any other in-service trainings on use of a mechanical lift. Record review of an Employee In-Service Attendance Record, dated 01/15/24, revealed CNA A was in-serviced on mechanical lift transfers. Record review of the facility's policy on Safe Lifting and Movement of Residents, revised July 2017, revealed In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents .1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents .5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. This was determined to be an Immediate Jeopardy (IJ) on 03/25/24 at 6:53 PM. The facility Assistant Administrator was notified. The Assistant Administrator was provided with the IJ template on 03/25/24 at 6:53 PM. On 03/26/24 the facility provided a plan of removal titled: Plan of Removal. The plan of removal was accepted on 03/26/2024 at 7:49 PM. It is documented as follows: Plan of Removal Problem: F689 Failure to prevent accidents allegation Interventions: -CNA A was suspended, and terminated as of 03/26/24 -In the course of investigation, it was reported that CNA A stated Resident #1's foot hit the floor hard. A written statement from CNA A contradicted this, and there was no mention of resident hitting his foot on the floor. -CNA A also admitted that she transferred Resident #1 with no assistance, which is against company policies and procedures -In-service nursing staff on Mechanical Lift Transfer with two staff members at all times, starting on 3/24/24. New in-servicing regarding proper sling placement, and the wear and tear of a sling, as well as the steps to be taken if no other staff members are available at the time of transfer, will begin on 3/26/24. Staff not present on 03/25/24 will be in-serviced prior to attempting to transfer a resident with a mechanical lift. -Abuse and neglect in-service for all staff started on 03/24/24 -Inspection of all lift slings, with removal from service any sling that is frayed or torn, will be conducted on 03/26/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Maintenance supervisor to visually inspect both mechanical lifts to ensure that they are in proper working order, and that there is no damage that would prevent the safety of patient transfers Monitoring -The DON and/or Designee will monitor at least 5 lift transfers per week, observing for proper technique and staff assistance, and maintain a running log of said transfers. -The DON/Designee will observe and log that all slings are in good working order at least once a week -The QAPI committee will review findings monthly for no less than 90 days and makes changes as needed The facility's POR Verification was as follows: In an interview on 03/27/24 at 2:30 PM, the Assistant Administrator stated CNA A was terminated from employment on 3/26/24. In an interview on 03/27/24 at 2:00 PM, the DON Designee, RN D, said she had a list of two employees who had not received the education and would not schedule them to work until they received the in-service training. In an interview on 03/27/24 at 3:00 PM, the Assistant Administrator stated the DON Designee had identified employees who had not received education at that time and the employees were not scheduled to work until they have received the education. The Assistant Administrator stated the facility had a QAPI meeting on 03/27/24 and discussed the findings of the deficient practice and the plan of removal. The Administrator said the findings of the audits would be brought to the monthly QAPI meetings and reviewed. He stated the information would be used to determine if the interventions in place were effective or if they need to make changes to their systems. In an interview on 3/27/24 at 3:05 PM, the Maintenance Director stated he inspected both mechanical lifts on 3/26/24 and the lifts were functioning properly. He stated the mechanical lifts were inspected weekly and kept an inspection log in a binder and if there was a concern with a mechanical lift, it would be removed from service and be repaired and notify the DON and the Assistant Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a group interview on 03/28/24 at 11:15 AM with the Assistant Administrator and the DON Designee, RN D stated an audit log was created to document observations of mechanical lift transfers. RN D stated she or the DON would observe 5 mechanical lift transfers weekly; and two observations were completed on 3/27/24 at 4:45 PM and on 3/28/24 at 8:30 AM. RN D stated there were no concerns with the mechanical lift, technique used by staff or the sling that was used for the transfer. RN D stated she observed the mechanical lift slings used during the transfer and the slings were in good condition. The Administrator stated the log would be reviewed and facility would track the findings and use the information to determine if further education was needed or if staff performed the transfers correctly. The Assistant Administrator stated the audit information would be brought to QAPI meeting monthly and the information would be reviewed to determine effectiveness and if changes needed to be made to the system, policy, or procedure. The Assistant Administrator stated the Housekeeping Supervisor completed a sling audit on 03/27/24 at 4 PM that revealed 9 slings in use were in good working condition. He stated the slings will be observed weekly by the Housekeeping Supervisor and would be recorded on the audit log. He stated any slings with holes, tears or frays would be removed from service. He stated the audit information will be reviewed and used to track the condition of the sling supply and determine when new slings should be purchased. In an interview on 03/28/24 at 1:35 PM, the housekeeping Supervisor stated she completed the sling audit on 03/27/24, there were 9 slings in use, and they were in good condition. She stated if a sling was found with worn, torn, or frayed material she would remove it from service, log the information on the audit log and place an order to replace the sling. Interviews with 23 of 29 direct care staff from different shifts was completed on 03/27/24 and 03/28/24 which consisted of 13 direct care staff from day shift (6 AM-6 PM) and 10 direct care staff from night shift (6 PM-6 AM). All 23 staff members reported there were educated and trained on the use of mechanical lifts. Interviews on 03/27/24 and 03/28/24 with 50 of 66 facility staff from different shifts revealed staff have received education on abuse and neglect. Observations on 03/27/24 and 03/28/24 of resident and staff interactions revealed no signs of abuse or neglect. Observations on 03/26/24 of 5 resident slings and on 03/27/24 of 4 resident slings revealed no holes, tears, or frays on the slings. Record Review of CNA A's termination paperwork dated 3/26/24 revealed she was terminated on 03/26/24 for operating a mechanical lift without 2 people; the document was signed by the Assistant Administrator, and he noted CNA A refused to sign the document. Record review of education sign in sheet, dated 03/24/24, revealed 48 staff received education on proper techniques of a mechanical lift transfer which always included the use of 2 persons for mechanical lift transfers. Record review of education sign in sheet, dated 03/26/24, revealed 66 staff received education on using 2 people to perform a safe mechanical lift transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of education sign in sheet, dated 03/26/24, revealed 66 staff received education on reporting incidents of abuse and neglect immediately to the Assistant Administrator, DON, and Charge Nurse. Record Review of the facility sling audit tool dated 03/27/24 revealed documentation 9 slings were in use and in good condition. Record Review of an inspection check off list completed on 3/26/24 for two facility mechanical lifts showed no concerns with the mechanical lifts. Record review of an audit form reflecting a mechanical lift observation was done on 03/27/2024 at 4:45 PM by CNA G and CNA H, who performed a mechanical lift of a resident revealed no concerns were noted. Record Review of the QAPI meeting Sign-in Sheet revealed a QAPI meeting was held on 03/26/24 at 8:30 AM and in attendance was the Administrator, Medical Director, RN Designee-RN D, Director of Marketing, Director of Rehab and 9 other department managers. On 03/28/24 at 3:42 PM, the Assistant Administrator was notified the immediacy was lifted on 03/28/24 at 3:42 PM but the facility remained out of compliance at scope of isolated and a severity with actual harm due to the facility's need to monitor the implementation and effectiveness of its POR.