STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675540	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health Care Center	1206 N Travis St Liberty, TX 77575

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 11 residents (Resident #1) reviewed quality of care. LVN C did not immediately assess Resident #1 after she was informed Resident #1 had left leg swelling on 03/07/26 at approximately 5:15 a.m. LVN B assessed Resident #1 at approximately 6:40 a.m. (after being asked by LVN C) on 03/07/26 and discovered discoloration to arms and legs and pain when touched. The noncompliance was identified as PNC (past noncompliance). The IJ began on 03/07/26 and ended on 03/10/26. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk of not receiving adequate care and medical interventions to maintain their health and prevent worsening health conditions.Findings included: Record review of Resident #1's face sheet dated 03/17/26 indicated she was an [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (form of dementia), cerebral infarction (stroke), dementia (decline in cognitive function), and muscle weakness. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she had clear speech and sometimes was able to make herself understood and sometimes understood others. She had severe cognitive impairment (BIMS-4). She utilized a wheelchair for mobility. She was dependent for all ADLS and transfers. Record review of Resident #1's care plan dated 12/26/23 (revised 11/28/25) indicated she had limited physical mobility or was at risk for decline related to Alzheimer's', and limited ROM to right arm and hand. Interventions included: Total assist for all ADLS (revised 07/15/25) and Resident #1 was non weight bearing and was a Hoyer lift X2 by staff at all times with transfers (revised 11/20/25). Record review of Resident #1's Kardex (electronic care record utilized by care staff) dated 03/17/26 indicated Resident #1 was non weight bearing and was a Hoyer lift X2 by staff at all times with transfers. Record review Resident #1's daily note dated 03/06/26 at 1:56 p.m., completed by LVN B indicated no edema present. There were no injuries noted. Record review of Resident #1's daily note dated 03/06/26 at 11:24 p.m., signed on 03/07/26, by LVN C indicated edema present. Location and grade were not noted. There was no signs or symptoms of pain or discomfort this PM. There were no injuries noted. Record review of Resident #1's progress note dated 03/07/26 at 8:33 a.m., completed by LVN B indicated she was asked by LVN C to look at Resident #1. Upon entering the room, LVN B pulled back the covers and discovered discoloration to arms and legs and resident having pain when being touched. LVN B immediately called the administrator and completed a full head to toe assessment and pain assessment. Resident #1 was not able to tell LVN B what happened. LVN B obtained a verbal order from MD to transfer Resident #1 to hospital for further evaluation. RP was notified. Record review of Resident #1's progress note dated 03/07/26 at 9:07 a.m., completed by LVN B, LVN B identified Resident #1 had skin tears and bruising. Resident #1 was lying in bed with the sheets pulled up. A full head to toe assessment was completed. Resident #1 had bilateral bruising to both arms right side and right thigh. Left lower extremity swelling and discoloration. There were 4 skins tears. The right forearm had swelling with a knot. There was a scratch on her forehead. Resident #1 was not able to articulate what happened. The MD was notified with new order to send to (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital for continuation of care. The RP, DON and Administrator were notified. There was no progress notes completed by LVN B on 03/06/26 or 03/07/27. Record review of hospital records dated 03/07/26 indicated Resident #1 was sent to the hospital out of concern for bruising on her extremities. There was a small 2 cm linear abrasion over the right superior forehead, obvious deformities of the left lower extremity, severe hematoma (trauma or injury to blood vessels to the right upper extremity along the distal brachium (lower arm), elbow and forearm, bilateral upper extremity contusion (bruise) with avulsion injuries around both wrists. CAT scan indicated displaced comminuted fractures (bone is broken into three or more pieces and the pieces have moved apart creating a gap) of the distal shafts of the left tibula and fibula and soft tissue swelling. Concern for elder abuse was noted. Resident was placed in cast. Orthopedic surgeon consulted for possible surgery following stabilization. These are life threatening diagnosis. Patient was treated with morphine. At the time of the investigation the surgical records were not available for review. Record review of the facility investigation dated 03/12/26 indicated: On 03/07/2026 at approximately 06:40 AM, the Facility Abuse Coordinator was notified Resident #1 was observed with bruises, and skin tears to her upper extremities. Swelling and discoloration was also noted to her left leg. The abnormalities were identified by day shift nurse LVN B. Review of facility documentation revealed no reported or documented falls or incidents on the prior shift that would explain the injuries. Facility nursing staff were unable to determine or identify how the injuries occurred. LVN B stated she was notified by the night nurse LVN C that Resident #1 had Edema. LVN B immediately went to assess the resident. LVN B was also the day shift nurse for 03/06/2026 from 6:00 am to 6:00 pm. LVN B stated that Resident #1 did not have any skin tears or abnormalities when she left her prior day shift at 6:00 pm. Prior to transferring to the hospital, the resident was interviewed by facility nursing staff. The resident, who is cognitively impaired but able to answer simple questions, was asked whether she had fallen or if anyone had harmed her. The resident responded no. Resident #1 was immediately assessed by nursing staff. A full head-to-toe assessment was completed, which confirmed the presence of bruising, swel1ing, and skin tears. Due to the unknown origin of the injuries and the need for further evaluation, the resident was transferred to (named hospital) for continuation of care. The physician (MD), responsible party (RP), police department, and Ombudsman were notified immediately. Documentation review showed that the resident received a shower on 03/06/2026 (time not indicated). The shower aide reported that at the time of care the resident did not have visible bruising, swelling, or skin tears. Additionally, the resident had been seen in person by the facility physicians on both 03/05/2026 and 03/06/2026, with no new or abnormal findings documented during those visits. CNA A stated that after placing the resident in bed, she requested assistance from the 600 Hall CNA E to help reposition the resident in bed. She stated she noticed bruising on the resident's arms and inquired about it. She reported she was told by CNA A that the bruising and skin tears were old and that the nurse had already been notified. The 100 Hall nurse LVN C acknowledged to the facility Director of Nursing and Administrator that she had been notified around approximately 5:00 AM that the resident's leg appeared bruised. The nurse stated she was providing care to another resident at the time and did not go to assess the resident following notification. Due to concerns identified during the investigation, CNA A and LVN C assigned to the resident's hall were immediately suspended pending investigation. Following further review, the nurse was terminated for failure to assess and document a resident after being notified of a change in condition. CNA A resigned effective immediately during questioning regarding the circumstances surrounding the resident's injuries. Additional investigative actions included:Facility-wide skin assessments completed with no new or abnormal findings.Environmental and safety rounds conducted with no hazards or abnormal findings identified.Resident safe surveys conducted, with residents reporting they feel safe in the facility environment.Staff education provided on abuse, neglect, and exploitation policies.Mechanical lift competencies completed with nursing staff.Targeted staff interviews conducted with employees who had direct contact with the resident within the previous 72 hours, specifically addressing (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	whether abnormalities were observed and whether they were reported appropriately. Re-education provided to staff regarding the role of the Facility Abuse Coordinator, incident and accident reporting, documentation requirements, and charting expectations. Record review of LVN C's personnel records indicated her date of hire was 11/03/09. She signed she was trained and completed competencies on 11/20/25 that included performing physical assessments/evaluations, documenting change of condition and monitoring pain. During an interview on 03/17/26 at 12:00 p.m., the Administrator said she was the Facility Abuse Coordinator. She said on 03/07/26 at approximately 6:40 a.m. she was notified that Resident #1 was observed with bruises, skin tears to her upper extremities, and swelling and discoloration of her left leg. The injuries were identified by LVN B. She said they were not able to determine how the injuries occurred. She said LVN B was notified by the night nurse, LVN C, that Resident #1 had edema and LVN B immediately went to assess Resident #1. LVN B was also the day shift nurse for 03/06/26 from 6:00 a.m. to 6:00 p.m. She said LVN B stated Resident #1 did not have any skin tears or abnormalities when she left her prior day shift at 6:00 p.m. Resident #1 was asked whether she had fallen or if anyone had hurt her. Resident #1 responded no. Resident #1 was assessed with bruising, swelling and skin tears. Due to the unknown origin of the injuries and the need for further evaluation, the resident was transferred to the hospital for continuation of care. The MD, RP, police department, and Ombudsman were notified immediately. Staff interviews did not reveal any reports of falls, injuries, or incidents involving Resident #1. No staff member was able to identify the cause of the observed injuries. She said Resident #1 received a shower on 03/06/26, before the lunch meal. The shower aide (CNA G) reported Resident #1 did not have visible bruising, swelling, or skin tears. Resident #1 was seen by the facility physicians on both 03/05/26 and 03/06/26, with no new or abnormal findings documented during those visits. She said CNA A worked the night shift of 03/06/26 to 03/07/26. She said CNA A reported at approximately 10:30 p.m. on 03/06/26 she was notified Resident #1 remained in her chair and needed to be placed in bed. Resident #1 was dependent for transfers, and her care plan and Kardex identified her as a two-person transfer using a mechanical Hoyer lift. CNA A stated that she transferred Resident #1 to bed using the Hoyer lift alone, without a second staff assist. She said CNA A acknowledged she had been trained Hoyer lifts required two staff for safe operation but did not provide a reason for performing the transfer alone. CNA A denied dropping the resident, denied finding the resident on the floor, and denied knowledge of any incident occurring prior to or during her shift. She said CNA A requested assistance from CNA F to help reposition Resident #1 in bed. She said CNA F noticed bruising on Resident #1's arms and inquired about it. CNA F said CNA A reported the bruising and skin tears were old and that the nurse had already been notified. The Administrator said LVN C acknowledged she had been notified around approximately 5:00 a.m. on 03/07/26 that Resident #1's leg appeared bruised. LVN C stated she was providing care to another resident at the time and did not go to assess the resident following notification. CNA A and LVN B were immediately suspended pending investigation. She said LVN B was terminated for failure to assess and document a resident after being notified of a change in condition. CNA A resigned during questioning of Resident #1's injuries. She spoke with Resident #1's family member, who reported Resident #1 had sustained a break in her leg in multiple places. She said the facility was unable to determine the exact cause of the injuries. She said Resident#1's roommate was not interviewable and did not provide any information regarding the incident. She said all staff were trained with Hoyer transfer during orientation, annually, and as needed, were aware two staff were required, and were aware the information was located in the Kardex. She said residents were at risk of injuries if they were not transferred with 2 staff as required with the Hoyer. During an interview on 03/17/26 at 2:09 p.m., CNA A said she arrived at the facility on 03/06/26 at 6:30 p.m. She said she started on Hall 500 and used a Hoyer lift to transfer Resident #5. She said she did not ask anyone to help. She said CNA H directed her to work on hall 100 and put Resident #1 to bed. She said she took the Hoyer she previously used on Resident #5 and went to Resident #1's room and transferred Resident #1 to her bed from her wheelchair. She said when she changed Resident #1 and (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	took off her sweater she found the skin tears on her arms by her wrists. She said she went to the nurse and asked if this resident was the resident who was always black and blue and the nurse said no. She said she put a gown on Resident #1 and told the nurse Resident #1 appeared in pain. She said the nurse said Resident #1 would be screaming if she was in pain. She said she did not ask for help. She said she did not notice any skin tears or bruises before she completed the Hoyer lift transfer without assist from a second staff. She said when she provided incontinent care for Resident #1 she noticed there was bruising on the left leg. She said she told her supervisor (CNA H) and the supervisor said it was always like that. She said the supervisor did not check Resident #1's leg. She said she asked LVN C to check Resident #1's leg. She said LVN C said it was edema and to elevate her leg. She said her leg was already on a pillow so she got a sheet and added it to the pillow for more elevation. She said she did not drop Resident #1 when she did the Hoyer transfer or when she provided incontinent care. She said she was aware Resident #1 was two person Hoyer lift. She said she was not trained in the facility with the Hoyer lift. She said she did not check the Kardex because she did not have access to the electronic system. During an interview on 03/18/26 at 10:23 a.m., LVN C said she saw Resident #1 in her wheelchair at approximately 10:30 p.m. She said Resident #1 was in her room. She said she looked over Resident #1 while she was in her wheelchair because Resident #1's Medicare charting was due. She said she did not see anything wrong with Resident #1. She said there were no bruises or skin tears. She said she asked CNA H to have CNA A put Resident #1 in bed. She said she saw CNA A go to Resident #1's room with the Hoyer lift. She said she saw CNA A walk past the nurse station and then she came back with CNA E and assumed it was to assist with the Hoyer lift to transfer Resident #1 from her wheelchair to her bed. She said she checked Resident #1 at 1:00 a.m. and Resident #1 was sleeping. She said she did not pull covers back because Resident #1 was sleeping and she did not want to wake her. She said she saw Resident #1 again at 3:00 a.m. and she was still sleeping. She said she was doing rounds at 5:00 a.m. and CNA A was changing Resident #1. She said the door to Resident #1's room was closed and she did not observe Resident #1 at 5:00 a.m. She said CNA A asked her to look at Resident #1's foot at approximately 5:10 a.m. or 5:15 a.m. She said CNA A rolled back the blanket on Resident #1's left foot and she saw the edema. She said she told CNA A to elevate Resident #1's leg and she continued to provide care to other residents. She said she checked Resident #1's chart to see if there was any prior documentation of the edema because CNA A said the edema was already known. She said she did not find any documentation of the edema. She said she asked LVN B to witness while she completed an assessment of Resident #1. She said she always had a witness for skin assessments. She said she and LVN B went to Resident #1's room and LVN B pulled back the covers and observed Resident #1's left leg was bruised and there were skin tears on both arms. She said the top layer of skin was missing from the skin tears and there were no skin flaps. She said Resident #1 was turned towards her (LVN C) and LVN B observed a cantaloupe sized bruise on her back. Resident #1 also had a scratch on her face. She said when Resident #1 was touched or moved she grimaced and moaned in pain. She said LVN B immediately called the Administrator to report the injuries. She said the Administrator called the police, the police arrived very quickly and asked for statements. She said CNA A had already left. She said the MD was notified and EMS arrived to transfer Resident #1 to the hospital for evaluation. She said she did not provide care or use the Hoyer lift to transfer for Resident #1. She said she did not properly assess Resident #1 when she was informed of the edema. She said she was not informed of any bruises or skin tears. She said not properly assessing a resident could lead to further decline of health and resident would not receive timely care. She said all Hoyer lift transfers are supposed to be with 2 person assist. She said risks of not having 2 person could include injuries and death. During an interview on 03/18/26 at 3:05 p.m., LVN B said she observed Resident #1 on 03/06/26 and Resident #1 had no injuries when she left the faciity on [DATE] at 6:00 p.m. She said Resident #1 wore a dress and had no edema or bruises on her legs. She said she arrived at the facility on 03/07/26 at 6:00 a.m. and received report. She said there was no report of any issues or concerns related to Resident #1. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She said LVN C asked her to assess Resident #1 at approximately 6:40 a.m. She said she pulled back Resident #1's covers and was shocked and immediately called the Administrator. She said Resident #1 was in the same condition the day before. She said Resident #1 had fresh skin tears on both her arms that had no skin flaps with purple and red bruises. She said there was a scratch on her right forehead. She said Resident #1's left leg was bruised and purple. She said there was fresh blood on her gown and blankets. She said Resident #1 showed pain with grimace and frown when she was moved and touched. She said the police arrived and told her to tell the administrator Resident #1 needed to go to the hospital. She said she told the administrator she had to send Resident #1 out because her left leg was twisted and propped up on a pillow. She said she asked LVN C did she know of Resident #1's injuries and LVN C said no. She said LVN C said she had not seen Resident #1 since 10:30 p.m. on 03/06/26 when she was in her wheelchair. She said LVN C said CNA A told her at 5:15 a.m. that Resident #1's legs were swollen and she told her to prop up it up with a pillow and she would look at it after she was done with another resident. She said after the police arrived, LVN B said she was notified of the edema at approximately 5:15 a.m. but was doing trach care on another resident. She said LVN C said CNA A pulled the cover back and she saw the edema on the left foot but she did not see the whole left leg. LVN B said she believed Resident #1 was dropped. She said the Kardex has the information related to resident care and if they required a Hoyer. She said all Hoyer transfers required 2 persons. She said residents were at risk of injuries if they were not transferred with 2 staff as required with the Hoyer. Record review of the facility's policy Unexplained Injuries dated 2023 indicated 1. Observations of any unexplained injuries shall be reported immediately to the resident's nurse. 2. Care and treatment shall be provided to the resident as needed. This includes physician notification and implementation of physician orders or facility protocols. An incident report form shall be completed. An injury should be classified as an injury of unknown source when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of: i. The extent of the injury or ii. The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or iii. The number or injuries observed at one particular point in time or iv. The incidence of injuries over time. Relevant information shall be documented in the resident's medical record, including but not limited to: a. Physical assessment findings, including objective descriptions of the injury. b. Risk factors and conditions that could cause or predispose someone to similar signs and symptoms. c. Notification of physician and his/her response. d. Actions taken to meet the resident's immediate needs and implementation of physician orders. E. Notification of resident representative. The facility took the following actions to correct the noncompliance prior to surveyor entrance: Record review of the facility-wide skin assessments dated 03/07/26 indicated no new or abnormal findings. Record review of the facility environmental and safety rounds dated 03/07/26 indicated no hazards or abnormal findings identified. Record review of resident safe surveys dated 03/07/26 indicated residents reported they felt safe in the facility environment. Record review of staff education indicated they were trained on abuse, neglect, and exploitation policies from 03/07/26 through 03/10/26. Record review of mechanical lift competencies indicated they were completed with nursing staff 03/07/26 through 03/10/26. Record reviews of electronic records of residents indicated no issues identified with assessments. Record review of an AD HOC QAPI meeting dated 03/07/26 indicated the interdisciplinary team included the Medical Director, DON, Administrator, the police were notified, SW, and Regional Nurse. The facility identified LVN B reported to the abuse coordinator Resident #1 had swelling, discoloration and bruising to her lower and upper extremities. Resident #1 had skin tears to both arms. There were no abnormal reports on 03/06/26 for Resident #1. Resident #1 was sent out to hospital for further evaluation and treatment. LVN C was suspended pending the investigation. The facility would continue to monitor the residents daily. The facility implemented staff training and competency testing/demonstration to include abuse, neglect, reporting, documentation, transfers, resident assessment, and pain assessment. In-services: Record (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	review of in-services initiated on 03/07/26 through 03/10/25 were conducted for all direct care staff by the DON in person and/or via phone. All staff who were not present for in-services were not permitted to work their assignment until in-serviced. All new hires would be in-serviced during facility orientation. All agency staff would be in-serviced prior to working their floor assignment. Record review of an In-Service Training Report that included falls, documentation, stop and watch alert tool in PCC, and documentation, the abuse coordinator and staff to report, abuse, neglect immediately to the abuse coordinator (the Administrator), conducted by the DON from 03/07/26 through 03/10/26, indicated 100% of staff were trained. Record review of the staff training for skin assessment, pain assessments, and competencies conducted by the ADON on 03/07/26 through 03/10/26 indicated 100% of nursing staff were trained. Record review of the facility's incident reports from 03/07/26 through 03/18/26 indicated there were no concerns related to resident injuries. Staff interviews conducted on 03/17/26 and 03/18/26 with staff who worked all shifts (6:00 a.m.-6:00 p.m., 6:00 p.m. - 6:00 a.m., 7:00 a.m. - 7:00 p.m., and 8:00 .m. - 4:30 p.m. (LVN K, LVN B, LVN L, LVN O, LVN P, LVN R, and ADON) indicated they were aware of the facility's abuse prevention and reporting policy, were aware the Administrator was the Abuse Coordinator and were to report any suspicion or allegation of abuse or neglect immediately. They were aware all changes of condition should be reported immediately to the charge nurse, documented, and assessed. Nursing staff indicated they had received training and passed competency tests from 03/07/26 through 03/10/26 on resident assessment and pain assessments. During an interview on 03/17/26 at 12:00 p.m., the Administrator said facility-wide skin assessments were completed with no new or abnormal findings, environmental and safety rounds were conducted with no hazards or abnormal findings identified, resident safe surveys conducted and residents reported they felt safe in the facility environment, staff education provided on abuse, neglect, and exploitation policies, mechanical lift competencies were completed with nursing staff, re-education was provided to staff regarding the role of the Facility Abuse Coordinator, incident and accident reporting, documentation requirements, and charting expectations. The Administrator said an Ad Hoc QAPI meeting was conducted to review the incident and identify opportunities for system improvement. She said the facility was conducting impromptu observations and skills knowledge of Hoyer lift transfers and resident assessments. She said she, the DON and ADON were conducting reviews of resident records for assessments upon review of the daily 24 hour reports. She said there were no problems identified since 03/07/26. During an interview on 03/18/26 at 3:32 p.m., the DON said all staff who were trained abuse, neglect, and exploitation policies, mechanical lift, the role of the Facility Abuse Coordinator, incident and accident reporting, assessment and documentation requirements, and charting expectations. Staff that were trained over the phone were tested for competence or had to demonstrate competency prior to working their scheduled shift. She said all staff passed the testing and demonstrations. She said there were no concerns noted. She said staff would be retrained as necessary if there were problems observed. She said staff were monitored daily and impromptu knowledge checks were conducted. She said the 24-hour reports were reviewed daily and resident charts were reviewed for required charting. The Medical Director was notified of the Immediate Jeopardy on 03/18/26 by the Administrator. On 03/18/26 at 1:28 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 03/06/26 and ended on 03/10/26. The facility had corrected the noncompliance before survey began.

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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** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 11 (Resident #1) residents reviewed for accidents. The facility failed to ensure CNA A performed a 2 person Hoyer lift transfer for Resident #1. CNA A transferred Resident #1 from wheelchair to bed, Resident #1 sustained a fractured left tibia (shin bone) and fibula (calf bone), avulsion injuries (skin torn away from its normal attachment) to her bilateral upper extremities, a large bruise on her back and a scratch to her forehead on 03/06/26. Resident #1 required surgical intervention. The noncompliance was identified as PNC (past noncompliance). The IJ began on 03/06/26 and ended on 03/10/26. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of potential accidents, injuries, harm, or death.Findings included: Record review of Resident #1's face sheet dated 03/17/26 indicated she was an [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (form of dementia), cerebral infarction (stroke), dementia (decline in cognitive function), and muscle weakness. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she had clear speech and sometimes was able to make herself understood and sometimes understood others. She had severe cognitive impairment (BIMS-4). She utilized a wheelchair for mobility. She was dependent for all ADLS and transfers. Record review of Resident #1's care plan dated 12/26/23 (revised 11/28/25) indicated she had limited physical mobility or was at risk for decline related to Alzheimer's, and limited ROM to right arm and hand. Interventions included: Total assist for all ADLS (revised 07/15/25) and Resident #1 was non weight bearing and was a Hoyer lift X2 by staff at all times with transfers (revised 11/20/25). Record review of Resident #1's Kardex (electronic care record utilized by care staff) dated 03/17/26 indicated Resident #1 was non weight bearing and was a Hoyer lift X2 by staff at all times with transfers. Record review Resident #1's daily note dated 03/06/26 at 1:56 p.m., completed by LVN B indicated no edema present. There were no injuries noted. Record review of Resident #1's daily note dated 03/06/26 at 11:24 p.m., and signed on 03/07/26, completed by LVN C indicated edema present. Location and grade were not noted. There were no signs or symptoms of pain or discomfort this PM. There were no injuries noted. Record review of Resident #1's progress note dated 03/07/26 at 8:33 a.m., completed by LVN B indicated she was asked by LVN C to look at Resident #1. Upon entering the room, LVN B pulled back the covers and discovered discoloration to arms and legs and resident having pain when being touched. LVN B immediately called the administrator and completed a full head to toe assessment and pain assessment. Resident #1 was not able to tell LVN B what happened. LVN B obtained a verbal order from MD to transfer Resident #1 to hospital for further evaluation. RP was notified. Record review of Resident #1's progress note dated 03/07/26 at 9:07 a.m., completed by LVN B, indicated Resident #1 had skin tears and bruising. Resident #1 was lying in bed with the sheets pulled up. A full head to toe assessment was completed. Resident #1 had bilateral bruising to both arms right side and right thigh. Left lower extremity swelling and discoloration. There were 4 skins tears. The right forearm had swelling with a knot. There was a scratch on her forehead. Resident #1 was not able to articulate what happened. The MD was notified with new order to send to hospital for continuation of care. The RP, DON and Administrator were notified. There was no progress notes completed by LVN B on 03/06/26 or 03/07/27. Record review of hospital records dated 03/07/26 indicated Resident #1 was to the hospital out of concern for bruising on her extremities. There was a small 2 cm linear abrasion over the right superior forehead, obvious deformities of the left lower extremity, severe hematoma (trauma or injury to blood vessels to the right upper extremity along the distal brachium (lower arm), elbow and forearm, bilateral upper extremity contusion (bruise) with avulsion injuries around both wrists. CAT scan indicated displaced (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health Care Center	1206 N Travis St Liberty, TX 77575

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	comminuted fractures (bone is broken into three or more pieces and the pieces have moved apart creating a gap) of the distal shafts of the left tibula and fibula and soft tissue swelling. Concern for elder abuse was noted. Resident was placed in cast. Orthopedic surgeon consulted for possible surgery following stabilization. These are life threatening diagnosis. Patient was treated with morphine. At the time of the investigation the surgical records were not available for review. Record review of the facility investigation dated 03/12/26 indicated: On 03/07/2026 at approximately 06:40 AM, the Facility Abuse Coordinator was notified Resident #1 was observed with bruises, and skin tears to her upper extremities. Swelling and discoloration was also noted to her left leg. The abnormalities were identified by day shift nurse LVN B. Review of facility documentation revealed no reported or documented falls or incidents on the prior shift that would explain the injuries. Facility nursing staff were unable to determine or identify how the injuries occurred. LVN B stated she was notified by the night nurse LVN C that Resident #1 had Edema. LVN B immediately went to assess the resident. LVN B was also the day shift nurse for 03/06/2026 from 6:00 am to 6:00 pm. LVN B stated that Resident #1 did not have any skin tears or abnormalities when she left her prior day shift at 6:00 pm. Prior to transferring to the hospital, the resident was interviewed by facility nursing staff. The resident, who is cognitively impaired but able to answer simple questions, was asked whether she had fallen or if anyone had harmed her. The resident responded no. Resident #1 was immediately assessed by nursing staff. A full head-to-toe assessment was completed, which confirmed the presence of bruising, swel1ing, and skin tears. Due to the unknown origin of the injuries and the need for further evaluation, the resident was transferred to (named hospital) for continuation of care. The physician (MD), responsible party (RP), police department, and Ombudsman were notified immediately. As part of the investigation, staff statements were collected from employees who had contact with the resident within the previous 72 hours. Staff interviews did not reveal any reports of falls, injuries, or incidents involving the resident. No staff member was able to identify the cause of the abnormalities observed. Alert and oriented residents who reside on the 100 hall were interviewed and asked if they noticed or heard anything out of the ordinary for the night of 03/06/2026 into 03/07/2026, no abnormal reporting.Documentation review showed that the resident received a shower on 03/06/2026 (time not indicated). The shower aide reported that at the time of care the resident did not have visible bruising, swelling, or skin tears. Additionally, the resident had been seen in person by the facility physicians on both 03/05/2026 and 03/06/2026, with no new or abnormal findings documented during those visits.CNA A who worked the night shift of 03/06/2026 to 03/07/2026 reported that at approximately 10:30 PM she was notified that the resident remained in her chair and needed to be placed in bed. Resident #1 was dependent for transfers, and her care plan and Kardex identify her as a two-person transfer using a mechanical Hoyer lift. CNA A stated that she transferred the resident to bed using the Hoyer lift; however, she acknowledged that she performed the transfer alone without a second staff member present, which is contrary to facility policy. CNA A acknowledged she had been trained that Hoyer lifts required two staff members for safe operation but did not provide a reason for performing the transfer alone. CNA A denied dropping the resident, denied finding the resident on the floor, and denied knowledge of any incident occurring prior to or during her shift.CNA A further stated that after placing the resident in bed, she requested assistance from the 600 Hall CNA E to help reposition the resident in bed. She stated she noticed bruising on the resident's arms and inquired about it. She reported she was told by CNA A that the bruising and skin tears were old and that the nurse had already been notified.The 100 Hall nurse LVN C acknowledged to the facility Director of Nursing and Administrator that she had been notified around approximately 5:00 AM that the resident's leg appeared bruised. The nurse stated she was providing care to another resident at the time and did not go to assess the resident following notification.Due to concerns identified during the investigation, CNA A and LVN C assigned to the resident's hall were immediately suspended pending investigation. Following further review, the nurse was terminated for failure to assess and document a resident after being notified of a change in condition. CNA A resigned (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	effective immediately during questioning regarding the circumstances surrounding the resident's injuries.Additional investigative actions included:Facility-wide skin assessments completed with no new or abnormal findings.Environmental and safety rounds conducted with no hazards or abnormal findings identified.Resident safe surveys conducted, with residents reporting they feel safe in the facility environment.Staff education provided on abuse, neglect, and exploitation policies.Mechanical lift competencies completed with nursing staff.Targeted staff interviews conducted with employees who had direct contact with the resident within the previous 72 hours, specifically addressing whether abnormalities were observed and whether they were reported appropriately.Re-education provided to staff regarding the role of the Facility Abuse Coordinator, incident and accident reporting, documentation requirements, and charting expectations. Record review of the police report dated 03/07/26 at 1:00 p.m., completed by PD E indicated he was dispatched to the facility in reference to injury to elderly. He observed Resident #1 laying in bed but she had no verbal response to PD E. He observed purple and red bruising on both hands, fresh blood in the area of the bruising. Dried blood was observed on the sheets. He observed her left leg and it was bruised, coloration of purple, turned in opposite of normal direction, and inflamed. Observations of the pictures provided by the police department on 03/19/26 at 8:30 a.m. indicated the following: purple and red bruising on both hands fresh blood in the area of the bruising, dried blood on the sheets, and the left leg was bruised, purple, turned in opposite of normal direction, and inflamed. Record review of CNA A's personnel records indicated her date of hire was 01/23/26. She resigned 03/07/26. She was trained and completed competencies that included safe resident transfers on 01/23/26 and 02/02-03/26. She was trained on fall prevention on 02/03/26. She had access to the facility electronic records and Kardex information. Record review of LVN C's personnel records indicated her date of hire was 11/03/09. She signed she was trained and completed competencies on 11/20/25 that included performing physical assessments/evaluations, documenting change of condition and monitoring pain. During an interview on 03/16/26 at 5:13 p.m., PD E said he arrived at the facility in reference to injury to elderly. He observed Resident #1 laying in bed but she had no verbal response to him (PD E). He observed purple and red bruising on both hands, fresh blood in the area of the bruising. Dried blood was observed on the sheets. He observed her left leg and it was bruised, coloration of purple, turned in opposite of normal direction, and inflamed. He said the case was handed to PD D for investigation of abuse to an elderly person. During an interview on 03/17/26 at 12:00 p.m., the Administrator said she was the Facility Abuse Coordinator. She said on 03/07/26 at approximately 6:40 a.m., she was notified that Resident #1 was observed with bruises, skin tears to her upper extremities, and swelling and discoloration of her left leg. The injuries were identified by LVN B. She said they were not able to determine how the injuries occurred. She said LVN B was notified by the night nurse, LVN C, that Resident #1 had edema and LVN B immediately went to assess Resident #1. LVN B was also the day shift nurse for 03/06/26 from 6:00 a.m. to 6:00 p.m. She said LVN B stated Resident #1 did not have any skin tears or abnormalities when she left her prior day shift at 6:00 p.m. Resident #1 was asked whether she had fallen or if anyone had hurt her. Resident #1 responded no. Resident #1 was assessed with bruising, swelling and skin tears. Due to the unknown origin of the injuries and the need for further evaluation, the resident was transferred to the hospital for continuation of care. The MD, RP, police department, and Ombudsman were notified immediately. Staff interviews did not reveal any reports of falls, injuries, or incidents involving Resident #1. No staff member was able to identify the cause of the observed injuries. She said Resident #1 received a shower on 03/06/26, before the lunch meal. The shower aide (CNA G) reported Resident #1 did not have visible bruising, swelling, or skin tears. Resident #1 was seen by the facility physicians on both 03/05/26 and 03/06/26, with no new or abnormal findings documented during those visits. She said CNA A worked the night shift of 03/06/26 to 03/07/26. She said CNA A reported at approximately 10:30 p.m. on 03/06/26 she was notified Resident #1 remained in her chair and needed to be placed in bed. Resident #1 was dependent for transfers, and her care plan and Kardex identified her as a two-person transfer using a mechanical (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hoyer lift. CNA A stated that she transferred Resident #1 to bed using the Hoyer lift alone, without a second staff assist. She said CNA A acknowledged she had been trained Hoyer lifts required two staff for safe operation but did not provide a reason for performing the transfer alone. CNA A denied dropping the resident, denied finding the resident on the floor, and denied knowledge of any incident occurring prior to or during her shift. She said CNA A requested assistance from CNA F to help reposition Resident #1 in bed. She said CNA F noticed bruising on Resident #1's arms and inquired about it. CNA F said CNA A reported the bruising and skin tears were old and that the nurse had already been notified. The Administrator said LVN C acknowledged she had been notified around approximately 5:00 a.m. on 03/07/26 that the Resident #1's leg appeared bruised. LVN C stated she was providing care to another resident at the time and did not go to assess the resident following notification. CNA A and LVN B were immediately suspended pending investigation. She said LVN B was terminated for failure to assess and document a resident after being notified of a change in condition. CNA A resigned during questioning of Resident #1's injuries. She spoke with Resident #1's family member, who reported Resident #1 had sustained a break in her leg in multiple places. She said the facility was unable to determine the exact cause of the injuries. She said Resident#1's roommate was not interviewable and did not provide any information regarding the incident. She said all staff were trained with Hoyer transfer during orientation, annually, and as needed, were aware two staff were required, and were aware the information was located in the Kardex. She said residents were at risk of injuries if they were not transferred with 2 staff as required with the Hoyer. During an interview on 03/17/26 at 2:09 p.m., CNA A said she arrived at the facility on 03/06/26 at 6:30 p.m. She said she started on Hall 500 and used a Hoyer lift to transfer Resident #5. She said she did not ask anyone to help. She said CNA H directed her to work on hall 100 and put Resident #1 to bed. She said she took the Hoyer she previously used on Resident #5 and went to Resident #1's room and transferred Resident #1 to her bed from her wheelchair. She said when she changed Resident #1 and took off her sweater she found the skin tears on her arms by her wrists. She said she went to the nurse and asked if this resident was the resident who was always black and blue and the nurse said no. She said she put a gown on Resident #1 and told the nurse Resident #1 appeared in pain. She said the nurse said Resident #1 would be screaming if she was in pain. She said she did not ask for help. She said she did not notice any skin tears or bruises before she completed the Hoyer lift transfer without assist from a second staff. She said when she provided incontinent care for Resident #1 she noticed there was bruising on the left leg. She said she told her supervisor (CNA H) and the supervisor said it was always like that. She said the supervisor did not check Resident #1's leg. She said she asked LVN C to check Resident #1's leg. She said LVN C said it was edema and to elevate her leg. She said her leg was already on a pillow so she got a sheet and added it to the pillow for more elevation. She said she did not drop Resident #1 when she did the Hoyer transfer or when she provided incontinent care. She said she was aware Resident #1 was two person Hoyer lift. She said she was not trained in the facility with the Hoyer lift. She said she did not check the Kardex because she did not have access to the electronic system. During an interview on 03/17/26 at 5:48 p.m., Family Member I said on 03/07/26, Resident #1 had numerous skin tears and bruises on her arms. She had a large bruise on her back and a scratch on her right forehead. He said she had a broken left tibia and fibula that required surgery. He said metal rods were placed in each bone. He said he was very upset Resident #1 had sustained injuries and was not assessed by the nurse timely. He said he believed the staff transferred Resident #1 without a second staff and dropped her during the transfer and did not report the incident to the nurse. He said he was extremely upset Resident #1 was in her bed from 11:00 p.m. on 03/06/26 until 6:40 a.m. on 03/07/26 with injuries and pain and not assessed or sent to hospital. He said Resident #1 would not return to the facility and was admitted to a different facility for care. During an interview on 03/18/26 at 9:20 a.m., CNA F said she did not know what happened to cause injuries to Resident #1. She said CNA A asked her to assist to pull Resident #1 up in her bed at approximately 11:00 p.m. on 03/06/26. She said she noticed the skin tears on both (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of Resident #1's arms and asked CNA A what happened. She said CNA A said the skin tears were there already and the nurse was aware. She said the skin tears looked bloody but were not bleeding. She said she did not see Resident #1's legs because they were covered with the sheet. She said she did not provide any care to Resident #1 and did not assist with the Hoyer transfer from wheelchair to the bed. She said she had been trained and was aware all Hoyer lift transfers were supposed to be completed with 2 staff. She said the information was available in the Kardex. She said residents were at risk of injuries if they were not transferred with 2 staff as required with the Hoyer. During an interview on 03/18/26 at 10:23 a.m., LVN C said she saw Resident #1 in her wheelchair at approximately 10:30 p.m. She said Resident #1 was in her room. She said she looked over Resident #1 while she was in her wheelchair because Resident #1's Medicare charting was due. She said she did not see anything wrong with Resident #1. She said there were no bruises or skin tears. She said she asked CNA H to have CNA A put Resident #1 in bed. She said she saw CNA A go to Resident #1's room with the Hoyer lift. She said she saw CNA A walk past the nurse station and then she came back with CNA E and assumed it was to assist with the Hoyer lift to transfer Resident #1 from her wheelchair to her bed. She said she checked Resident #1 at 1:00 a.m. and Resident #1 was sleeping. She said she did not pull covers back because Resident #1 was sleeping and she did not want to wake her. She said he saw Resident #1 again at 3:00 a.m. and she was still sleeping. She said she was doing rounds at 5:00 a.m. and CNA A was changing Resident #1. She said the door to Resident #1's room was closed and she did not observe Resident #1 at 5:00 a.m. She said CNA A asked her to look at Resident #1's foot at approximately 5:10 a.m. or 5:15 a.m. She said CNA A rolled back the blanket on Resident #1's left foot and she saw the edema. She said she told CNA A to elevate Resident #1's leg and she continued to provide care to other residents. She said she checked Resident #1's chart to see if there was any prior documentation of the edema because CNA A said the edema was already known. She said she did not find any documentation of the edema. She said she asked LVN B to witness while she completed an assessment of Resident #1. She said she always had a witness for skin assessments. She said she and LVN B went to Resident #1's room and LVN B pulled back the covers and observed Resident #1's left leg was bruised and there was skin tears on both arms. She said the top layer of skin was missing from the skin tears and there were no skin flaps. She said Resident #1 was turned towards her (LVN C) and LVN B observed a cantaloupe sized bruise on her back. Resident #1 also had a scratch on her face. She said when Resident #1 was touched or moved she grimaced and moaned in pain. She said LVN B immediately called the Administrator to report the injuries. She said the Administrator called the police nd the police arrived very quickly and asked for statements. She said CNA A had already left. She said the MD was notified and EMS arrived to transfer Resident #1 to hospital for evaluation. She said she did not provide care or use the Hoyer lift to transfer for Resident #1. She said she did not properly assess Resident #1 when she was informed of the edema. She said she was not informed of any bruises or skin tears. She said not properly assessing a resident could lead to further decline of health and resident would not receive timely care. She said all Hoyer lift transfers are supposed to be with 2 person assist. She said risks of not having 2 person could include injuries and death. During an interview on 03/18/26 at 3:05 p.m., LVN B said she observed Resident #1 on 03/06/26 ad Resident #1 had no injuries when she left the faciity on [DATE] at 6:00 p.m. She said Resident #1 wore a dress and had no edema or bruises on her legs. She said she arrived at the facility on 03/07/26 at 6:00 a.m. and received report. She said there was no report of any issues or concerns related to Resident #1 She said LVN C asked her to assess Resident #1 at approximately 6:40 a.m. She said she pulled back Resident #1's covers and was shocked and immediately called the Administrator. She said Resident #1 was in the same condition the day before. She said Resident #1 had fresh skin tears on both her arms that had no skin flaps with purple and red bruises. She said there was a scratch on her right forehead. She said Resident #1's left leg was bruised and purple. She said there was fresh blood on her gown and blankets. She said Resident #1 showed pain with grimace and frown when she was moved and touched. She said the police arrived (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and told her to tell the administrator Resident #1 needed to go to the hospital. She said she told the administrator she had to send Resident #1 out because her left leg was twisted and propped up on a pillow. She said she asked LVN C did she know of Resident #1's injuries and LVN C said no. She said LVN C said she had not seen Resident #1 since 10:30 p.m. on 03/06/26 when she was in her wheelchair. She said LVN C said CNA A told her at 5:15 a.m. that Resident #1's legs were swollen and she told her to prop up it up with a pillow and she would look at it after she was done with another resident. She said after the police arrived, LVN B said she was notified of the edema at approximately 5:15 a.m. but was doing trach care on another resident. She said LVN C said CNA A pulled the clover back and she saw the edema on the left foot but she did not see the whole left leg. LVN B said she believed Resident #1 was dropped. She said the Kardex has the information related to resident care and if they required a Hoyer. She said all Hoyer transfers required 2 persons. She said residents were at risk of injuries if they were not transferred with 2 staff as required with the Hoyer. During an interview on 03/18/26 at 3:34 p.m., CNA G said Resident #1 was brought to the shower room in the shower chair on 03/06/26 before the lunch meal was served. She said she had no bruises or skin tears nd there was no injury to her left leg. She said she was brought back to her room and transferred back to her bed with the Hoyer lift and two staff. CNA G said she was trained on Hoyer lift transfers and all required 2 person. She said residents were at risk of injuries if they were not transferred with 2 staff as required with the Hoyer. During an interview on 03/18/26 at 3:39 p.m., CNA H said she assisted with transferring Resident #1 with the Hoyer lift on 03/06/26. She said Resident #1 did not have any bruises, skin tears or leg injuries. She said she came back to work late in the evening on 03/06/26 because there was call-ins and she had to find staff to work. She said she saw Resident #1 was still in her wheelchair at approximately 10:30 p.m. She said she advised CNA A to put Resident #1 to bed. She said CNA A was scheduled to work the 100 hall where Resident #1 was and there was no reason she should have been using the Hoyer to put another resident to bed. She said CNA A did not report any injuries or bruises to her on 03/06/26. She said all staff were trained on Hoyer lift transfers and were to find the Kardex information upon hire and annually. She said residents were at risk of injuries if they were not transferred with 2 staff as required with the Hoyer. Record review of the facility's Safe Resident Handling/Transfers policy dated 2023 indicated Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used.3. Mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies.10. Two staff members must be utilized when transferring residents with a mechanical lift. 11. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. 12. The staff must demonstrate competency in the use of mechanical lifts prior to use and annually with documentation of that competency placed in their education file. 13. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. 14. Resident lifting and transferring will be performed according to the resident's individual plan of care. The facility took the following actions to correct the noncompliance prior to surveyor entrance: Record review of the facility-wide skin assessments dated 03/07/26 indicated no new or abnormal findings. Record review of the facility environmental and safety rounds dated 03/07/26 indicated no hazards or abnormal findings identified. Record review of resident safe surveys dated 03/07/26 indicated residents reported they felt safe in the facility environment. Record review of staff education indicated they (continued on next page)

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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	were trained on abuse, neglect, and exploitation policies from 03/07/26 through 03/10/26. Record review of mechanical lift competencies indicated they were completed with nursing staff 03/07/26 through 03/10/26. Record reviews of electronic records of residents indicated no issues identified with assessments. Record review of an AD HOC QAPI meeting dated 03/07/26 indicated the interdisciplinary team included the Medical Director, DON, Administrator The police were notified, SW, and Regional Nurse. The facility identified LVN B reported to the abuse coordinator Resident #1 had swelling, discoloration and bruising to her lower and upper extremities. Resident #1 had skin [NAME] to both arms. There were no abnormal reports on 03/06/26 for Resident #1. Resident #1 was sent out to hospital for further evaluation and treatment. LVN C was suspended pending the investigation. The facility would continue to monitor the residents daily. The facility implemented staff training and competency testing/demonstration to include abuse, neglect, reporting, documentation, transfers, resident assessment, and pain assessment. In-services:Record review of in-services initiated on 03/07/26 through 03/10/25 were conducted for all direct care staff by the DON in person and/or via phone. All staff who were not present for in-services were not permitted to work their assignment until in-serviced. All new hires would be in-serviced during facility orientation. All agency staff would be in-serviced prior to working their floor assignment. Record review of an In-Service Training Report that included falls, documentation, stop and watch alert tool in PCC, and documentation, the abuse coordinator and staff to report, abuse, neglect immediately to the abuse coordinator (the Administrator), conducted by the DON from 03/07/26 through 03/10/26, indicated 100% of staff were trained. Record review of the staff training for skin assessment, pain assessments and competencies conducted by the ADON on 03/07/26 through 03/10/26 indicated 100% of nursing staff were trained. Record review of the facility's incident reports from 03/07/26 through 03/18/26 indicated there were no concerns related to resident injuries. Observation on 03/17/26 at 12:40 p.m. indicated CNA G and CNA H were able to use the Hoyer correctly for the transfer of Resident #5. There was no observed concerns. Observations conducted on 03/17/26, 03/18/26, and 03/19/26 indicated no observed hazards related to resident transfers. Interviews conducted with Resident #4 and Resident #5 who required a Hoyer lift transfer indicated they felt safe. They indicated they were transferred with Hoyer lift and always had two staff. Staff interviews conducted on 03/17/26 and 03/18/26 with staff who worked all shifts (6:00 a.m.-6:00 p.m., 6:00 p.m. - 6:00 a.m., 7:00 a.m. - 7:00 p.m., and 8:00 .m. - 4:30 p.m. (LVN K, LVN B, CNA E, CNA H, LVN L, CNA G, CNA H, CNA M, CNA N, LVN O, LVN P, CMA Q, LVN R, LVN S, CNA T, CNA U, and ADON) indicated they were aware of the facility policy for Hoyer lift transfers, had received training and had demonstrated competencies. They were aware of the facility's abuse prevention and reporting policy, were aware the Administrator was the Abuse Coordinator and were to report any suspicion or allegation of abuse or neglect immediately. They were aware all changes of condition should be reported immediately to the charge nurse, documented, and assessed. Nursing staff indicated they had received training and passed competency tests from 03/07/26 through 03/10/26 on resident assessment and pain assessments. During an interview on 03/17/26 at 12:00 p.m., the Administrator said facility-wide skin assessments were completed with no new or abnormal findings, environmental and safety rounds were conducted with no hazards or abnormal findings identified, resident safe surveys conducted and residents reported they felt safe in the facility environment, staff education provided on ab[TRUNCATED]