STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675624	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitehall Rehab & Nursing	1116 E Loop 304 Crockett, TX 75835

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	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** 46436 Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents and supervision. 1. The facility failed to properly secure Resident #1 in the facility van on [DATE] and Resident #1 fell forward while in transport striking his head on the side of the van causing a laceration and emergency room care. An IJ (Immediate Jeopardy) was identified on [DATE] at 4:30 pm. The IJ template was provided to the facility on [DATE] at 5:05 pm. While the IJ was removed on [DATE] at 12:07 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems. This failure placed all residents that used the facility van at risk of injury and death. Findings: Record review of a facility face sheet dated [DATE] indicated Resident #1 was an [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of myocardial infarction (heart attack). Record review of a significant change MDS assessment dated [DATE] indicated Resident #1 had a BIMS of 9 indicating moderately impaired cognition and had impairment to both upper and lower extremities, was an amputee and was dependent for all ADLs. Record review of a comprehensive care plan dated [DATE] indicated Resident #1 had an ADL Self Care Performance Deficit and was at risk for not having their needs met in a timely manner and had the potential for falls with new intervention dated [DATE] to ensure prosthesis was in place for added safety and stability. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an incident report dated [DATE] at 8:20 am during transport with two facility staff Resident #1 was witnessed leaning forward and hitting the inside wall of the van. Staff jumped up to catch wheelchair and Resident #1 but Resident #1 bumped his head on the inside of the van resulting in a small gash on his forehead. Resident #1 was assessed, and emergency medical services were notified to send to the emergency room (ER) . The doctor and family were notified of the incident. During an interview on [DATE] at 10:15 am Resident #1's family member said Resident #1 had gone to see his heart doctor in another city by the facility van. She and another family member met the van at the doctor's appointment. She said after the appointment the aide and driver loaded Resident #1 in the van and she and the other family member left. She said shortly after, her phone rang, and the van driver told her there was an incident when she came down a steep hill and applied the brakes, Resident #1 fell from his chair forward and hit his head. She said she and the other family member arrived and 911 had been called. She said she was in such a panic she did not pay attention to his wheelchair and if there was a restraint or not. She said she does not know if the facility could have done anything else because she did not know if they failed to secure him or not. During an interview on [DATE] at 1:00 pm CNA A said she had worked at the facility since 1980 and currently was in medical records but was also an aide. She said she was the aide on transport the day Resident #1 fell in the van. She said the driver had loaded Resident #1 and secured him with the lap belt, but she could not recall there being a shoulder harness in the van. She said she did not routinely ride as the attendant but did that day. She said they left the doctor's office and headed home. She said the driver was going slowly down a hill and she saw out of the corner of her eye Resident #1 falling forward but she could not reach him. She said the driver stopped and they assisted Resident #1 to the floor while they called the nursing home and 911. She said the ambulance picked him up and took him to the ER to be evaluated. She said a shoulder harness would be safer for the residents and could prevent falls or injuries. During an interview on [DATE] at 1:26 pm the van driver said she had been employed since [DATE]. She said on hire she was trained by the previous driver and the maintenance director. She said she was trained on how to properly secure the wheelchair wheels and place the seatbelt across the resident's lap. She said the day of the incident with Resident #1, Resident #1 was in a high back wheelchair that reclined, and she had leaned him slightly backwards for his comfort, secured the wheels and placed the seatbelt across his lap. She said when she was going down a hill and applied the brakes, Resident #1 fell over the front right side of his wheelchair and struck the side of the van. She said CNA A was sitting in the seat in front of him and tried to reach him but could not. She said Resident #1 did not fall out of the wheelchair onto the floor, but she and CNA A had assisted him to the floor. She said they tried to reposition Resident #1 in his wheelchair but could not because of his size and felt it was safer to lower him to the floor. She said they called his family and 911. She said by not having a shoulder harness in the van residents could become injured during transport. During an observation and interview on [DATE] at 1:35 pm the facility van was parked behind the facility. The van driver demonstrated how she loaded and secured residents for transport. The wheelchair was loaded, and wheels locked and secured using 4 straps. She then applied a lap belt under the armrest and over the lap and secured. No shoulder harness was applied, and the van driver said there had not been a shoulder harness and she was not trained on needing to apply one. She said a shoulder harness should be in place to secure the resident and keep them from going forward and getting hurt. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:09 pm the maintenance director said he had worked at the facility for 1 , d+[DATE] years and he did a weekly check on the facility van. He said the checks included checking the fluids, lights, wheelchair lift, straps to secure the wheelchair and the seat belts. He said the van only had a lap belt and there was not a shoulder harness in the van that was used. He said he was trained on the van on hire by the previous van driver and by just having common knowledge on vehicles. He said he and the previous van driver trained the current van driver and training included verbal and demonstration of properly securing and transporting residents. He said he and the previous van driver did a few transports with the current van driver to ensure she was ready before her first trip. He said there was no literature of manufacturer information for the seatbelts in the van. He said there was not a vehicle operating manual to follow that he has seen but would try to locate one online. He said the van was a 2008 Ford Econoline van and was purchased before his hire date. He said the van driver was not trained on applying a shoulder harness because there was not one to apply. He said by not having a shoulder harness it could result in injury of a resident during transport. During an interview on [DATE] at 2:40 pm the Administrator said she had been the administrator since 2022 and had participated in the training of the van driver when she was hired along with the previous van driver. She said the maintenance director retrained the van driver after the incident with Resident #1. She said securing the resident properly was part of the initial training. She said that she thought the lap and shoulder harness were in use and was not aware there was no shoulder harness being used. She said the maintenance director was responsible for checking the securement devices in the van weekly and as needed. She said the training was to check the lap belt or the shoulder harness and at least one device had to be in place. She said by not having a shoulder harness it could cause falls and injuries. She said there were no other staff that drove the van and if the current van driver was not available, she used a private transport service. She said she would take the van out of service until a shoulder harness could be installed. Record review of an orientation checklist for community Driver-Van-Bus dated [DATE] indicated the van driver had received proper training on hire for transporting residents including applying lap and shoulder belts. Record review of a facility policy titled Transportation Policy and Procedure for Facility Based Vehicle dated , d+[DATE] indicated assure that the vehicle is in good repair and in full compliance with all recommended maintenance as per vehicle operating manual. The authorized driver must complete a competency-based training to include but not limited to b. application of seat belt . Record review of Code of Federal Regulations website https://www.ecfr. gov/current/title-49/subtitle-A/part-38/subpart-B/section-38.23 at Title 49 Subtitle A Part 38 Subpart B S 38. 23 Mobility aid accessibility last amended [DATE] indicated, .(d) Securement devices (7) Seat belt and shoulder harness. For each wheelchair or mobility aid securement device provided, a passenger seat belt and shoulder harness, complying with all applicable provisions of part 571 of this title, shall also be provided for use by wheelchair or mobility aid users. Such seat belts and shoulder harnesses shall not be used in lieu of a device which secures the wheelchair or mobility aid itself. Record review of weekly center-based vehicle maintenance logs dated from [DATE] to present date indicated the seatbelts operable including all straps, for wheelchair tie down, shoulder strap and floor wheelchair tie down straps were ok. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unable to review vehicle operating manual due to no manual found at the facility. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:30 pm. The facility's Administrator was notified. The Administrator was provided the IJ template on [DATE] at 5:05 pm. The following Plan of Removal (POR) submitted by the facility was accepted on [DATE] at 9:20 am. Plan of Removal - F 689 Free of Accidents and Hazards/supervision/devices Tag Cited: F-689 Issue Cited: Free of Accidents/Hazards/Supervision Tag Cited: F-689 Issue Cited: Free of Accidents and Hazards Failure to ensure the facility van had proper securement devices (shoulder harness and lap belt) and resulted in a resident falling forward out of wheelchair striking his head. 1. Immediate Action Taken A. Resident # 1 expired in the facility on [DATE] . B. The facility's van immediately stopped all van transport on [DATE] at 4:30 pm C. The facility's van is scheduled for replacement / installation of shoulder harness this Thursday [DATE]. D. The Administrator or designee completed the following with the one facility designated van driver: o In-service education on the Transportation Policy which provides direction on duties and responsibilities of driver, van safety, and forms required was completed on [DATE] at 7:00pm. Skills check off on driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair was completed on [DATE] at 8:00am at neighboring facility with a similar van. Van driver performed return demonstration on noted skills. This process will be redone once our van has the shoulder harness installed. o In-service education provided to van driver by administrator/designee on weekly maintenance log which includes checking Operable seatbelt straps, wheelchair tie down, shoulder strap, floor W/C tie down straps that van driver will complete and provide to administrator/designee weekly. This was completed on [DATE] at 7:00 pm. o The Administrator reviewed with van driver, a new signed job description. This was completed on [DATE] at 7:00 pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Identification of Residents Affected or Likely to be Affected: A. No other residents identified, all scheduled van transports for the remainder of the week will be transported by an outside vendor and will continue if needed until repairs are made to the facility van. 3. Actions to Prevent Occurrence/Recurrence: A. As of [DATE], any staff member hired for van transports will be provided the following by the facility maintenance supervisor. o In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair prior to driving the van. o In-service education on weekly maintenance log which includes checking Operable seatbelt straps, W/C/ tie down, shoulder strap, floor W/C tie down straps that van driver will complete and provides to administrator/designee weekly o Completed a skills validation check list on van driver to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness, and will complete a return demonstration. o Have van driver sign job description duties Immediate Jeopardy Removal Plan F-689 - (Free of Accidents and Hazards) B. The weekly maintenance log will be reviewed in the morning meeting by the Administrator or designee on [DATE] the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to Accidents/Hazards/Supervision and reviewed plan to sustain compliance. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: _____[DATE]_____ Plan of removal was monitored as follows: During an interview on [DATE] at 9:40 am the van driver was able to verbalize the proper technique for loading and securing a resident in a wheelchair, weekly completing the check of operable seatbelt straps, understanding of transportation policy, job description, and new skills checkoff with maintenance director using another facility van. The van driver verbalized the facility van was no longer in operation and all appointments had been rescheduled with a private transportation service. During an observation on [DATE] at 11:45 am the van driver was able to properly demonstrate using a different facility van how to place both the lap belt and shoulder harness to secure a resident during transport. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:00 pm the maintenance director said he went through the checklist with the van driver 3 times, then observed her secure a wheelchair in the van, and verbalized the inservice training to include the van was not to be used until it was repaired, weekly maintenance log and checkoff with each transport once transports resume and a lap and shoulder belt must be in place. Record review of inservice training titled Van safety (review weekly maintenance log, checkoff form prior to transport, van to have lap belt and shoulder belt, and new training to occur after shoulder harness was installed) dated [DATE] indicated Administrator, Maintenance director and van driver signed and understood the information. Record review of a Transportation Policy dated [DATE] indicated the van driver signed on [DATE]. Record review of an Orientation checklist Community Driver-Van-Bus dated [DATE] indicated the van driver had received new skills validation by the maintenance director. Record review of a job description for the van driver indicated had been resigned on [DATE]. Record review of an email dated [DATE] indicated an appointment had been made with a wheelchair van company to evaluate and repair restraint system. Record review of facility form titled appointments for remainder of week indicated 3 residents had appointments and transportation had been arranged with a private transport company. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 12:07 pm.; however, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 46436 Based on observations , interviews, and record reviews the facility failed to ensure 4 of 6 (NA B, NA C, NA D, and NA E) staff were not working in the facility longer than four months without having completed a nurse aide competency evaluation program. The facility failed to ensure NA B, NA C, NA D, and NA E became certified within four months of hire as full-time staff. This deficient practice could place residents at risk for receiving care from an individual whose skill level was not known. Findings include: Record review of the facility staff roster dated 8/19/24 indicated the following staff were listed as nurse aides with hire dates: *Nurse Aide B hire date of 12/13/2023. *Nurse Aide C hire date of 1/30/2024. *Nurse Aide D hire date of 5/10/2021. *Nurse Aide E hire date of 12/28/2023. Record review of employee personnel files indicated the following staff had not completed a training and competency evaluation program, or a competency evaluation program approved by the State: *Nurse Aide B *Nurse Aide C *Nurse Aide D *Nurse Aide E Record review of competency evaluations for NA B, NA C, NA D and NA E indicated they had received skills checkoff training by the facility staff on hire and annually for resident care. Record review of working schedules dated 8/19/24 to 8/23/24 indicated NA B, NA C, NA D, and NA E were on the schedule to work. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/19/24 at 10:08 am NA D was on 100 hall and said she was assigned 100 hall with another certified nurse aide. She said she was non-certified and had been employed with the facility for 3 years. She said she had attempted the CNA course 2 previous times and did not pass her written test and she began the program again 3 weeks ago. She said during her employment she had performed nurse aide tasks such as bathing, dressing and transfers with assist of another aide and had been trained and checked off on skills. She said she will retest orally this time and was not aware she had to complete the course in 4 months. She said when she hired it was after Covid and everything was different. She said she was knowledgeable on providing care and felt the residents were safe. She said she could see where resident care could be affected if nurse aides were not trained accordingly. Attempted phone interview on 8/20/24 at 8:15 am with NA E but there was no answer, voicemail left, and no return call received. During an interview on 8/20/2024 at 1:28 pm the ADON said she was responsible for staffing in the facility. She said when a nurse aide was hired, the administrator enrolled them into the NATCEP (Nurse Aide Training and Competency Evaluation Program), but she was not sure on how long the nurse aide had to complete the program. She said the administrator kept up with that information. She said the nurse aide was not to perform hands on resident care until they were enrolled in the program and had completed the skills competency. She said she and the DON completed the inhouse competency checkoffs and once they completed, they were placed with a CNA for further training. She said there was no system in place to ensure the nurse aides were completing the course assignments and getting their certificates. She said she scheduled the nurse aides and oversaw that they did not provide care alone until they were certified. She said if nurse aides did not receive proper training a resident could have negative outcome. During an interview on 8/20/2024 at 1:52 pm the DON said she had been the DON for 3 years and the administrator took care of the nurse aides being hired and enrolled in the NATCEP program. She said originally the facility would assist the nurse aide with enrolling in the in-person class but now utilize the online course because there have been instances that the nurse aide did not attend the in-person classes. She said she was not aware of the 4-month timeframe until yesterday but had met with the administrator to discuss the nurse aides currently on the schedule that have not completed the program within 4 months of hire. She said the facility did their own training for the nurse aides and each one was checked off for skill competency before being scheduled. She said the nurse aide was scheduled with a CNA for supervision and training as well as overseen by the charge nurses. She said if a nurse aide does not complete the program per the regulation, it could cause a safety issue. During an interview on 8/20/24 at 3:31 pm the Administrator said she had been at the facility for 2 years and was responsible for the oversight of the nurse aides and enrolled them in the NATCEP program. She said after the Covid waiver ended they were enrolling the NAs in the in-person hybrid courses but some like NA B, NA C and NA E were having trouble getting to the classes. She said they completed skills training and competencies and assisted with transport if they needed it. She said she was not aware the 4-month timeframe had started since the Covid waiver lifted. She said they were now using the online NATCEP program and that had helped, and she had been able to enroll the NAs in the program as of July 2024. She said she did not have a tracking system for ensuring the NAs completed their training but had developed a new form to track their progress in the program. She said the NAs were competent and felt there was no risk for not completing the program in the required timeframe because they had been training NAs in house since Covid. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Long-Term Regulatory Provider Letter 2023-05 revised 5/8/2023 indicated, .if the nurse aide hire date begins on or after 5/11/2023; certification date should be 4 months from date of hire, if the nurse aide began employment before 5/11/23, and has worked 4 months or more certification date should be no later than 9/10/23 . Record review of a facility policy titled Nursing Services and Sufficient Staff dated 4/10/2022 indicated, .It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 6. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for the residents' needs . Record review of Nurse Aide job description, undated, reflected: nurse aides were to complete all required on-line education as deemed necessary by the state and facility.