

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER Walnut Springs Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1637 N King St Seguin, TX 78155	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that each resident received adequate assistance devices to prevent accidents for 2 of 2 Residents (Resident #1 and Resident #2) who were observed for mechanical lift transfers.</p> <ol style="list-style-type: none"> CNA A and CNA B failed to lock and widen the base of the mechanical lift while transferring Resident #1 from the wheelchair to the bed. CNA C and CNA D failed to position the mechanical lift in a manner that would allow staff to widen the base of the mechanical lift while transferring Resident #2 from the Geri-chair to the bed. <p>These deficient practices could affect residents who used a mechanical lift for transfers and contribute to avoidable falls.</p> <p>The findings were:</p> <ol style="list-style-type: none"> Review of Resident #1's face sheet, dated 5/2/25, revealed she was admitted into the facility on 7/11/25 with diagnoses including unspecified Dementia, contracture left knee and left ankle. <p>Review of Resident #1's quarterly MDS assessment, dated 2/22/25, revealed her BIMS score was 10 of 15 reflective of moderate cognitive impairment and Resident #1 was dependent on staff for all ADL care including chair to bed transfers.</p> <p>Review of Resident #1's Care Plan, edited on 3/6/25, revealed she had a self-care performance deficit and required assistance by 2 staff with all transfers via Hoyer lift (according to microsoft [NAME], a patient lift is used by caregivers to safely transfer patients).</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview while transferring Resident #1 from a wheelchair to the bed on 5/2/25 at 1:30 PM revealed CNA A operated the mechanical lift. She positioned the base of the mechanical lift under the wheelchair. CNA A and CNA B hooked the sling to the cradle of the mechanical lift. CNA A did not widen to maximum open position or lock casters at the base of the mechanical lift and then lifted Resident #1 from the wheelchair. She rotated Resident #1 to the left, pushed the mechanical lift and positioned the base under the bed. CNA A lowered Resident #1 onto the bed. She did not lock the caster or widen to the maximum open position the base. Interview with CNA A revealed she thought she widened the base before lifting Resident #1 from the wheelchair but was not certain. She stated she for sure did not lock the base at all during the transfer and did not widen the base of the mechanical lift when she positioned it under the bed. CNA A stated she should have widened the base for stability so the lift would not tilt and she should have locked the lift so it did not move. CNA A commented she did not know why she didn't widen or lock the base. Interview with CNA A and CNA B revealed they recently had training about a week prior on how to safely transfer a resident using a mechanical lift. CNA B stated CNA A did it right during training and believed she just got nervous. Both CNA A and CNA B stated it was important to lock and widen the base to prevent a resident from falling.</p> <p>2. Review of Resident #2's face sheet, dated 5/2/25, revealed she was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, single episode, Attention and Concentration Deficit and Anxiety Disorder.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 3/18/25, revealed her BIMS score was 3 of 15 reflective of severe cognitive impairment. Further review revealed Resident #2 was dependent on staff for all ADL care including chair to bed transfers.</p> <p>Review of Resident #2's Care Plan edited 4/7/25 revealed she had a self-care performance deficit, she used a Geri-chair due to decreased trunk control and to assist with positioning and she required total assistance by 2 staff for transfers with a Hoyer lift.</p> <p>Observation and interview while transferring Resident #2 from a Geri-chair to the bed on 5/2/25 at 2:30 PM revealed CNA C operated the mechanical lift. CNA C positioned the base of the mechanical lift between the feet of the Geri-chair which did not allow her to widen the base to the maximum open position of the mechanical lift. CNA C and CNA D hooked the sling to the cradle of the mechanical lift. CNA C lifted Resident #2 from the Geri-chair, pulled the lift backwards, rotated the lift to her right and pushed the lift towards the bed. She positioned the base underneath the bed, widened to the maximum open position the base and locked casters of the base before lowering Resident #2 onto the bed. Interview with CNA C revealed she positioned the bed between the feet of the Geri-chair. She stated there was not enough space to widen the base even though she knew she had to widen the base for stability. That would keep the mechanical lift from tilting and Resident #2 from falling if the lift became off-centered or unbalanced. Interview with CNA D revealed when he used a mechanical lift for transfers, he would angle it allowing him to position one of the legs of the base between the feet of the Geri-chair and position the other leg on the opposite side behind the foot of the Geri-chair. He stated that allowed him to widen the base for stability. Further interview revealed both CNA C and CNA D stated the rooms were small with limited space when using a mechanical lift and had not been instructed during training the best technique to use.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON and ADM on 5/2/25 at 3:00 PM revealed the DON stated nursing staff should always lock and widen the base of a mechanical lift when transferring a resident to keep the lift from moving and for stability. The DON and ADM stated that was the technique they expected nursing staff to use to ensure a safe transfer while using a mechanical lift.</p> <p>Review of the mechanical lift manual, undated, read in relevant part, 7. Patient Lifting. Warning! The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the legs of the lift under a bed close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the bed are no longer under the bed, return the legs of the lift to the maximum open position and immediately lock the shift handle. 7.2 Warning! Do not lock the casters of the patient lift when lifting an individual. Locking the rear casters could cause the patient lift to tip and endanger the patient and assistants.</p>