STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675818	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cyfair	11001 Crescent Moon Dr Houston, TX 77064

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 - Minimal harm or potential for actual harm 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 interviews and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 (CR #1) of 5 residents reviewed for accidents and supervision. The facility failed to ensure CNA A and CNA B did not improperly transfer CR #1. CNA A and CNA B transferred CR #1 without a gait belt from the bed to the shower chair on 04/01/25. This failure could place residents at risk for harm, pain, and injury. The findings included: Record review of CR #1's admission Record, dated 04/11/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), type 2 diabetes mellitus (high blood sugar) without complications, obstructive sleep apnea (sleep disorder that causes breathing pauses at night due to blocked upper airway), and functional quadriplegia (complete inability to move). Record review of CR #1's MDS Assessment, dated 03/31/25, revealed a BIMS score of 13, indicating cognition was intact. Further review revealed resident was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers was required for the resident to complete the activity with toileting hygiene, shower/bathe, and sit to stand. Record review of CR #1's Care Plan, undated, revealed resident was at risk for falls. Record review of CR #1's progress notes, entered by Nurse A and dated 04/01/25 at 19:30 [7:30 p.m.], revealed CNA came and reported to the nurse that patient was lowered on the floor while transferring her from bed to chair. Patient was being transferred x2 persons to shower chair when her legs gave in. Assessment done; no new skin alteration noted . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/11/25 at 10:17 a.m., CNA A said CNA B got her and told her he needed her to assist him with a shower. She said she went to CR #1's room and the resident was in a sitting position on the bed. She said the resident's family member was in the room. She said they tried to transfer the resident to the shower chair, but the resident was so weak that they had to sit her down in front of the bed on the floor. She said she was holding up the resident by her arm under her armpit. She said they called the nurse on duty (did not know their name) and called another CNA (did not know their name) and resident was transferred from the floor to the shower chair. During an interview on 04/11/25 at 2:02 p.m., Nurse A said CNA A came to her and told her that CR #1 was being transferred to the shower chair and got lowered to floor because the resident was weak. She said she checked for bruises when resident was on the floor, she checked her head, body, and ran her hands through her head. She said she took her vital signs when she was still on the floor. She said she completed change in condition, incident report, and doctor was notified. She said she did not ask them what technique they used to transfer the resident. She said a gait belt should be put on the resident with one person on the right and the other on the left side. She said she did not see a gait belt. She said she did not ask if a gait belt was used. During a follow-up interview on 04/11/25 at 2:26 p.m., CNA A said they were not using a gait belt. She said she had one she used but that day she did not bring it. During an interview on 04/11/25 at 2:45 p.m., CNA B said he went and got CNA A to assist him and in the middle of transferring CR #1 to the shower chair, her legs got weak, and they lowered her to the floor. He said he stood behind the resident until CNA A went and got the nurse and another CNA. He said they should have had a gait belt, but they did not have one. He said he did not really think they needed one. He said she did not have any injuries. He said CR #1 did not express any pain and there was no bruising. During an interview on 04/15/25 at 10:30 a.m., the Director of Rehabilitation said a gait belt should be used for every situation whether it's a 2-person or 1-person transfer. She said it was not a proper technique to lift from under the shoulders because one could pull arm out of socket or hurt themselves. Record review of the facility's Safe Lifting and Movement of Residents policy, revised October 2009, read in part .2. Manual lifting of residents shall be eliminated when feasible .4. Staff responsible for direct care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices .5. Mechanical lifting devices shall be used for heavy lifting, including lifting, and moving residents when necessary .