STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675831	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemere Estates	10880 Edgemere Blvd El Paso, TX 79935

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** 43871 Based on the observation, interview, and record review, the facility failed to ensure that the residents environment remains free of accidents hazards as possible and each resident receives adequate supervision to prevent accidents for 1 (Resident #1) of 2 residents reviewed for accidents and supervision. The facility failed to ensure CNA B secured the brakes on a mechanical lift when lowering Resident #1 to bed. This failure could place residents at risk for falls or injury. The findings included: Record review of Resident #1's face sheet dated 1/2/25 revealed a [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses of vascular dementia (common type of dementia that happens when there's decreased blood flow to areas of your brain), muscle weakness, and hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infraction (is a type of stroke that occurs when a blood vessel in the brain is blocked, causing damage to brain tissue). Record review of Resident #1's annual MDS assessment dated [DATE] revealed BIMS score of 00, indicating her cognition was severely impaired, and she was dependent on staff for transfers. Record review of Resident #1's care plan dated 11/06/24 revealed a focus area for requires mechanical lift/ 2 person transfers with interventions that included safety measures- including strategies to reduce the risk of infection, falls, injury initiated as appropriate and goal was will remain free from injury. In an observation on 1/2/25 at 10:20 am, CNA A and CNA B assisted with Resident #1's mechanical lift transfer. Resident #1 was informed of the procedure and reminded to cross her arms over her chest. The brakes on the lift were secured. CNA A supported Resident #'s 1 legs and provided reassurance while CNA B released the brakes and moved Resident #1 to the bed. As CNA B lowered Resident #1 to the bed, the brakes were not applied, causing slight movement of the mechanical lift. CNA B quickly secured the brakes in place. The transfer was completed without incident, and no anxiety was observed. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/2/25 at 10:34 am, CNA B stated that she should have applied the brakes on the mechanical lift before lowering Resident #1, but forgot to do so. CNA B stated the potential risks included the resident swinging, tipping over, and possibly falling. CNA B stated she had received training on proper mechanical lift transfer procedures. In an interview on 1/2/25 at 1:24 pm, the Director of Nursing (DON) explained that it was always expected for two staff members to assist with mechanical lift transfers. The DON stated staff were instructed to check the battery and ensure the lift was working properly, prepare the resident, position the sling, and secure the sling hooks. The DON stated brakes were to be engaged before lifting or lowering the resident to prevent movement and released only when ready to move the lift. The DON stated one CNA maneuvered the mechanical lift, while the other guided the resident. The DON stated that failing to apply the brakes could result in movement of the lift, increasing the risk of a resident fall or injury. The DON stated staff received training on mechanical lift transfers upon hire, including when the facility transitioned ownership, and quarterly random competency checks were conducted by the DON and lead CNA. In an interview on 1/2/25 at 2:53 pm, the Administrator stated that mechanical lift transfers were performed by direct care staff who were trained at hire, annually, and as needed during competency checks. The Administrator stated nurse managers and lead CNAs were responsible for that training. The Administrator stated that brakes should always be secured before lifting or lowering the resident. The Administrator stated the risk of not following those steps included potential injury to the resident or staff. Record review of the facility's Full mechanical lift safety guidelines policy dated November 2022 read in part when transferring from/to a wheelchair, shower chair or bed, make sure that the wheels are in the locked position on the wheelchair, shower or bed.