

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Park Bend Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2122 Park Bend Dr Austin, TX 78758	

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** 42600</p> <p>Based on observation, interview, and record review the facility failed to ensure residents environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents which resulted in a mechanical lift falling on 1 resident for 1 of 3 (Resident #6) residents reviewed for safe transfers.</p> <p>The facility failed to ensure the legs of the mechanical lift were widened during a transfer for Resident #6.</p> <p>This failure could place residents who require mechanical lift transfers at risk for falls and/or injury.</p> <p>The findings include:</p> <p>Record Review of Resident #6's face sheet dated 05/02/2024 revealed an admitted [DATE] with diagnoses of unspecified dementia, hemiplegia (paralysis on one side of body), unspecified intracranial injury (injury to the brain), major depressive disorder, conversion disorder with seizures (condition where mental health issue disrupts how your brain works), cirrhosis of liver (liver damage leading to scarring and liver failure), morbid obesity (when weight is significantly more than ideal body weight), chronic kidney disease (condition in which the kidneys are damaged and cannot filter blood as well as they should), and chronic pain syndrome (persistent pain that lasts weeks to years).</p> <p>Record review of Resident #6's quarterly MDS assessment dated [DATE] reflected a BIMS score of 11 which reflects moderate cognitive impairment. Further review of MDS revealed Resident #6 was dependent for chair/bed-to-chair transfers.</p> <p>Record review of undated care plan reflected Resident #6 has an ADL self-care deficit and required total dependence with mechanical lift transfer.</p> <p>Record review of nurse progress note from RN A dated 02/24/2024 at 1:37 PM revealed nurse and CNA (unnamed) helped Resident #6 to transfer in wheelchair with mechanical lift. Record review revealed mechanical lift tilted on Resident #6 during transfer. The progress note reflected Resident #6 was assessed for injury and reflected no injury was found.</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>Record review of nurse progress note dated 02/24/2024 at 9:46 PM reflected no change in condition related to mechanical lift lift accident for Resident #6.</p> <p>Review of video footage dated 02/24/2024 at 12:52 PM revealed mechanical lift fell on Resident #6 during transfer from bed to wheelchair. Further review revealed a leg of the mechanical lift lift was under the wheels of the wheelchair with the other leg of the mechanical lift lift in the front of the wheelchair and did not appear to be widened.</p> <p>Record review revealed in-service dated 02/24/2024 was completed with facility staff regarding mechanical lift lift use.</p> <p>Record review of facility's undated Mechanical Lift Skill Assessment reflected staff should open the legs of the lift to their widest position.</p> <p>Observation on 04/30/2024 at 9:45 AM revealed electronic monitoring posting outside of Resident #6's room. Further observation revealed electronic monitoring device in Resident #6's room.</p> <p>Observation on 05/01/2024 at 9:21 AM displayed CNA D and CNA E transfer Resident #24 with mechanical lift lift out of bed to wheelchair. Observation showed mechanical lift lift legs widened and placed around front of wheelchair and Resident #24 lowered into wheelchair.</p> <p>Observation on 05/01/2024 at 10:02 AM displayed CNA H and CNA F utilized mechanical lift lift to weigh Resident #27. Observation showed CNA H and CNA F widened mechanical lift lift legs during this lift.</p> <p>Observation on 05/01/2024 at 10:12 AM displayed CNA E, CNA G and ADON transfer Resident #6 with mechanical lift lift. Observation showed staff widened mechanical lift lift legs and placed them around the wheelchair to lower Resident #6.</p> <p>During an interview on 05/01/2024 at 11:09 AM, CNA A stated that the legs of the mechanical lift lift were always supposed to be widened during transfers.</p> <p>During an interview on 05/01/2024 at 11:11 AM, CNA D stated the legs of the mechanical lift lift were supposed to be opened and the wheelchair was supposed to go between the legs of the mechanical lift lift and from the front of the wheelchair. CNA D stated she could not recall the last time she received an in-service regarding mechanical lift lift transfers.</p> <p>During an interview on 05/01/2024 at 11:15 AM, LVN A stated the placement of the mechanical lift lift legs depended on the size of the chair. LVN A stated if it was a larger chair you may need to go through the wheelchair, but if able the legs should go around the wheelchair and were widened.</p> <p>During an interview on 05/01/2024 at 11:24 AM, CNA C stated that during a mechanical lift transfer legs were supposed to go around the wheels of the wheelchair and transfers were supposed to be done from the front of the wheelchair with the mechanical lift lift legs widened.</p> <p>During an interview on 05/02/2024 at 11:04 AM: CNA F stated the legs of the mechanical lift were supposed to be opened and go around the wheelchair so it does not tip over.</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>During an interview on 05/01/2024 at 1:46 PM, RN A stated there was an incident (on 2/24/2024) with Resident #6 and a mechanical lift tipping over. She stated there was a CNA present during this transfer but she was unable to recall who the CNA was. RN A stated the CNA was leading the transfer and the CNA forgot to widen the mechanical lift lift legs during the transfer. When RN A was asked why she did not ask the CNA to widen the legs prior to lifting Resident #6, RN A stated she did not notice the legs of the mechanical lift lift were not opened all the way until after the mechanical lift lift tipped. RN A stated that Resident #6 was in the chair and then the mechanical lift fell over. RN A stated the mechanical lift lift did not hit Resident #6. RN A stated that initially Resident #6 was scared but Resident #6 was assessed and was not injured. RN A stated that she completed an incident report and notified the on-call NP and ADM. RN A stated that Resident #6 was assessed for 72 hours after the incident to ensure there was not injury or bruising.</p> <p>During an interview on 05/02/2024 at 12:54 PM, DON stated during a mechanical lift transfer two people should be present and the legs of the mechanical lift should be opened wide. The DON stated if the legs of the mechanical lift lift are not opened wide this could cause the resident to be dropped or the mechanical lift may tip over. The DON stated it is the expectation that employees should have the legs of the mechanical lift lift widened for every mechanical lift lift transfer. The DON stated the mechanical lift lift legs should go around the entire wheelchair from the front of the wheelchair.</p> <p>Record Review of facility policy titled Safe Lifting and Movement of Residents dated July 2017 reflected in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.</p>		