STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675862	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Bend Health Center	2122 Park Bend Dr Austin, TX 78758

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45830 49097 Based on observation, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for five of 20 residents (Residents #9, Resident #69, Resident #71, Resident #352, and Resident #6) reviewed for accommodation of needs. The facility failed to ensure Residents #9, #69, #71, #352 and #6's call-lights were within reach. This failure placed residents at risk of not being able to call for needed care and services which could result in not having their needs met or being unable to call for help in an emergency. Findings included: Review of Resident #69's Face Sheet dated 05/01/2024 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident's diagnoses included dementia, overactive bladder, heart disease, weakness, urinary tract infection, toxic brain disease, and blood clots in the veins. Review of Resident #69's Quarterly MDS assessment dated [DATE] revealed his BIMS score was zero, which means resident is severely cognitively impaired. The MDS also revealed that Resident #69 was totally dependent on staff assistance with transfers, toileting, and bed mobility. Record review of Resident #69's care plan dated 03/14/2024 revealed in part (Resident #69) is high risk for falls related to: dementia, overactive bladder and high blood pressure. Further review of above plan revealed Be sure to keep residents call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request of assistance. Observation and interview on 04/30/2024 at 11:25 AM, observation of CNA A walked out the Resident #69's room with a bag in her hand . Resident was lying in bed and his call light was on the floor. Resident #69 stated that he had just been changed and that he usually has his call light and that he uses the call light. In an observation and interview on 04/29/2024 at 11:36 AM RN A stated Resident #69 used his call light sometimes. RN A went into Resident #69's room and observed the call light on the floor. RN A picked up the call light and put it in the resident's reach. (continued on next page)

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/29/2024 at 11:41 AM CNA A stated Resident #69 liked to put his call light on the floor. She stated that she had just finished changing Resident #69. When asked if she forgot to put the call light back in reach of the resident she did not answer. Review of Resident #9's Face Sheet dated 05/02/2024 reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident's diagnoses included diabetes, swelling in the legs, asthma, morbid obesity, cancer of pituitary gland, insomnia, sleep apnea, depression, reflux, glaucoma, heart disease, and abnormal bone growth. Review of Resident #9's Quarterly MDS assessment dated [DATE] reflected her BIMS score was fifteen, which means resident has no cognitive impairment. The MDS also revealed that Resident #9 needs maximal assistance with transfers, toileting, and bed mobility. Record review of Resident #9's care plan dated 04/07/2024 reflected in part (Resident #9) is high risk for falls related to: obesity, sleep apnea, depression, glaucoma. Further review of above plan revealed Be sure to keep residents call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request of assistance. Review of Resident #71's Face Sheet dated 05/02/2024 reflected he was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident's diagnoses included dementia, lung disease, retention of water, kidney disease, anemia, absence of right leg, urine retention, reflux, heart failure, prostatic cancer, blocked arteries, and irregular heart rate. Review of Resident #71's Quarterly MDS assessment dated [DATE] reflected her BIMS score was eleven, which means resident is moderately cognitively impaired. The MDS also revealed that Resident #71 needs extensive assistance with toileting, and bed mobility. Resident #71 was totally dependent for transfers. Record review of Resident #71's care plan dated 02/29/2024 reflected in part (Resident #71) is at risk for falls related to: dementia, chronic obstructive pulmonary disease, chronic kidney disease, and congestive heart failure. Further review of above plan revealed Be sure to keep residents call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request of assistance. Observation and interview on 05/01/2024 at 9:29 AM, Resident #9 sitting in wheelchair, dressed and well groomed. Resident was sitting approximately three feet away from her bed, along the side of her bed. Resident's call-light was wrapped around the bed rail that was farthest away from the resident. Resident #9 stated she used her stick to get the call light or would wheel herself out to the hall for assistance. Observation and interview on 05/02/2024 at 8:28 AM with Resident #71 revealed Resident #71 was sitting up on the edge of his bed, in the middle of the bed. Resident was groomed and in a hospital gown. Resident #71's call light was hanging straight down from the wall on the floor in between his bed and the wall. The call light was not in the resident's reach. Resident #71 stated that staff do not answer his call light and that he did not know where it was. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #352's undated Face Sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Acute Respiratory failure with Hypoxia (condition where there is not enough oxygen in body tissues), Hemiplegia (paralysis affecting one side of body) and Hemiparesis (partial weakness) following Cerebral Infarction (brain stroke) affecting left non-dominant side and Major Depressive Disorder (mood disorder causing persistent feeling of sadness and loss of interest). Record review of Resident #352's initial MDS assessment dated [DATE] reflected a BIMS score of 14 indicating intact cognitive status. Functional abilities and goals reflected he was dependent for repositioning in bed, transferring from bed to chair and for toileting hygiene. Record review of Resident #352's Care Plan dated 05/01/2024 reflected he had a moderate risk for falls r/t weakness. Intervention: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Observation on 04/30/2024 at 10:44 AM revealed Resident # 352's call light was on the floor and under his bed. He was sleeping and not responsive to any questions. In an observation and interview on 04/30/2024 at 10:50 AM the DON stated Resident #352's call light should not have been on the floor and was not in reach if the resident needed something. The DON placed the call light back on Resident #352's bed. Record Review of Resident #6's face sheet dated 05/02/2024 revealed an admitted [DATE] with diagnoses of unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), 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 kidney are damaged and cannot filter blood as well as they should), and chronic pain syndrome (persistent pain that lasts weeks to years). Record review of Resident #6's quarterly MDS assessment dated [DATE] reflected a BIMS score of 11 which indicated the resident has moderate cognitve impairment. Further review revealed Resident #6 is dependent for chair/bed-to-chair transfers. Observation on 4/30/2024 at 9:47 AM revealed Resident #6's call button was on the ground and not in reach of Resident #6. During an interview on 04/30/2024 at 9:47 AM, Resident #6 stated he was not sure where his call button was. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/02/2024 at 11:27 AM LVN A stated that the policy was the call light should be within the resident's reach. He also stated there were several types of call lights for residents with different needs. He stated that the call lights should be answered within five minutes. He stated all care staff were responsible for answering the call lights. LVN A stated care staff and CNAs were responsible for placement of the call lights. He stated it was important the call lights were in reach of the residents so that they can call staff if they need something or in an emergency. He stated the call light should never be out of the resident's reach. He stated he was not aware of the call lights not being in reach of the residents. He stated they may have fallen but if staff noticed it should have been put back in the resident's reach. In an interview on 05/02/2024 at 11:39 AM the ADM stated the policy on the call lights were to be always in reach of the resident. She stated all staff in the facility were responsible for ensuring the call lights were in the resident's reach. She stated it was important to make sure the call light was in reach so the staff can accommodate the resident's needs or in case of an emergency. She stated Resident #71's light may have fallen. She stated that Resident #9's light was missed by staff because they may have gotten busy and were not thinking about the light. She stated they did not have a written policy. In an interview on 05/02/2024 at 11:52 AM CNA B stated everyone was responsible for answering call lights. She stated CNAs are responsible for placing the call light in the resident's reach. She stated it was important to place the call light in the resident's reach so, when the resident needs something, or needed to go to the bathroom they can call a staff member. CNA B stated the call light should be always in the resident's reach. She did not know why Resident #9's and Resident #71's call lights were not in their reach. In an interview on 05/02/2024 at 12:02 PM CNA C stated the policy was the call light needed to be next to the resident. She stated if the resident is in the chair the call light should be next to them. She also stated if the resident was in bed the call light should be on the bed with the resident. She stated any staff can answer the call light but CNAs, ma's and nurses are responsible for ensuring the call light was in the resident's reach. She stated it was important for the resident to be able to call for help when they need something. CNA C stated that the call light should be anywhere the resident is at in the room. She stated she did not know why Resident #9 and Resident #71's call lights were not within their reach. In an interview on 05/02/2024 at 12:11 PM the Director of Clinical Services stated call lights should be in reach of the resident so they can get the assistance they need. She stated if the resident's call light was not in reach, they wouldn't be able to get help and that could potentially lead to them falling. In an interview on 05/02/2024 at 1:51 PM the DON stated the policy on the call lights should be in the resident's reach and answered. He stated anyone who walks past the light or up and down the hall is responsible for answering the call light or checking the call light placement. He stated that the call light should always be in the resident's reach when the resident is in their room. He stated it is important to have it within the resident's reach so that the resident's need can be met. He stated that Resident #9 and Resident #71's call lights were not in reach of the resident because someone did not do what they were supposed to do. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Daily Care: Assigned Rounds for Excellence not dated reflected call light in reach of resident (check function). Bathroom call light functional were on the checklist.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interview and record review, the facility failed to ensure the residents' right to formulate an advance directive for 3 of 5 residents (Resident #52, Resident #62, and Resident #99) reviewed for advanced directives: The facility failed to ensure Resident #52's MPOA included all pages and was signed, dated, and witnessed or notarized to confirm it was valid. The facility failed to ensure Resident #62's OOH-DNR form has the physician's license number, date of signature and printed name in the physician's statement section which made the document invalid. The facility failed to ensure Resident #99's OOH-DNR was signed and dated by a legal guardian, agent, proxy or qualified relative and witnessed or notarized or executed by two physicians which made the document invalid. These failures could place residents at-risk of having their wishes dishonored or delay necessary medical treatment or intervention due to confusion regarding authority to make medical decisions on behalf of the resident. The findings include: Record review of Resident #52's face sheet dated [DATE] revealed an admitted [DATE] with diagnoses of: Encephalopathy (brain disease that alters brain function) unspecified dementia, alcohol dependence, and major depressive disorder. Further review revealed Resident #52's family member was listed as responsible party and POA of care. Record review of partial MPOA for Resident #52 reflected this document only included two pages and did not include any signatures or dates therefore rendering it incomplete and invalid. The signature pages should include Resident #52's dated signature and the dated signatures of two individuals who were witnesses or a dated notary signature Record review of Resident #52's undated care plan reflected interventions to ensure resident wishes were followed as desired and to follow advance directives. Record Review of neuropsychological report dated [DATE] revealed Resident #52 had increased cognitive impairment. Record Review of letter from MD dated [DATE] reflected that Resident #52's MD suggested her MPOA make all decisions regarding health care, finances, and legal matters. Record review of The St. Louis University Mental Status (SLUMS) examination dated [DATE] indicated Resident #52 scored in the dementia range. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #62's face sheet dated [DATE] reflected an admitted [DATE] and diagnoses of unspecified dementia, type 2 diabetes, unspecified glaucoma (eye disease that can cause vision loss), overactive bladder, restless legs syndrome, depression, and heart disease. Record review of Resident #62's clinical records revealed an OOH-DNR order form reflected an MD signature in section F and no signature in the physician's statement section. The physician's statement section lacked an MD's license number, date signed, printed name and signature in the physician's statement section. Record review of Resident #62's undated care plan reflected resident chose DO NOT RESUSCITATE status with intervention to ensure that Resident had a completed Texas OOH-DNR in the medical chart. Record review of Resident #62's quarterly MDS assessment dated [DATE] reflected a BIMS score of 1 and indicated severe cognitive impairment. Record review of Resident #99's face sheet dated [DATE] revealed a readmitted [DATE] with diagnoses of acute respiratory failure with hypoxia (when oxygen is not available in sufficient amounts), schizoaffective disorder (a mental health condition which includes symptoms of schizophrenia and mood disorder), anemia (a condition when a lower amount of red blood cells are produced), type 2 diabetes, metabolic encephalopathy (an imbalance in the brain), essential hypertension (high blood pressure), pressure ulcer of sacral region (skin injury in the lower region of body near back and spine), and colostomy status (opening of large intestine through the abdomen). Record review of Resident #99's clinical record revealed an OOH-DNR order form dated [DATE] lacked both required physician's dated signatures, printed name and license numbers under section F as required for an OOH-DNR order form executed by a physician. Record review of undated care plan for Resident #99 reflected resident chose DNR status. Record review of Resident #99's MDS dated [DATE] reflected that Resident #99 expired. Record review of Resident #99's clinical records indicated he was admitted to hospice on [DATE]. In an interview on [DATE] at 12:34 PM, RN B stated when a new resident was admitted the facility received a report from the hospital and were notified of code status (resident's preferred resuscitation procedures) for the resident. RN B stated the resident was asked what their code status was when they were admitted . RN B stated that if a Resident was unable to answer what their code status was then their documents were reviewed and family members were called. RN B stated code status can be discussed during care plan meetings. RN B stated if the resident did not have DNR paperwork they were considered full code until the facility obtained paperwork. RN B stated that she was able to check if a DNR was filled out correctly and then confirmed with the social worker and updated the order in the system. RN B stated that the DNR for Resident #99 was filled out correctly. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:41 PM, LVN A stated that they determined code status by looking it up in the computer and looked to verify if there was an actual document and if the document was filled out correctly. LVN A stated that the DNR must be filled out correctly to be valid and that he was able to determine if it was filled out correctly when he reviewed it. LVN A stated that if it was found that the OOH-DNR was incorrect he would let someone know in management so it could be corrected. LVN A stated that social worker was responsible to ensure the OOH-DNR was filled out correctly. During an interview on [DATE] at 12:48 PM, the DON stated that the social worker initiated advanced directives and the physician signs and executed them. The DON stated that the social worker and family were responsible to ensure it was filled out completely and accurately and then it was reviewed by medical staff. The DON stated he should ensure that advanced directives were in PCC (point click care, the facility's electronic health record) and ensure they were filled out correctly. The DON stated if it is filled out incorrectly staff may have to initiate CPR which may not meet the residents' wishes. The DON reviewed Resident #62's OOH-DNR and stated that it was not filled out correctly. The DON reviewed Resident #52's MPOA and stated it was not considered a full MPOA and there were no signatures. The DON stated that he believes it is the social worker who reviewed the advanced directives. During an interview on [DATE] at 2:00 PM, the ADM stated that first the social worker checked advanced directives upon admission to see if the resident had any. Then, the social worker reviewed code status and what the resident wishes were and what the resident had in place. The ADM stated it is the expectation that all advanced directives are filled out accurately and complete. Record review of the facility's advance directives policy dated [DATE], titled Advance Directive revealed The resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Record review of Texas DSHS Instructions for Issuing an OOH-DNR Order dated [DATE] reflected the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is a representative of the ethics or medical committee of the health care facility in which the person is a patient. Record review of health and safety code 166.151 dated [DATE] revealed the medical power of attorney must be signed by the principal in the presence of two witnesses or have the signature acknowledged by a notary public; witnesses must also sign the document.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 28689 Based on observation and, and interview, and record review the facility failed to maintain a clean, sanitary, comfortable, and homelike environment for two of two shower rooms (100-200 Hall and 300-400 Hall) in the facility used by the residents. The facility failed to ensure the shower curtains would close for privacy in both shower rooms used by the residents. This failure could place all residents at risk for lack of privacy, dignity, and a diminished quality of life. Findings included: In a confidential interview, an interviewee stated the shower curtains did not close all the way in the 100 and 200 hall shower room, and she did not have privacy during her showers. Observation on 05/01/2024 at 2:04 PM of the shower curtains in shower room for the 100-200 halls revealed the curtains in three shower stalls were missing hooks and did not close all of the way. Observation on 05/01/2024 at 2:10 PM of the shower curtains in the shower room for 300-400 halls revealed hooks were missing on the middle shower stall curtain and it did not close all of the way. The shower curtain closest to the 300 hall was missing hooks and did not close completely. In an interview on 05/02/2024 at 10:45 AM the Maintenance Director stated he made rounds in shower rooms but did not notice anything wrong with the curtains. He could not say when he last made rounds in the shower rooms but stated he was informed on 05/01/2024 that the curtains needed repair and he fixed them. He stated the staff were supposed to put maintenance requests into a computer application for maintenance. In an interview on 05/02/2024 at 10:49 AM CNA F stated she had worked at the facility since 2017 but did not know how to access the computer application for maintenance. She stated if she saw an issue that required maintenance she notified the nurse, and they would enter it into the computer. In an interview on 05/02/24 at 10:52 AM CNA A stated she had worked at the facility for 6 months. She stated she did not know how to enter a maintenance request. She further stated she would just tell the Maintenance Director because he spoke Spanish. Observation on 05/02/2024 at 11:00 AM revealed a posting on the wall next to a desk on 100 hall that was used by the CNAs. The posting stated, How to make a Maintenance Request. It stated the computer application was how the Maintenance Director managed his work orders and there were step by step instructions on how to enter a work order into the computer. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/02/2024 at 1:20 PM the ADM stated she expected the Maintenance Director to check the shower rooms weekly and to make sure everything was functioning correctly. She stated if the shower curtains did not close all the way it could affect the resident's dignity. In an interview on 05/02/2024 at 1:53 PM the Director of Clinical Services stated her expectation was to provide privacy for residents. She stated the shower curtains not closing all of the way could affect the residents' dignity. She further stated the staff made rounds daily, and shower curtains might need to be added to the checklist. In an interview on 05/02/2024 at 1:25 PM the DON stated his expectation was that bathroom doors would be closed during showers and ensure the shower curtains were in working order to preserve the resident's dignity. Record review of an undated checklist titled Daily Care: Assigned Rounds for Excellence reflected shower curtains were not listed. Record review of a facility policy and procedure titled Homelike Environment dated 2001 and revised February 2021 reflected, Residents are provided with a safe, clean, comfortable homelike environment.

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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** 42600 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 lift falling on 1 resident for 1 of 3 (Resident #6) residents reviewed for safe transfers. The facility failed to ensure the legs of the mechanical lift lift were widened during a transfer for Resident #6. This failure could place residents who require mechanical lift lift transfers at risk for falls and/or injury. The findings include: 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). 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. Record review of undated care plan reflected Resident #6 has an ADL self-care deficit and required total dependence with mechanical lift lift transfer. 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 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. 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. 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. Record review revealed in-service dated 02/24/2024 was completed with facility staff regarding mechanical lift lift use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675862	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Bend Health Center	2122 Park Bend Dr Austin, TX 78758

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's undated Mechanical Lift Skill Assessment reflected staff should open the legs of the lift to their widest position. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	675862	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Bend Health Center	2122 Park Bend Dr Austin, TX 78758

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.