STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675973	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McLean Care Center	605 W Seventh St McLean, TX 79057

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 - Immediate jeopardy to resident health or safety 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 observation, interview, and record review, the facility failed to ensure the resident's environment remained free from accidents as was possible and each resident received adequate supervision and assistance devised to prevent accidents for 1 of 5 residents (Resident #2) reviewed for accidents, hazards, and supervision. The facility failed to ensure the TA securely fastened Resident #2's seat to the floor of the facility van when taking him to dialysis. Resident #2's seat tipped sideways, causing Resident #2 to strike the van door with his right shoulder and side, resulting in a fractured right collarbone and rib when the TA made a left turn. The noncompliance was identified as PNC. The IJ began on 3/18/26 when Resident #2 fell in the facility van and ended on 3/19/26. The facility had corrected the noncompliance before the surveyor entered the facility. This failure could place residents at risk of serious injury, harm or other medical complications. Findings Included: Record review of Resident #2's face sheet, dated 3/20/26, documented a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: congestive heart failure (heart cannot pump enough blood to meet the body's needs, causing fluid buildup in the lungs, legs and abdomen), mild dementia (memory loss, increased confusion, poor decision-making), end stage renal disease (kidneys no longer function on their own), gastro-esophageal reflux (stomach acid frequently flows back into the esophagus, causing irritation), abdominal aortic aneurysm (enlargement in the lower aorta, usually caused by a weakened [NAME] wall, aging and smoking), atrial Fibrillation (fast, irregular heartbeat), cerebral infarction (blockage in an artery supplying blood to the brain, resulting in oxygen deprivation and tissue death), atherosclerosis of renal artery (narrowing of kidney arteries due to plaque buildup), dependence on oxygen, hypertension (high blood pressure), skin cancer, kidney failure, severe protein-calorie malnutrition. Record review of Resident #2's quarterly MDS, dated [DATE], documented the resident had a BIMS score of 10 out of 15, indicating moderate cognitive impairment. Resident #2 was ambulatory with a walker. Record review of Resident #2's March 2026 nurses notes documented the following: -3/18/26 at 11:00 a.m. - The AD of facility called me (DON) and notified that residents chair tipped over during transport to dialysis and the resident did fall in-between the door of van and seat the resident was sitting in had tipped over. The DON notified the NP of the incident, and the resident had no visible injuries noted. The resident stated he had pain in right shoulder, and the resident could move the right shoulder at that time. The DON notified the NP and ordered for x-ray of shoulder when the resident arrived back at facility and to continue to dialysis treatment as the resident was in the parking lot about to go into dialysis. The Resident Statement: I was sitting in seat of facility van and when driver made turn, the chair tipped and I was against the door of the van. The Van driver stopped and helped me get back up and checked for injuries, MD, RP notified. Interventions: Monitoring loading/unloading and use of the van lift and secure of chairs to make sure everything in proper orders are in place. -3/19/26 at 8:25 a.m. - x-ray results of shoulder were negative for fractures. Resident notified. -3/27/26 at 4:12 p.m. - NP ordered CT without contrast of right shoulder due to shoulder pain scheduled for 3/30/26 at 8:00 a.m., resident notified. -3/30/26 at 1:46 p.m. - unable to do CT scan of right shoulder without contrast due to order not being received (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with physician signature. New appointment for CT of right shoulder without contrast scheduled for 4/3/26 at 4:00 p.m., resident notified of change of appointment. Record review of an x-ray dated 3/18/26 of Resident #2's right shoulder, revealed no acute fracture or dislocation of right shoulder. Record review of a CT scan dated 4/3/26 f Resident #2's right upper extremity, , documented an acute, mildly comminuted (multiple small, splintered pieces) and minimally displaced, fracture of the right distal clavicular (collarbone) head and neck, and acute, nondisplaced, right anterior 2nd rib fracture. (The facility received the results of the CT scan on 4/8/26 while the state surveyor was in the facility). Record review of the Provider Investigation Report, dated 3/18/26, revealed Resident #2 was being transported by the TA to dialysis. The AD was also in the van for resident shopping and witnessed the incident. During transport the TA was making a low speed left turn from a stop sign when the van seat/chair tipped sideways, which caused the resident to strike the van door. The driver immediately pulled over and secured the resident in a different chair. The TA asked Resident #2 if he was okay, and the resident said yes. Immediate actions taken to protect the resident's health and safety included immediately pulling over, checking on the resident who had no visible injuries, securing the resident in a different seat, and removing the TA from transport duties following the incident. The Administrator and MDS nurse drove to the dialysis center to safely transport the resident back to the facility. The resident was secured in a different chair. The van driver was suspended pending investigation. Witness statements from TA and AD were obtained and the TA was drug tested and the results were negative. Began abuse/neglect in-service. The chair was removed from the van.Investigation Summary: During the weekend, the van seat was repositioned to accommodate additional residents attending a parade in a local community. Subsequent inspection revealed the safety bar did not fully engage or seat properly within the groove intended to prevent the latch mechanism from loosening. The Administrator further determined the handle was difficult to manipulate into the position required to fully secure the seat within the floor track. As an immediate corrective action, the Maintenance Supervisor lubricated the latch hardware on all van seats and confirmed that each seat was properly locked and secured to the floor track. The van was removed for service for resident transport immediately and no residents will be transported in the van until it has been assessed by maintenance staff for proper function of all safety devices/equipment. In-serviced staff who transport or assist with transporting residents in the van on the following (with return demonstration) staff members not in-serviced will not transport residents - how to safely load and unload residents in the van using the lift. Properly securing a resident in the van - ambulatory resident - securing with seat belt., non-ambulatory resident - securing the wheelchair and the resident, maintain a list of staff who have completed training and provided return demonstration. Staff not listed will not transport residents. The medical director was notified of this incident. Each week the Administrator or designee monitors at least 4 instances of loading and /or unloading of a resident using the van lift to ensure the lift was used correctly and the resident was properly secured. This monitoring will continue for at least 4 weeks. The QAPI Committee will review the findings and make changes to this plan as needed. During an interview on 4/8/26 at 9:20 a.m., Resident #2 stated his shoulder still hurts from a fall in the van. Resident #2 stated the seat on the van was not latched good and he fell over and hit his head and bruised his shoulder. Resident #2 stated the TA pulled the van over and had to unhook him so he could get up from the floor of the van. Resident #2 stated he was sitting in a chair, not a wheelchair. Resident #2 stated after the fall, he went to dialysis and then back to the facility for an x-ray. Resident #2 stated the x-ray was negative. Resident #2 stated he had just gone to the hospital for a CT scan of his shoulder, but the facility had not gotten the results of the test yet. Resident #2 was ambulating in the hallway unassisted, had a steady gait and was carrying personal items in both arms. During an interview on 4/8/26 at 9:30 a.m., the TA stated she just did not understand how Resident #2 fell in the van. The TA stated she inspected the van before and after transporting residents. The TA stated there were three chairs in the van and they were all secured to the floor. The TA stated Resident #2 had his seat belt on him. The TA stated she was in a local (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	community at a stop sign and when she turned the corner, that was when Resident #2 fell. The TA stated Resident #2 was leaning to the right of his chair when he fell over and hurt his shoulder on the van door. Record review of the Daily Vehicle Pre-Trip/Post-Trip book revealed the following, the inspection dated 3/18/26 (the day of Resident #2's fall), documented the van had chips on the windshield with no other concerns. The book revealed that any time the van was taken out, the pre and post inspections were completed. An observation and interview on 4/8/26 at 9:50 a.m., the van had two high back chairs that were latched to rails on the floor and they were secure. The TA explained that day, there was another chair in the van which was latched to the rails on the floor. The TA stated Resident #2 was sitting in the extra chair and he had his seat belt on. The TA stated there were usually only two chairs in the van and she could get two residents in wheelchairs in the van so she could transport 4 residents at a time. The two chairs were shaken, and both chairs were sturdy and secure. During an interview on 4/8/26 at 11:08 a.m., the DON stated the TA and Resident #2 were on their way to a local community for dialysis for Resident #2. The DON stated the AD checked all the chairs for safety reasons before they left in the van and all the chairs were secured. The DON stated Resident #2 tipped over and hit his shoulder. The DON stated Resident #2 was very close to dialysis so the TA was instructed to take Resident #2 to dialysis as they had nurses there who could assess him for any injury and he could also get his dialysis. The DON stated they got an x-ray of Resident #2's shoulder and it was negative for any fractures. The DON stated they got a CT scan on his shoulder, and they should have the results soon and said she would look to see if the results were back and she would bring the state surveyor a copy. The DON was gone a few minutes and came back with the CT scan results which showed a mildly comminuted and minimally displaced fracture of the collarbone and a right 2nd rib fracture. During an interview on 4/8/26 at 11:23 a.m., the AD stated it was the first time going with TA to go shopping. The AD stated the chair was on the outside of the van and TA put the chair in the van and secured it. The AD stated she looked at the chair and one of the front legs looked like it was not on the track properly. The AD stated she told the TA to check the chair, and she said it was not right, so she reattached the chair to the railing on the floor again. The AD stated she checked the chair before Resident #2 got into it, and the chair was sturdy and solid. The AD stated they were in a local community and at a stop sign, then the TA turned to go to the dialysis center when they heard a thud and Resident #2 was leaning way over and still strapped to the chair. The AD stated she called the DON and told her what happened and they got Resident #2 off the chair as he was still strapped in. The AD stated Resident #2 kept saying he was sorry and did not want to get anyone in trouble. The AD stated the Administrator called them because someone saw the facility van on the side of the road and called the facility about it, so he knew something was wrong. The AD stated they were instructed to get Resident #2 to the dialysis so the nurses at the center could assess him for any injuries. The AD stated Resident #2 said his shoulder hurt so the NP called to get an x-ray and that was negative for any fractures. The AD stated Resident #2 was still complaining of his shoulder hurting so he went for a CT scan, but she didn't think the results were back. During an interview on 4/8/26 at 11:54 a.m., the MS stated the chair that failed was put in the back shed. The MS stated he did weekly vehicle inspections on all the facility vans. The MS stated he checked over the chair that was tipped over and he could not find anything wrong with it. The MS stated the latch hardware was somewhat stiff, so he lubricated all the latches on the chairs, so they moved better. Record review of the Weekly Vehicle Inspection Report revealed the facility van was inspected weekly for the following items: vehicle interior including floors, seats, doors and steps all clean and free of debris/stains, seat belts in good working order, wheelchair tie-downs inspected and working properly. Also inspected - Exterior, fluid levels and emergency equipment. An observation on 4/8/26 at 12:15 p.m., of the chair that was taken out of the van revealed all the parts were in working order. An observation on 4/8/26 at 1:10 p.m., the TA inspected the van before taking the state surveyor on a ride in the neighborhood. The TA had a check list she filled out before transporting any resident and checked everything again when she got back to the facility after the outing. The TA (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	demonstrated how she stopped at a stop sign, turned right and explained again how the resident tipped over and hit the van door. During a follow-up interview on 4/8/26 at 1:45 p.m., the TA stated she put the seat in the van that morning before she took Resident #2 to dialysis. The TA stated she started working at the facility in November 2025 and was trained over the wheelchair security on the van but not how to put the seats in the van and secure them. The TA stated the day Resident #2 fell in the van was the only time she had ever put a seat in the van. The TA stated she was told by the Administrator to not put seats in the van anymore as that would be the Maintenance Supervisors job. During an interview on 4/8/26 at 2:05 p.m., Administrator A stated the seat from the van was checked and the red pin at the bottom of the chair was hard to push down to properly secure the chair. Administrator A stated the TA should not put the seats in the van or out, that it was a job for the MS. Administrator A stated they in-serviced all staff who transport/assist with transporting resident. During an interview on 4/8/26 at 5:00 p.m., the ADO stated if the MS was not available to put seats in or out of the van, she would have the regional maintenance staff person do it and she would oversee it. During a telephone interview on 4/10/26 at 3:31 p.m., the DON stated she did not get a written assessment from the dialysis center about Resident #2. The DON stated the dialysis nurse told her Resident #2 said his shoulder hurt but he was fine and wanted to continue with dialysis treatment since he was already there. During an observation on 4/17/26 at 9:58 a.m., Resident #2 was ambulating unassisted on the front sidewalk with the TA walking behind him. Resident #2 was nicely dressed and had a sling around his waist with a strap going around his right arm. During an interview on 4/17/26 at 10:00 a.m., Resident #2 stated he was going to dialysis as he was starting to not fell well. Resident #2 stated he was not having any pain in his shoulder anymore. During an interview on 4/17/26 at 10:15 a.m., Administrator B stated she was made aware of the PNC with the fall in the van. Administrator B stated she had a feeling that state would come back for more information. Administrator B stated if the resident was not screaming out in pain or had blood everywhere, she would not expect EMS to be called for that. During an interview on 4/17/26 at 10:47 a.m., LVN C, dialysis nurse, stated RN D was on duty and assessed Resident #2 on the day he fell in the van. LVN C stated Resident #2 told them he had fallen in the van and his shoulder hurt. LVN C stated she remembered Resident #2 wanted his dialysis treatment and was not in a lot of pain. LVN C stated RN D was off today, but she could fax the paperwork for Resident #2's visit on 3/18/26. Awaiting fax from dialysis center. During a follow up interview on 4/17/26 at 10:58 a.m., the DON stated the AD called her and told her what had happened. The DON stated she asked the AD if Resident #2 was still on the floor. The DON stated she was informed they had already put him in a different chair. The DON stated she told them not to do anything else until she called the NP to see what she wanted done. The DON stated the NP was told the chair was tipped over and they had already got Resident #2 up and into a different chair, was in some pain but he could move his arms and legs and asked where they were at right now. The DON stated the NP said to ask him if he was able to go through dialysis, Resident #2 said yes, and the NP ordered a mobile x-ray when he got back from dialysis. The DON stated she was not sure of the distance Resident #2 was away from the dialysis center. Fax from the dialysis center was received 4/17/26 at 11:10 a.m. and it revealed the following:3/18/26 - patient complained of falling on his right shoulder. No swelling noted. Patient reports pain. PRN acetaminophen (over the counter pain reliever) administered for pain. NH DON reports patient is to have x-rays post treatment. NP (dialysis) informed of patient condition. No orders received. Low Blood Pressure before treatment. Temperature 98.4. Nursing Evaluation 3/18/26 at 11:48 a.m. - alert, oriented, ambulates with assistive device, uses walker, fall on shoulder, no associated symptoms, irregular pulse, pleasant, lungs are clear. During a follow-up interview on 4/17/26 at 11:20 a.m., the MS stated he was instructed to grease up the seats in the van by his company supervisor, and he would not have told him to do something that was not safe. The MS stated the facility van has over 75,000 miles and the levers on the seats must be greased occasionally because of the wind and dirt, the levers that attach the seats to the track start to rust if not greased. The MS stated he was not at (continued on next page)

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