

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2025
NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 E Loop 304 Crockett, TX 75835	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on observation, interview and record review the facility failed to implement written policies and procedures that prohibit and prevent neglect for 1 of 8 (Resident #1) residents reviewed for abuse and neglect. The facility did not implement their policy to report to HHSC within 24 hours when a fall incident to Resident #1 occurred on 3/04/2025. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings included: Record review of undated admission record printed on 3/08/25 indicated Resident #1 was an [AGE] year-old female who admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), depression (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy that can significantly interfere with daily life), cognitive communication deficit (difficulty communicating due to brain damage), arthropathy (any disease or condition that affects the joints) and dementia (an umbrella term for a group of diseases that cause a decline in mental ability severe enough to interfere with daily life, encompassing memory, thinking, and behavior). Record review of quarterly MDS dated [DATE] indicated Resident #1 had difficulty communicating some words or finishing thoughts but was but was able if prompted or given time and usually understood others. The MDS indicated Resident #1 had severe cognitive impairment in thinking with a BIMS score of 00 and was totally dependent on staff for transfers. Record review of a care plan for Resident #1 revised on 01/11/2024 indicated she had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner. Interventions included: Transfers: dependent: mechanical lift x 2 NA. Record review of a care plan for Resident #1 revised on 1/14/25 indicated she had the potential for falls related to cognitive impairment, incontinence, gait/balance problems and confusion. Interventions included: Staff education/assist with transfers dated 8/12/2024. Record review of progress note for Resident #1 indicated the following: (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/4/25 at 6:10pm Completed by LVN C- Called to room by [NA B]. [Resident #1] [was] lying on her right side on the floor. She is positioned between the mechanical lift legs. [NA B] reported [Resident #1] was sliding off sling when [NA B] was transferring [Resident #1] from Geri-chair to bed. [NA B] grabbed [Resident #1s] shirt and mechanical lift sling and assisted [Resident #1] to the floor. Action: Head to toe assessment completed. [Resident #1] moved all extremities within normal limits for this resident. No knots [NAME] on scalp. No pain when pressure applied to all joints. [Resident #1] stated I'm ok. -3/4/25 at 8:01pm Completed by LVN C: Data: [virtual medical visit] provider, and doctor notified of event and [Resident #1's] assessment. Action: Provider given details of incident and resident's assessment. Provider video chatted with resident. Response: Orders received for fall precautions, neuros per facility protocol, notify clinician for any change in condition. -3/4/25 at 8:41pm_[Virtual Medical Visit] note - Date of Service: 3/4/25 @ 7:59pm, Details: Nurse Name: [LVN C], Patient Name: [Resident #1] Primary Chief Complaint: Fall Without Injury History Present Illness: [AGE] year-old female who had a fall that evening. [NA B] was transferring [Resident #1] from Geri chair to bed using a mechanical lift . [Resident #1] started sliding out of sling and the [NA B] was able to grab [Resident #1's] shirt and mechanical lift sling and lowered [Resident #1] to the ground. [Resident #1] denied pain or injuries. [Resident #1] had good ROM without c/o pain. No deficits noted - at [Resident #1] baseline. No obvious injuries, lacerations, abrasions, bleeding. [Resident #1] did not hit her head. Witnessed. Neuro was checks started and were normal. Record review of 72-hour neuro checks report dated effective 3/4/25 indicated Resident #1 had no change in neuro status. [Resident #1] did not follow finger with her eyes and her neuro remain at baseline and voiced no pain complaints. During an observation and attempted interview on 3/9/25 at 2:03pm, Resident #1 was in her room lying in bed resting, she did not respond to questions asked. Resident #1 did was clean, well-groomed with no unpleasant odor. There was no visible bruising, skin tears or marks to Resident #1's upper body area. Record review of witness statement form dated 3/4/25 completed by NA B indicated the following: [NA B] used mechanical lift, connected all 4 loops on mechanical lift, and pushed the button. [Resident #1] was in the air, she leaned forward, and [NA B] saw [Resident #1] coming out of the [mechanical lift] swing. [NA B] immediately grabbed both the sling and [Resident #1] shirt, brought [Resident #1] close to [NA B] while supporting [Resident #1] back and head; once safely on the floor [NA B] got help. Record review of a skills validation checklist for transfers dated 1/24/2025 indicated NA B was in attendance by her signature and was observed by the DON on mechanical lift transfer. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Administrator's typed statement dated 3/4/25 regarding the incident indicated the following: At 6:27 pm [the Administrator] received a call from DON stating there had been an accident involving the mechanical lift. [NA B] was putting [Resident #1] to bed BY HERSELF using the mechanical lift. [Resident #1] was not injured and did not hit the floor, per [NA B]. [NA B] stated she knew she was not to use the mechanical lift without a partner, but that she was trying to get her residents in bed. She stated when [the facility] is short, we just do what we have to do sometimes. [NA B] also stated she used blue hooks on one side and green hooks on the other side when she put [Resident #1] in the mechanical lift sling. She stated [Resident #1] was facing her as she steered the mechanical lift and as she got close to the bed, [Resident #1] started to fall toward her, she grabbed her shirt and wrapped her arm around her causing [Resident #1] to turn in the sling. She stated at no time did [Resident #1] hit the floor. [NA B] stated she lowered [Resident #1] to the floor. [NA B] gave us a written statement and was suspended investigation. Staff presents were in-serviced on mechanical lift usage and gave a return demonstration. [Name of Virtual Medical Visit Provider] was called and did a Facetime visit, doctor was notified and a QAPI meeting was had. All nursing staff will be in-serviced that are on the facility employee roster. Record review of an undated typed note provided by the Administrator indicated the following: An off-cycle QAPI meeting was held on March 4, 2025, at approximately 8:13 pm via phone conversation with medical director to discuss an incident in which [Resident #1] was lowered from the mechanical lift by a [NA B] as [Resident #1] started to fall from the sling. We discussed the facility's follow up plan to sustain compliance. The following individuals were in attendance: Facility Medical Director - via phone, Facility Administrator and the Facility Interim DON. During an attempted interview on 3/12/2025 at 9:11am, the NA B was called but she did not answer, and it went to voice mail and a message was left to return the call related to the investigation. During a phone interview on 3/12/25 at 9:17am, LVN C said she had been employed at the facility for about [AGE] years and worked the 6pm-6am as a charge nurse. She said she was the nurse on duty the day Resident #1 was involved in the mechanical lift fall incident on 3/4/25. She said NA B ran out into the hall and yelled for help, LVN C said herself, the DON who no longer worked there and several others who she could not recalled ran and assisted. LVN C said she saw Resident #1 laying on the floor between the legs of the lift and NA B explained what happened. She Said NA B explained she was transferring Resident #1 from chair to bed using the mechanical lift and Resident #1 started slipping or coming out the mechanical lift sling, and NA B explained to her she grabbed Resident #1 by her shirt and guided Resident #1 to the floor. LVN C said she could tell NA B did grab Resident #1 by the shirt because Resident #1's shirt did appear to be gathered as if used as described by NA B. LVN C said the resident was assessed by her, they moved the lift out of the way, checked her vital signs, and talked to Resident #1 and she voiced she was okay and they assisted Resident #1 back into bed. LVN C said Resident #1 did not appear distressed, no injuries and did not appear to be in pain so she was not sent out to the hospital. LVN C said she notified the appropriate people and doctor ordered fall precautions and initiate the 72-hour neuro checks post fall. Record review of the state agency reporting system revealed from 3/4/25 -3/9/25 there were no self-reported incidents submitted regarding Resident #1's mechanical lift fall incident. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/9/25 at 4:20pm Regional Nurse Consultant said she was not an employee of the facility when the incident occurred with Resident #1 and replied No, the incident was not reported to HHSC, the incident was investigated by the facility, and it was determined that the incident did not meet HHSC criteria of neglect. [Resident #1] did not have any injury, emotional harm, pain, and/or death due to the mechanical lift incident. Therefore, it was determined that this incident did not meet the reportable criteria defined in HHSC provider letter. It was [Regional Nurse Consultant] expectation that the facility staff are to use the mechanical lift in accordance with the facility mechanical lift and the clinical manufacturer guidelines. During an interview on 3/9/25 at 5:33pm, the Administrator said all allegations of abuse and neglect was reportable to the state agency, but it just depended on each situation, and she determined what allegations were reported to state agency by following the guidelines in the Long-Term Care Regulation Provider Letter issued 8/29/24 and followed the facility's Abuse Policy. Administrator said it was her responsible for making reports of allegations to the state agency, but according to the most recent provider letter she felt the letter did not indicate potential for severe injury due to the neglectful actions of a staff member was a reportable incident and especially since Resident #1 was not hurt. The Administrator said she was the Abuse Coordinator. The Administrator said Resident #1's family has electronic monitoring in her room, and she had reached out the day of the incident to Resident #1's family requesting to see the video footage or for the family member to review it and also reached a couple of times during family member's visit and she said the family member had not followed up and said they was satisfied with care provided. Record review of an undated associate disciplinary memorandum for NA B indicated on 3/4/25 she was suspended for transferring a resident using the mechanical lift without assistance resulting in an unsafe transfer of resident. Effective 3/7/25 after completion of investigation NA B discharged [terminated] due to failure to follow policy of two-person transfer using the mechanical lift . Record review of termination form dated 3/7/25 indicated NA B was terminated involuntary on 3/7/25 due to a safety violation. Her hired date was 3/20/23 and NA B last day worked was on 3/4/25. NA B transferred a resident using the mechanical lift without assistance resulting in an unsafe transfer of a resident. Record review of a Validation Checklist Mechanical List undated indicated, .Purpose: To determine if the staff is performing mechanical lift procedure in accordance with the facility's standard of practice. 1. Employee understands the maximum weight for each lift. 2. Employee understands to inspect sling for tears or loose stitching and report any findings to DON or designee. 3. Employee understands to not use any plastic back incontinence pad or seat cushion between resident and sling that could cause sliding. 4. Lifting the Resident: must have two staff members when using a lift. 5. Explain procedure to resident. 6. The adjustable legs must be in the maximum opened position and always locked while resident is in the lift. 7. Make sure the arms of the sling (leg sections) are crossed under the resident's legs and attach on the opposite side hook. 8. Match the corresponding colors on each side of the sling for an even lift of the resident. 9. When the sling is elevated a few inches, check to make sure that all hooks are connected to lift. 10. Do not lock the rear casters of the lift, this could cause tipping of the lift. 12. Use the steering handle when moving the lift. 13. When moving the resident lift away from the bed or chair, turn the resident so that he/she faces the employee transferring from or to a wheelchair, shower or bed is locked. 14. Employee understands how to activate the emergency release. 15. Employee understands to inspect lift for wear, tear, and broken parts: reporting any findings to DON or designee . (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a revised facility policy titled Abuse, Neglect and Exploitation dated 9/6/24 indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Policy Explanation and Compliance Guidelines: .2) The facility's abuse prevention coordinator is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . VII) Reporting/Response: A) The facility reports abuse and abuse allegations that include: 1)Reporting allegation involving staff to-resident abuse . 2)Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes: a)Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse (with or without bodily injury) . c) Not later than 24 hours after the incident occurs or is suspected. An incident that does not result in serious bodily injury but that involves any of the following: -Neglect . B) The Administrator will follow up with government agencies, during business hours, to confirm the initial repot was received, and to report the results of the investigation when final withing 5 working days of the incident, as required by state agencies .		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but , but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury for 1 of 5 (Resident #1) residents reviewed for abuse and neglect. The facility did not report to the state agency within 24 hours when NA B dropped Resident #1 during a mechanical lift transfer on 3/4/25. These failures could place residents at risk for serious injury and accidents. Findings included: Record review of undated admission record printed on 3/08/25 indicated Resident #1 was an [AGE] year-old female who admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), depression (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy that can significantly interfere with daily life), cognitive communication deficit (difficulty communicating due to brain damage), arthropathy (any disease or condition that affects the joints) and dementia (an umbrella term for a group of diseases that cause a decline in mental ability severe enough to interfere with daily life, encompassing memory, thinking, and behavior). Record review of quarterly MDS dated [DATE] indicated Resident #1 had difficulty communicating some words or finishing thoughts but was but was able if prompted or given time and usually understood others. The MDS indicated Resident #1 had severe cognitive impairment in thinking with a BIMS score of 00 and was totally dependent on staff for transfers. Record review of a care plan for Resident #1 revised on 01/11/2024 indicated she had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner. Interventions included: Transfers: dependent: mechanical lift x 2 NA. Record review of a care plan for Resident #1 revised on 1/14/25 indicated she had the potential for falls related to cognitive impairment, incontinence, gait/balance problems and confusion. Interventions included: Staff education/assist with transfers dated 8/12/2024. Record review of progress note for Resident #1 indicated the following: (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/9/25 at 4:20pm Regional Nurse Consultant said she was not an employee of the facility when the incident occurred with Resident #1 and replied No, the incident was not reported to HHSC, the incident was investigated by the facility, and it was determined that the incident did not meet HHSC criteria of neglect. [Resident #1] did not have any injury, emotional harm, pain, and/or death due to the mechanical lift incident. Therefore, it was determined that this incident did not meet the reportable criteria defined in HHSC provider letter. It was [Regional Nurse Consultant] expectation that the facility staff are to use the mechanical lift in accordance with the facility mechanical lift and the clinical manufacturer guidelines. During an interview on 3/9/25 at 5:33pm, the Administrator said all allegations of abuse and neglect was reportable to the state agency, but it just depended on each situation, and she determined what allegations were reported to state agency by following the guidelines in the Long-Term Care Regulation Provider Letter issued 8/29/24 and followed the facility's Abuse Policy. Administrator said it was her responsible for making reports of allegations to the state agency, but according to the most recent provider letter she felt the letter did not indicate potential for severe injury due to the neglectful actions of a staff member was a reportable incident and especially since Resident #1 was not hurt. The Administrator said she was the Abuse Coordinator. The Administrator said Resident #1's family has electronic monitoring in her room, and she had reached out the day of the incident to Resident #1's family requesting to see the video footage or for the family member to review it and also reached a couple of times during family member's visit and she said the family member had not followed up and said they was satisfied with care provided. Record review of an undated associate disciplinary memorandum for NA B indicated on 3/4/25 she was suspended for transferring a resident using the mechanical lift without assistance resulting in an unsafe transfer of resident. Effective 3/7/25 after completion of investigation NA B discharged [terminated] due to failure to follow policy of two-person transfer using the mechanical lift . Record review of termination form dated 3/7/25 indicated NA B was terminated involuntary on 3/7/25 due to a safety violation. Her hired date was 3/20/23 and NA B last day worked was on 3/4/25. NA B transferred a resident using the mechanical lift without assistance resulting in an unsafe transfer of a resident. Record review of a revised facility policy titled Abuse, Neglect and Exploitation dated 9/6/24 indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Policy Explanation and Compliance Guidelines: .2) The facility's abuse prevention coordinator is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . VII) Reporting/Response: A) The facility reports abuse and abuse allegations that include: 1)Reporting allegation involving staff to-resident abuse . 2)Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes: a)Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse (with or without bodily injury) . c) Not later than 24 hours after the incident occurs or is suspected. An incident that does not result in serious bodily injury but that involves any of the following: -Neglect . B) The Administrator will follow up with government agencies, during business hours, to confirm the initial repot was received, and to report the results of the investigation when final withing 5 working days of the incident, as required by state agencies .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2025
NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 E Loop 304 Crockett, TX 75835	
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** 35340 Based on observations, interviews, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents reviewed for accidents. (Resident #1). The facility failed to properly secure Resident #1 during a mechanical lift transfer on 3/4/25 when she fell out of the mechanical lift and there was a potential for severe injury due to the neglectful actions of NA B. These failures could place residents at risk for serious injury and accidents. The noncompliance was determined to be past noncompliance (PNC). The past noncompliance began on 3/4/25 and ended on 3/7/25. The facility had corrected the noncompliance before the survey began. Findings included: Record review of undated admission record printed on 3/08/25 indicated Resident #1 was an [AGE] year-old female who admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), depression (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy that can significantly interfere with daily life), cognitive communication deficit (difficulty communicating due to brain damage), arthropathy (any disease or condition that affects the joints) and dementia (an umbrella term for a group of diseases that cause a decline in mental ability severe enough to interfere with daily life, encompassing memory, thinking, and behavior). Record review of quarterly MDS dated [DATE] indicated Resident #1 had difficulty communicating some words or finishing thoughts but was but was able if prompted or given time and usually understood others. The MDS indicated Resident #1 had severe cognitive impairment in thinking with a BIMS score of 00 and was totally dependent on staff for transfers. Record review of a care plan for Resident #1 revised on 01/11/2024 indicated she had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner. Interventions included: Transfers: dependent: mechanical lift x 2 NA. Record review of a care plan for Resident #1 revised on 1/14/25 indicated she had the potential for falls related to cognitive impairment, incontinence, gait/balance problems and confusion. Interventions included: Staff education/assist with transfers dated 8/12/2024. Record review of progress note for Resident #1 indicated the following: (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/4/25 at 6:10pm Completed by LVN C- Called to room by [NA B]. [Resident #1] [was] lying on her right side on the floor. She is positioned between the mechanical lift legs. [NA B] reported [Resident #1] was sliding off sling when [NA B] was transferring [Resident #1] from Geri-chair (reclining chair) to bed. [NA B] grabbed [Resident #1's] shirt and mechanical lift sling and assisted [Resident #1] to the floor. Action: Head to toe assessment completed. [Resident #1] moved all extremities within normal limits for this resident. No knots [NAME] on scalp. No pain when pressure applied to all joints. [Resident #1] stated I'm ok. -3/4/25 at 8:01pm Completed by LVN C: Data: [virtual medical visit] provider, and doctor notified of event and [Resident #1's] assessment. Action: Provider given details of incident and resident's assessment. Provider video chatted with resident. Response: Orders received for fall precautions, neuros per facility protocol, notify clinician for any change in condition. -3/4/25 at 8:41pm_[Virtual Medical Visit] note - Date of Service: 3/4/25 @ 7:59pm, Details: Nurse Name: [LVN C], Patient Name: [Resident #1] Primary Chief Complaint: Fall Without Injury History Present Illness: [AGE] year-old female who had a fall that evening. [NA B] was transferring [Resident #1] from Geri chair to bed using a mechanical lift. [Resident #1] started sliding out of sling and the [NA B] was able to grab [Resident #1's] shirt and mechanical lift sling and lowered [Resident #1] to the ground. [Resident #1] denied pain or injuries. [Resident #1] had good ROM without c/o pain. No deficits noted - at [Resident #1] baseline. No obvious injuries, lacerations, abrasions, bleeding. [Resident #1] did not hit her head. Witnessed. Neuro was checks started and were normal. Record review of 72-hour neuro checks report dated effective 3/4/25 indicated Resident #1 had no change in neuro status. [Resident #1] did not follow finger with her eyes and her neuro remain at baseline and voiced no pain complaints. During an observation and attempted interview on 3/9/25 at 2:03pm, Resident #1 was in her room lying in bed resting, she did not respond to questions asked. Resident #1 did was clean, well-groomed with no unpleasant odor. There was no visible bruising, skin tears or marks to Resident #1's upper body area. Record review of witness statement form dated 3/4/25 completed by NA B indicated the following: [NA B] used mechanical lift, connected all 4 loops on mechanical lift, and pushed the button. [Resident #1] was in the air, she leaned forward, and [NA B] saw [Resident #1] coming out of the [mechanical lift] swing. [NA B] immediately grabbed both the sling and [Resident #1] shirt, brought [Resident #1] close to [NA B] while supporting [Resident #1] back and head; once safely on the floor [NA B] got help. Record review of a skills validation checklist for transfers dated 1/24/2025 indicated NA B was in attendance by her signature and was observed by the DON on mechanical lift transfer. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Administrator's typed statement dated 3/4/25 regarding the incident indicated the following: At 6:27 pm [the Administrator] received a call from DON stating there had been an accident involving the mechanical lift. [NA B] was putting [Resident #1] to bed BY HERSELF using the mechanical lift. [Resident #1] was not injured and did not hit the floor, per [NA B]. [NA B] stated she knew she was not to use the mechanical lift without a partner, but that she was trying to get her residents in bed. She stated when [the facility] is short, we just do what we have to do sometimes. [NA B] also stated she used blue hooks on one side and green hooks on the other side when she put [Resident #1] in the mechanical lift sling. She stated [Resident #1] was facing her as she steered the mechanical lift and as she got close to the bed, [Resident #1] started to fall toward her, she grabbed her shirt and wrapped her arm around her causing [Resident #1] to turn in the sling. She stated at no time did [Resident #1] hit the floor. [NA B] stated she lowered [Resident #1] to the floor . During an attempted interview on 3/12/2025 at 9:11am, the NA B was called but she did not answer, and it went to voice mail and a message was left to return the call related to the investigation. During a phone interview on 3/12/25 at 9:17am, LVN C said she had been employed at the facility for about [AGE] years and worked the 6pm-6am as a charge nurse. She said she was the nurse on duty the day Resident #1 was involved in the mechanical lift fall incident on 3/4/25. She said NA B ran out into the hall and yelled for help, LVN C said herself, the DON who no longer worked there and several others who she could not recalled ran and assisted. LVN C said she saw Resident #1 laying on the floor between the legs of the lift and NA B explained what happened. She Said NA B explained she was transferring Resident #1 from chair to bed using the mechanical lift and Resident #1 started slipping or coming out the mechanical lift sling, and NA B explained to her she grabbed Resident #1 by her shirt and guided Resident #1 to the floor. LVN C said she could tell NA B did grab Resident #1 by the shirt because Resident #1's shirt did appear to be gathered as if used as described by NA B. LVN C said the resident was assessed by her, they moved the lift out of the way, checked her vital signs, and talked to Resident #1 and she voiced she was okay and they assisted Resident #1 back into bed. LVN C said Resident #1 did not appear distressed, no injuries and did not appear to be in pain so she was not sent out to the hospital. LVN C said she notified the appropriate people and doctor ordered fall precautions and initiate the 72-hour neuro checks post fall. Record review of the state agency reporting system revealed from 3/4/25 -3/9/25 there were no self-reported incidents submitted regarding Resident #1's mechanical lift fall incident. During an interview on 3/9/25 at 2:27pm The Administrator indicated the mechanical lift fall incident that occurred on 3/4/25 with Resident #1 was not reported to HHSC due to not meeting HHSC reportable criteria of neglect. The incident involving [Resident #1] did not meet the neglect reportable criteria as [Resident #1] did not have any evidence of an injury, emotional harm, pain and/or death. During an interview on 3/9/25 at 4:20pm Regional Nurse Consultant said she was not an employee of the facility when the incident occurred with Resident #1 and replied No, the incident was not reported to HHSC, the incident was investigated by the facility, and it was determined that the incident did not meet HHSC criteria of neglect. [Resident #1] did not have any injury, emotional harm, pain, and/or death due to the mechanical lift incident. Therefore, it was determined that this incident did not meet the reportable criteria defined in HHSC provider letter. It is [Regional Nurse Consultant] expectation that the facility staff are to use the mechanical lift in accordance with the facility mechanical lift and the clinical manufacturer guidelines. (continued on next page)		

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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 an interview on 3/9/25 at 5:33pm, the Administrator said all allegations of abuse and neglect was reportable to the state agency, but it just depended on each situation, and she determined what allegations were reported to state agency by following the guidelines in the Long-Term Care Regulation Provider Letter issued 8/29/24 and followed the facility's Abuse Policy. Administrator said it was her responsible for making reports of allegations to the state agency, but according to the most recent provider letter she felt the letter did not indicate potential for severe injury due to the neglectful actions of a staff member was a reportable incident and especially since Resident #1 was not hurt. The Administrator said she was the Abuse Coordinator. The Administrator said Resident #1's family has electronic monitoring in her room, and she had reached out the day of the incident to Resident #1's family requesting to see the video footage or for the family member to review it and also reached a couple of times during family member's visit and she said the family member had not followed up and said they was satisfied with care provided. She said the previous DON had started in-servicing staff and began an investigation and determined that it was an accident. Record review of an undated associate disciplinary memorandum for NA B indicated on 3/4/25 she was suspended for transferring a resident using the mechanical lift without assistance resulting in an unsafe transfer of resident. Effective 3/7/25 after completion of investigation NA B discharged [terminated] due to failure to follow policy of two-person transfer using the mechanical lift. Record review of termination form dated 3/7/25 indicated NA B was terminated involuntary on 3/7/25 due to a safety violation. Her hired date was 3/20/23 and NA B last day worked was on 3/4/25. NA B transferred a resident using the mechanical lift without assistance resulting in an unsafe transfer of a resident. Record review of a Validation Checklist Mechanical List undated indicated, .Purpose: To determine if the staff is performing mechanical lift procedure in accordance with the facility's standard of practice. 1. Employee understands the maximum weight for each lift. 2. Employee understands to inspect sling for tears or loose stitching and report any findings to DON or designee. 3. Employee understands to not use any plastic back incontinence pad or seat cushion between resident and sling that could cause sliding. 4. Lifting the Resident: must have two staff members when using a lift. 5. Explain procedure to resident. 6. The adjustable legs must be in the maximum opened position and always locked while resident is in the lift. 7. Make sure the arms of the sling (leg sections) are crossed under the resident's legs and attach on the opposite side hook. 8. Match the corresponding colors on each side of the sling for an even lift of the resident. 9. When the sling is elevated a few inches, check to make sure that all hooks are connected to lift. 10. Do not lock the rear casters of the lift, this could cause tipping of the lift. 12. Use the steering handle when moving the lift. 13. When moving the resident lift away from the bed or chair, turn the resident so that he/she faces the employee transferring from or to a wheelchair, shower or bed is locked. 14. Employee understands how to activate the emergency release. 15. Employee understands to inspect lift for wear, tear, and broken parts: reporting any findings to DON or designee . Record review of a facility policy titled Incident/Accident Policy revised on 11/17 indicated, .It is the policy of this facility to report and investigate all incidents and accidents that occur in the facility or on facility property in a timely manner. 9. The Administrator and Director of Nursing will review the incident/accident to determine if investigation is required . Record review of a mechanical lift policy last reviewed on 9/13/24 indicated Policy: To enable one individual to lift and move a resident safely, with as little effort as possible. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Fall Management System revised on 1/3/17 indicated, .Fundamental Information: A fall occurs when there is an unintentional coming to rest on the floor, ground, or other lower level but not as a result of an overwhelming external force (ex: resident pushes another resident) .A fall without injury is still a fall . It was determined these failures resulted in Resident #1's mechanical lift fall on 3/4/25. Facility took the following actions to correct the noncompliance: Record review of Administrator's typed statement dated 3/4/25 indicated in-services was conducted on 3/4/25 [Name of Virtual Medical Visit Provider] with staff regarding mechanical lift usage and gave a return demonstration. [Name of Virtual Medical Visit Provider] was called and did a Facetime visit, doctor was notified and a QAPI meeting was had. All nursing staff was in-serviced that are on the facility employee roster. During interviews with 7 CNA s and 4 LVNs covering day and night shifts indicated they were In-serviced by the previous DON and ADON who showed them the proper way to use the lift with a return demonstration. During an observation on 3/9/25 at 1:52pm, NA D and NA E provided a return demonstration with no issues or concerns. Record Review of [NA B] provided a written statement and was suspended on 03/04/2025 during investigation and later terminated involuntary on 3/7/25 due to a safety violation. Record review of an undated typed note provided by the Administrator indicated the following: An off-cycle QAPI meeting was held on March 4, 2025, at approximately 8:13 pm via phone conversation with medical director to discuss an incident in which [Resident #1] was lowered from the mechanical lift by a [NA B] as [Resident #1] started to fall from the sling. We discussed the facility's follow up plan to sustain compliance. The following individuals were in attendance: Facility Medical Director - via phone, Facility Administrator, and the Facility Interim DON.		