

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2025
NAME OF PROVIDER OR SUPPLIER Azle Manor Health Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 721 Dunaway LN Azle, TX 76020	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43815</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 1 of 12 residents (Residents #1) reviewed for accidents/hazards.</p> <p>1. The facility failed to remove a mechanical lift that was missing a metal clip from service from 04/15/25-04/25/25.</p> <p>2. The facility failed to ensure CNA A and CNA B safely transferred Resident #1. CNA A and CNA B placed Resident #1 in the lift and did not secure the sling resulting in the resident falling out of the sling on 4/15/25. This fall caused an orbital fracture to the face of Resident #1.</p> <p>An IJ was identified on 04/25/25. The IJ template was provided to the facility on [DATE] at 2:31 PM. While the IJ was removed on 04/26/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility was continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure could place residents at risk of falls, a loss of quality of life, severe injuries, hospitalization , and death.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated 4/25/25 for Resident #1 indicated that she was a 83 -year-old female admitted to the facility on [DATE] with diagnoses including hypertension (a condition where the force of blood pushing against the artery walls is consistently too high), hyperlipidemia (an elevated level of lipids-like cholesterol and triglycerides-in your blood), advanced Alzheimer's dementia (lose the ability to communicate), and Major Depressive Disorder (a mood disorder characterized by persistent low mood, loss of interest or pleasure in most activities).</p> <p>Record review of a quarterly MDS Staff Assessment of Mental Status dated 01/13/25 for Resident #1 indicated she was dependent on two or more helpers to complete activities.</p> <p>Record review of the discharged MDS assessment dated [DATE] reflected a Staff Assessment for Mental Status section reflected Resident #1 had memory problem and her cognitive skills for daily decision making was severely impaired and she was dependent on two or more helpers to complete activities.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a comprehensive care plan dated 02/28/25 for Resident #1 indicated the problem was that she had an ADL self- care performance deficit, her goal was to maintain her dignity, the intervention was she was totally dependent on two staff for transferring with a mechanical lift.</p> <p>Record review of incident report dated 04/15/25 reflected, CNA's reported the resident fell from [mechanical] lift when she was raised in the air. CNA stated the resident fell hitting the left side of her face on the [Mechanical lift] leg. Resident unable to give description. Resident extremities moving per baseline for this resident, alert and non-verbal per baseline. Negative vocalization occasional moan or grown, low level of speech with a negative quality, Facial expression detail- sad, frightened, frown, mental status disoriented, injuries report- post incident bruise face, fracture face.</p> <p>Record review of facility investigation of fall investigation of Resident #1 undated reflected, Resident was being transferred by CNAs x2 when the sling came loose from the lift causing her to fall to the floor. She hit the left side of her face on the leg of the [mechanical]lift. EMS was called and resident was transferred to ER for evaluation. She was found to have a fx of the left orbital bone. Resident returned with new order for Tylenol #3 (used to treat mild to moderate pain) and antibiotics (a group of drugs that treat bacterial infections). CNAs wrote detailed accounts of the incident and were placed on suspension pending investigation. [mechanical] lift and sling were examined. Sling was intact, no tearing, in very good condition. Lift was found to be in working order. Both CNAs state they were transferring the resident from the wheelchair to the bed when the sling detached causing the resident to slide out of the sling. [CNA B] was maneuvering the lift and [CNA A] was guiding the resident towards the bed.</p> <p>Education was completed by [Sic]with CNAs including demonstration/return demonstration to reinforce proper use of [mechanical]lift and skills check off completed. [CNA A] and [CNA B] came in for [mechanical] training including demonstration/return demonstration and Skills check off on 4/17/25</p> <p>Record review of progress notes dated 04/15/25 reflected, CNAx2 came out into the hall next to residents room and stated they had an emergency situation. Upon entering the room resident noted on the floor underneath the [mechanical] lift and left side of body and face was resting on the [mechanical] lift leg. Resident was alert and non-verbal per baseline. Resident never lost consciousness. Unable to get vitals due to position and contractures. Resident has minimal amount of bleeding from unknown origin. Left face is swollen and blue in color. Pillow and ice slid under the residents face without moving her neck/head. 911 called and [family] notified. ADON at the bedside, DON and doctor notified.</p> <p>Record review of hospital visit summary dated 04/15/25 reflected, Reason for visit, fall, diagnoses closed fracture of left orbit, closed head injury, skin tear of left hand without complication.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 04/25/25 at 10:36 AM, CNA A, she stated on 04/15/25 between 1:00 PM and 1:20 PM, she and CNA B were preparing to put Resident #1 in bed for a rest after lunch. She stated CNA B had the sling under Resident #1 when she went into the room and CNA B hooked the sling up to the lift. She stated once the resident was high enough out of the chair, she moved the wheelchair and as she moved toward the other side of the bed, CNA B moved the mechanical lift toward the bed. She stated she saw Resident #1's head falling out of the sling, then she fell out of the side of the sling to the floor and hit her face on the base of the lift. CNA A stated prior to Resident #1 being lifted she did not notice the lift was missing the metal clip. She stated the lift used on 04/15/25 was still in the shower room. Observation of the lift revealed there were six hook point options to put the sling on the lift. Observation revealed one of the hook points had several layers of medical tape and the other five hooks had a metal clip. She stated the clip was on the lift to help secure the sling on the hook. CNA A stated the tape was not on the lift the afternoon of 04/15/25 at the time of incident . She stated she did not know who or why the tape was put on the lift. She stated she had an in-service training on the mechanical lift about three or four months prior to this incident. She stated the training consisted of how to open the legs of the lift, which sling should be use on the residents, and to make sure the sling was secure before lifting. She stated it was the responsibility of both CNA's to ensure the sling was secure. She stated she lasted used the lift on 04/25/25. She stated the resident was at risk of injury when equipment was not reported to not be working properly.</p> <p>During a telephone interview on 04/26/2025 at 12:45 PM, CNA B stated on 04/15/25 around 1:00 PM after lunch she and CNA A were getting Resident #1 ready to lay down. She stated CNA A hooked up the top of the sling and she hooked up the bottom of the sling. She stated she operated the lift to lift the resident up out of the wheelchair. She stated when the lift was at the highest level was when Resident #1 fell . She stated Resident #1 fell and hit the left side of her face, around her left eye on the bottom of the lift. She stated when Resident #1 fell she made the sound ou, ou. She stated she had received in-service training on the lift a few months prior to the incident, she did not know the exact date. She stated she received another in-service training again after the incident on 04/17/25. She stated prior to the incident she had not noticed the metal clip missing from the lift. She stated she was a PRN worker and usually worked at night and had not had a reason to get the people up out of bed. She stated the Resident's risk of injury was greater because the lift had not inspected prior to use. She stated it was the responsibility of both CNA A and her to ensure Resident #1 was secure in the lift.</p> <p>During an interview on 04/25/25 at 11:15 AM RN C, stated one of the CNA's notified her that Resident #1 had fall. She stated when she entered the room, she observed Resident #1 on the floor and her head was on the base part of the lift, her face was partially on the lift. She stated after the resident was sent to the hospital; she saw that there was a clip missing off the lift. She stated she thought the sling broke but when she checked it there was nothing wrong with the sling. She stated she saw the Administrator and Operations Director looking at the lift and they put a sign on the lift that said, Do Not Use. She stated it was the responsibility of both CNA's to ensure the sling was secure and the equipment was working properly before use. She stated the resident was at risk of injury when the equipment was not used properly or in proper working order.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/25/25 at 11:42 AM with Operations Director, he stated after the incident with Resident #1 on 04/15/25, he inspected the mechanical lift used by the two CNA's. He stated there was a clip missing from the lift. He stated the clip did not cause the lift to be unusable. He stated he did not put the tape on the lift, but he would try to find out. He stated prior to the incident he had not been made aware that the clip was missing from the lift. He stated he looked at the lifts quarterly to ensure they were in working order. He stated he did not keep a log of when or how often the lifts were inspected. He stated he could not say if the clip had been missing from the lift during his last inspection. He stated he would think the CNA's would inspect the lift before using each time. He stated the clip was a secondary safety measure to ensure the loop on the sling was on the lift properly. He stated when the lift was not used properly the resident could be injured.</p> <p>During an observation on 4/25/25 at 1:25 PM revealed CNA's Q and R were observed taking the mechanical lift with the missing metal clip into the room of a resident. The mechanical lift had been identified earlier by CNA A. CNA's Q and R locked the wheelchair, they discussed which color they should use on the sling to lift the resident up, the staff explained to the resident they were raising her up, they used the lift raise the resident out of her chair and place her on her bed.</p> <p>During an interview on 4/25/2025 1:50 PM the Administrator stated during his investigation of the incident it was determined if the strap on the sling was put on properly it would not have come off. He stated both CNA's would have been responsible to ensure the sling was secure before lifting the resident out of the chair. He stated both CNA's had training on how to use the lift prior to this incident. He stated he would search for the training documents. He stated the Operations Director put the tape on the lift, when informed the Operations Director stated he did not put the tape on the lift, he stated maybe one of the CNA's had put the tape on the lift. He stated even with the tape on the lift, it was still usable, the tape did not hinder the function of the lift. He stated the Operations Director checked the lifts quarterly. He stated he was not aware there was no documentation of the lifts being checked. He stated the resident had been at risk of injury when staff did not report to him or the Operations Director the metal clip was missing from the lift. He stated the resident was also put at risk when the staff did not securely hook the sling onto the lift prior to lifting the resident.</p> <p>Attempted phone call to POA of Resident #1 on 04/25/25 at 3:15 PM, message left for return phone call.</p> <p>Follow-up interview with the Administrator on 04/26/25 at 4:15 p.m. The Administrator stated the previous DON was not as organized as he would have liked, and he had been unable to locate the lift service trainings for CNA A and CNA B.</p> <p>During an interview on 04/30/2025 at 1:20 PM with the Senior Sales Rep for [[mechanical]Mechanical lift] revealed if the metal clip was not on the lift the sling would not be secure. She stated the clip was essential to securing the sling on the lift. She stated if there was any part missing on the lift to secure the sling the [[mechanical] lift should not have been used by the facility staff. She stated if the lift was used without the clip the resident would not be secured in the lift and could cause an injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of undated [mechanical] HPL500 manual reflected, Daily Check List: [[mechanical]Mechanical lift Company] strongly recommends the following checks be carried out on a daily basis and before using lift. Examine the sling hooks on the spreader bar for excessive wear. If in doubt-do not use. Maintenance [Mechanical lift [mechanical]Company] recommends regular inspection and maintenance.</p> <p>Record review of facility Safe Resident Handling/Transfers dated 03/22/2017 revised 06/21/2024 reflected, It is the policy of the facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines.</p> <p>Compliance Guidelines:</p> <p>6. The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly.</p> <p>7. Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility policy.</p> <p>10. Two staff members must be utilized when transferring residents with a mechanical lift.</p> <p>11. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur.</p> <p>12. The staff must demonstrate competency in the use of mechanical lifts prior to use and annually with documentation of that competency placed in their education file.</p> <p>13. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment.</p> <p>14. Resident lifting and transferring will be performed according to the resident's individual plan of care.</p> <p>15. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device.</p> <p>Record review of facility Employee Lifting Policy dated 05/30/2024 reflected All staff will be responsible for utilizing mechanical lifting devices, transferring devices, proper body mechanics to lift, transfer, and/or pivot non-ambulatory patients as indicated.</p> <p>Procedure</p> <p>4. If a lifting device is required, the manufacturer guidelines will be used to determine the type of lifting device and size of sling that should be utilized.</p> <p>Equipment Storage and Readiness</p> <p>(continued on next page)</p>		

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