STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676017	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Health Care Center	460 W Main St Ranger, TX 76470

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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 - 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 environment remained as free of accident hazards as was possible and ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Resident #1, who was transported via the facility van, was secured with the proper utilization of the 5-seatbelt restraint system, required when transporting residents in a van, which resulted in injury and hospitalization on 01/08/2026. An Immediate Jeopardy (IJ) situation was identified on 01/13/2026. While the IJ was removed on 01/13/2026, the facility remained out of compliance at a scope of an isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk of injury due to not being supervised and placed them at risk of serious bodily harm, physical impairment, hospitalization or death.Findings include: Record review of Resident #1's face sheet, accessed on 01/09/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: fracture of left femur, anxiety, and depression. Record review of Resident #1's admission MDS assessment, dated 11/24/2025, revealed a BIMS of 10, which indicated moderate cognitive impairment. Further review revealed sit to stand position and car transfer required substantial/maximal assistance and walking was not attempted due to medical condition. Record review of Resident #1's care plan, initiated on 11/04/2025, revealed: Focus: The resident has limited physical mobility related to fracture hip.Interventions: The resident requires assistance by one staff to walk. Record review of facility's incident report, dated 01/08/2026, revealed in part: CNA-A was doing transport to orthopedic surgeon for Resident #1. CNA-A has officially been the transporting aide in the past. She reports that she went to the South office and was supposed to be at the North location, when in route to North side, the van started spewing fluid and instrument panel now showing the van is running hot. She was pulling over to stop when she looked back, she could no longer see Resident #1 in her rearview mirror. The resident was now at the back of the van on the floor rolled forward from the waist.Her front safety belt was unclamped. The remaining safety belts were all intact. A good Samaritan stopped to help and called 911.The ambulance arrived, put a neck brace on Resident #1 and she was taken to the hospital. Record review of hospital records, dated 1/12/2026, revealed Resident #1 was admitted to the hospital on [DATE] with an admitting diagnosis of acute subdural hematoma and cervical fracture status post fall from wheelchair while being transported in a van. Observation and Interview on 01/11/2026 at 12:30 PM, revealed Resident #1 was lying in bed at the hospital. Resident #1 had a cervical collar in place. Resident #1 stated all she remembered was CNA-A hit the brakes and the wheelchair flipped. She stated she did not know if all of the straps were fastened. She stated that she had not unfasted any of the safety belts. During an interview on 01/09/2026 at 1:35 PM, the Office Manager stated CNA A was the (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	previous transportation aide, and NA-K was the current transportation aide. She stated transportation aides were trained regarding transportation safety and proper wheelchair securement and safety belt placement prior to ever transporting residents. She stated both CNA-A and NA-K had proven competency in those areas when hired prior to transporting any residents. She stated no residents had been transported since the incident and there were no plans to transport any residents over the weekend. She later stated she did not have any evidence of training or competencies for CNA-A or NA-K. During an interview on 01/09/2026 at 3:20 PM, the Administrator stated CNA-A told her the seat belts were all secured prior to driving the van. She stated the van was worked on after the incident regarding the overheating issue. She stated there had been no other incidents in the van regarding resident injuries or accidents. The Administrator stated there were no logs for maintenance on the van or routine checks regarding van maintenance or safety checks. She stated the van was not inspected routinely. During an observation and interview on 01/09/2026 at 3:30 PM, the Office Manager and the Administrator performed a test with an empty wheelchair in the van to ensure all 5 safety belts worked correctly and were secure. Observed 4 belt straps secured. 2 in the front and 2 in the back. Observed lap belt secured. Observed the Office Manager attempt to flip the wheelchair, and the chair did not budge. The Office Manager removed the lap belt, and the chair still would not budge. The Office manager refastened the lap belt and unlatched one front strap and the chair would not budge. The Office Manager then unfasted both front straps and with pressure to the back of the chair the wheelchair was able to flip backwards. The administrator stated the only way the chair could have flipped was if the 2 front safety belts were not fastened. During an interview on 01/09/2026 at 4:15 PM, CNA-A stated on 01/08/26 prior to the incident she arrived at a doctor's office with Resident #1 and wheeled the resident in. She was then told they were at the wrong office. She stated the other office stated they would see the resident if they got there quickly. She stated she pushed Resident #1 up the wheelchair ramp in the van, locked her wheelchair wheels, and fastened the 2 rear seatbelts. She stated she then climbed into the driver's seat and climbed behind in front of Resident #1. She stated she fastened the other 3 seatbelts. She stated the van began to overheat and she was in a construction zone with nowhere to exit. She stated she called the maintenance man on the phone, then she looked up and saw a yellow light and began slowing down. She stated that she heard a noise behind her, looked back, and saw Resident #1's wheelchair flipped backwards. She stated that she stopped the van and climbed back to help Resident #1. She stated she had to unbuckle the lap belt to move the wheelchair to get to the resident. She did not say anything regarding the 4 other safety belts. She stated she did not recall if the other safety belts were still intact but insisted, she secured them prior to transportation. She called 911 and EMS arrived and transported Resident #1 to the hospital. She stated the van had a 5-seatbelt restraint system. There were 2 safety belts behind the wheelchair that secured the wheelchair to the floor. There were 2 more safety belts in front of the wheelchair that secured the wheelchair to the floor. There was a lap belt that went through the arms of the wheelchair and over the resident's lap to secure the resident into the wheelchair. She stated when she started transporting residents, she was oriented by the previous transportation aide for a week. She stated she had not read any policies and had not received any computer training regarding seatbelt securement or safe transportation. She stated she never performed competency or was observed or check-off on wheelchair security. CNA-A stated she had never had any issues with wheelchair securement, and she had transported many residents. During an interview on 01/09/2026 at 4:45 PM, NA-K stated she had not completed any transportation or wheelchair securement training. She stated she had never been checked off regarding competency of wheelchair securement. She stated she always fastened all 5 safety (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	belts, and she did not see any way a wheelchair could flip if secured appropriately. She stated she had never had any issues with wheelchair securement and she had transported many residents. Record review of the facility's, undated, policy titled Wheelchair Securement in Facility Transportation Van, revealed in part: Staff responsible for transportation must be trained and demonstrate competency in wheelchair securement procedures. Staff involved in resident transportation must receive initial and ongoing training on wheelchair securement. Competency must be documented prior to independent transport duties. Record review of CNA A's personnel files revealed a hire date of 08/08/2025, and no evidence of training related to transportation safety or wheelchair securement. Record review of NA-K's personnel files revealed a hire date of 09/10/2025, and no evidence of training related to transportation safety or wheelchair securement. This was determined to be an Immediate Jeopardy (IJ) on 01/13/2026 at 3:00 PM. The Administration was notified. The Administrator was provided with the IJ template on 01/13/2026 at 3:00 PM. The following Plan of Removal was accepted on 01/15/2026 at 4:55 PM: 1. Immediate Cessation of Immediate JeopardyAction Taken: Effective 01/13/2026, upon receipt of the IJ, the facility ceased all resident transportation via van and wheelchair transfers requiring safety restraint usage. All other facility transports were ceased, unless staff were trained by nursing staff who have been trained in transporting residents safely using proper safety restraints.A licensed nursing staff trained in transport is available at the facility 24/7. Every resident who utilizes a wheelchair has been identified as a potential for wheelchair transport utilizing the facility van. The facility now requires verification that safety restraints are applied correctly, and staff supervision is present prior to movement. A check sheet for each transport is located at the nurses station. All transport staff have been trained on the proper use of the transport checklist. How Harm Is Prevented From Occurring or Recurring:No resident is permitted to be transported or transferred using the facility van until safety checks are completed and documented. All transport staff have signed an in-service for the training and notification of safety checks. A licensed nursing staff that has been trained on van safety transportation will provide supervisory oversight as a requirement for all transfers involving wheelchairs.Date Completed: 01/15/2026Responsible Party: Administrator / Director of Nursing (DON)2. Identification of Residents Who Have Suffered or Are Likely to Suffer HarmAffected Resident(s):The resident involved in the incident resulting in hospitalization.Residents Likely to Be Affected:All residents who:Are transported outside the facility (hospital, clinic, hospice)35 residents have been identified as likely to be affected, due to the use wheelchairs, and 9 residents do not. Action Taken:A 100% audit of all residents meeting the above criteria was completed immediately.Any resident identified as high risk had care plans updated and additional supervision implemented.Date Completed: Completion by 01/15/2026Responsible Party: DON3. Determination of the Underlying CauseRoot Cause Identified:Failure to consistently ensure wheelchair brakes and restraints were engaged prior to transport.Lack of a standardized transportation and wheelchair restraint checklist.Inadequate staff competency validation related to wheelchair transportation safety.The facility will establish a standardized maintenance checklist that will be reported monthly in QAPI meetings with the IDT. Date Completed: Completion by 01/14/20264. Specific Corrective Actions to Address NoncomplianceAction 1: Standardized Transportation Safety ProcessImplemented a Skilled Nursing Facility Transportation Safety Checklist and Wheelchair Van Restraint Safety Checklist for all Nursing Staff.Date Competed: 01/15/2026Responsible Party: DON / Transportation DesigneeAction 2: Staff Education and Competency ValidationAll staff involved in resident transfers and transportation (nurses, CNAs, drivers) will receive education training before their next work day:Wheelchair brake lockingProper restraint useSupervision requirementsCompetency validation completed prior to staff resuming (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	transport duties through a return demonstration for a supervisor. If the staff is not competent, they are not able to drive, supervise transports, and must have a competently trained staff in the facility to work with them. All nurses will be trained on proper procedure for transports with a wheelchair by prior to their next work day, immediately over the phone, upon hire, and annually. A nurse is available at the facility 24/7.Date Completed 01/15/2026Responsible Party: DON Action 3: Care Plan and Policy RevisionsCare plans updated to clearly identify supervision and transport requirements.Transportation and accident prevention policy created that includes training requirements, safety checklist, transportation safety, and restraint checklist.Date Completed: Completed by 01/15/2026Responsible Party: DON / Interdisciplinary Team5. Systemic Changes to Prevent RecurrenceFacility adopted a zero tolerance policy for noncompliance with transportation safety procedures through an in-service for staff currently at the facility and is mandatory for staff before starting their first shift. Supervisory sign?off required for all external transports.Preventive maintenance checks for wheelchairs and restraints conducted weekly.Date Completed: 01/13/2026Responsible Party: Administrator / DON6. Monitoring and OversightDON/designee conducts daily audits of transportation documentation for 7 days, then weekly for 4 weeks.Findings reviewed during QAPI meetings.Any identified non?compliance results in immediate corrective action.Date Completed: 01/13/2026 and ongoingResponsible Party: DON / QAPI Committee7. Sustainability PlanTransportation safety training incorporated into new hire orientation.Annual competency validation required for all applicable staff.Ongoing QAPI monitoring to ensure sustained compliance.Date Completed: 01/13/2026 and ongoing Monitoring of the facility's Plan of Removal revealed the following: Interview on 01/14/2025 at 4:45 pm, with the Administrator, ADON, and Office Manager revealed only 4 residents were transported since the IJ was called on 01/13/2026, none of which were transported it the van or in a wheelchair. Verified residents were transported via facility car, by NA-B who had been trained in transportation safety and wheelchair securement on 01/09/2026 by the Office Manager. Interview and observation on 01/14/2026 at 5:00 PM, NA-B (6am-2pm shift) stated she was observed properly securing a wheelchair in the van and showed competency. She stated she was trained on the new checklist and was aware all transports must have a nurse verify proper wheelchair securement, and the checklist must be completed prior to every transport. Observed NA-B properly secure a wheelchair into the van. Interview and observation on 01/14/2026 at 5:15 PM, NA-C (6am-2pm shift) stated she had been observed properly securing a wheelchair in the van and showed competency. She stated she had been trained on the new checklist and was aware that all transports must have a nurse verify proper wheelchair securement, and the checklist must be completed prior to every transport. Observed NA-C properly secure a wheelchair into the van. Interview on 01/14/2026 at 5:25 PM, CNA-A (8-5 PM shift) stated she was trained in transportation safety and proper wheelchair securement. She stated she was observed properly securing a wheelchair in the van and showed competency. She stated she had been trained on the new checklist and was aware all transports must have a nurse verify proper wheelchair securement, and the checklist must be completed prior to every transport. During interviews on 01/14/2026 from 5:00 PM- 6:00 PM, LVN-D, CNA-E, and NA-F (2pm-10pm shift) stated they were trained in transportation safety and proper wheelchair securement. They stated they were observed properly securing a wheelchair in the van and showed competency. They stated they were trained on the new checklist and were aware all transports must have a nurse verify proper wheelchair securement, and the checklist must be completed prior to every transport. During telephone interviews on 01/15/2026 from 11:00 AM- 12:30 PM, LVN-G, CNA-H, and NA-I (10pm-6am shift) stated they were trained in transportation safety and proper wheelchair securement. They stated they were observed properly securing a wheelchair in the van and showed competency. They stated they were trained on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the new checklist and were aware that all transports must have a nurse verify proper wheelchair securement, and the checklist must be completed prior to every transport. During an interview on 01/15/2026 at 12:35 PM, LVN-J (6am-2pm shift) stated he was trained in transportation safety and proper wheelchair securement. He stated he was observed properly securing a wheelchair in the van and showed competency. He stated he was trained on the new checklist and was aware all transports must have a nurse verify proper wheelchair securement, and the checklist must be completed prior to every transport. Record review of completed safety checklist, completed by ADON prior to each of the four residents being transported with no concerns noted. Record review of Skilled Nursing Facility Transportation Safety Checklist and Wheelchair Van Restraint Safety Checklist reflected it was completed on 01/09/2026 by NA-B. Record review of Skilled Nursing Facility Transportation Safety Checklist and Wheelchair Van Restraint Safety Checklist reflected it was completed on 01/09/2026 by NA-C. Record review of Skilled Nursing Facility Transportation Safety Checklist and Wheelchair Van Restraint Safety Checklist completed for LVN-D, CNA-E, NA-F, LVN-G, CNA-H, NA-I, CNA-C, and LVN J. Record review list of 35 residents identified at risk as wheelchair transfers and verified all 35 resident care plans were updated. Record review of the facility document, dated 01/14/2026, titled Weekly Preventative Maintenance Log,' revealed safety check completed on all 4 wheelchair straps in the van and all 35 residents' wheelchairs. The Administrator was informed the Immediate Jeopardy was removed on 01/15/2026 at 6:00 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for minimum harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review the facility failed to ensure an individual working in the facility as a nurse aide for more than 4 months, on a full-time basis was competent to provide nursing and nursing related services, completed a training and competency evaluation program approved by the State as meeting requirements and that individual was deemed or determined competent as provided for 5 of 9 nurse aides (NA-C, NA-F, NA-I, NA-K, and NA-L) reviewed for nursing services. The facility failed to ensure NA-C, NA-F, NA-I, NA-K, and NA-L were certified within 4 months of being hired. This failure could place residents at risk for receiving inappropriate care from individuals whose skill level was not known. Findings include: Record review of NA-F's employee file revealed a hire date of 04/19/2024 and worked full time. An employability status check dated 04/09/2025 indicated NA-F had no CNA certification. Record review of NA-I's employee filed revealed a hire date of 06/23/2025 and worked full time. An employability status check dated 06/14/2025 indicated NA-I had no CNA certification. Record review of NA-K's employee file revealed a hire date of 09/10/2025 and worked full time. An employability status check dated 09/10/2025 indicated NA-K had no CNA certification. Record review of NA-L's employee file revealed a hire date of 11/21/2024 and worked full time. An employability status check dated 01/14/2026 indicated NA-L had no CNA certification. During an interview on 01/14/2026 at 3:45 PM, the Office Manager stated NAs must be certified within 4 months of hire. She stated she was aware that many of the NA were past that deadline. She stated the facility was waiting for approval to have the nurse aide class. During an interview on 01/14/2026 at 4:00 PM, the Administrator stated she was aware many of her NAs were past the deadline of 4 months. She stated it was very hard to get people certified and it was very hard to find CNAs in a rural area. She stated the facility had just gotten certified to have a CNA class but was not sure if they would be able to have class due to the IJ that was called, and she did not know what she was going to do. Record review of the, undated, document provided by the Administrator titled Job Description for Nurse Aide, revealed in part: Qualifications: 1. Has completed a training and competency evaluation program or a competency evaluation approved by the state and holds a current certificate from the state. 2. must be enrolled in a competency training program approved by the state and performs only services of any type for which he or she has demonstrated competence.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition of 1 of 1 van reviewed. The facility failed to ensure the facility van was maintained. This failure could place residents at risk of injury due to not being supervised and placed them at risk of serious bodily harm, physical impairment, hospitalization or death.The findings include:During an interview on 01/09/2026 at 3:20 PM, the Administrator stated there were no logs for maintenance on the van or routine checks regarding van maintenance or safety checks. She stated the van was not inspected routinely. During an interview on 01/09/2026 at 4:15 PM, CNA-A stated on 01/08/26 while transporting a resident the van began to overheat and she was in a construction zone with nowhere to exit. She stated she called the maintenance man on the phone, then she looked up and saw a yellow light and began slowing down.