STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carlyle at Stonebridge Park	170 Stonebridge Lane Southlake, TX 76092

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** 32486 Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one (Resident #1) of one resident observed during a transfer. CNA A failed to transfer Resident #1 safely when he failed to use a gait belt and independently lifted Resident #1 under her armpits when transferring Resident #1 from her bed to her shower chair on 09/04/24. This failure could affect the residents by placing the residents at risk for discomfort, pain, and/or injury. Findings included: Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE], with the following diagnoses: osteoporosis (a condition in which bones become weak and brittle and dementia (a group of thinking and social symptoms that interferes with daily functioning). Resident #1 required substantial/maximal assistance (helper does more than half the effort) for bed to chair transfer. Resident #1's BIMS score of two indicated had severe cognitive impairment. Review of Resident #1's undated Care Plan, reflected, Resident #1's ADL functions: extensive assistance from staff with 1-2 staff members .Interventions: .Nursing: extensive/total with all transfers x2 staff members and the use of gait belt at all times . (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 - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/05/24 at 9:30 AM, the Administrator and surveyor reviewed a video provided by Resident #1's family member, Family Member B, recorded on 09/04/24 with a start time of 7:57 AM. The video revealed CNA A and Resident #1 was standing next to Resident #1's bed in Resident #1's room. CNA A transferred Resident #1 from her bed to the shower chair. CNA A placed his arms under the resident's arm pits and had Resident #1 place her arms to her side and lifted the resident from her bed to the shower chair without a gait belt or assistance of another staff member. The Administrator stated the video showed an inappropriate transfer of Resident #1 when CNA A placed his arms under the resident's arm pits and did not have another staff member assisting. The Administrator identified CNA A as the staff member in the video. The Administrator said there had been no reports or concerns regarding CNA A's care and treatment of the residents. The Administrator said the employees had received training with a competency check-off on appropriate transfer and gait belt usage and his expectation was for staff to use gait belts rather than to place their arms under a resident's arm pit to transfer a resident. The Administrator stated the risk of an inappropriate transfer could result in injury to the resident. The Administrator stated they taught staff to use a gait belt for all transfers for safety and to prevent injury to themselves and the residents. Observation and attempted interview on 09/05/24 at 8:15 AM, Resident #1 was seated in her wheelchair in her room with Family Member B present. Resident #1 was smiling and appeared to be in a good mood. Resident #1 was not able to answer questions appropriately. Interview on 09/05/24 at 8:25 AM, LVN C revealed Resident #1 was a two-person transfer at all times. Follow-up interview at 10:59 AM revealed Resident #1 was a two-person transfer with a gait belt for all transfers. LVN C was asked about the hand placement for a two-person transfer, LVN C stated you are to hold onto the gait belt during the transfer. LVN C was asked if transferring a resident by grabbing under a resident's armpit was appropriate and LVN C stated no armpit transfers are allowed you risk causing injury to a resident. Interview on 09/05/24 at 11:38 AM, CNA A revealed the observation of pictures from the video of Resident #1's transfer on 09/04/24. CNA A confirmed he was the staff member in the pictures from the video. CNA A stated he did not use a gait belt for the transfer and had been trained on safe transfers. CNA A knew Resident #1 was a two-person assist with transfers and to always use a gait belt. CNA A was asked about the placement of his arms in the pictures from the video and CNA A stated he had his arms under Resident #1's armpits which was incorrect. CNA A stated he knew he needed help with Resident #1's transfer and did not ask for help since help was not always readily available. CNA A stated he would use a gait belt for transfers and not place his arms under the Resident's armpits during transfers moving forward. CNA A stated that the risk of transferring a resident inappropriately could result in dislocation of a shoulder or bruising. Interview on 09/05/24 at 1:45 PM, PT D revealed Resident #1 was a two-person transfer with a gait belt for all transfers. PT D stated that they did not use a resident's armpit during a transfer because it was not safe for the resident and could cause an injury. Interview on 09/05/24 at 2:00 PM, the ADON revealed Resident #1 was a two-person transfer with a gait belt for all transfers. The ADON stated the staff were not supposed to place their arms in a resident's armpit during a transfer since that could pull a resident's shoulder out of socket. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/05/24 at 2:05 PM, the DON revealed Resident #1 was always a two-person transfer with a gait belt since that was standard practice. The DON stated the staff were not supposed to use a resident's armpits during a transfer because that could result in injury to resident or staff. Review of the facility's In-Service Training Report dated 09/03/24, Topic-Transfers-Hoyer's, Gait belts reflected: .gait belts are to be used with all transfers other than Hoyer transfers. Facility is a zero-lift facility; therefore, all transfers require use of Hoyer or gait belt. No exceptions. CNA A had signed as being in attendance for the in-service listed. Review of Reference E Clinical Nursing Skills and Techniques 9th edition page 276 reflected: . Patients should never be lifted by or under their arms. Review of the facility's policy, Transfers: Method, Equipment and Preparation, dated 06/14/06, reflected, .use gait belt on all assisted transfers. Patient's shoulders or arms are not appropriate to pull, push or lift upon. Cup your hand under the gait belt for greater control .Using a Transfer Belt .Belt should be used on any Patient who requires any type of level of assistance with transfers or ambulation .Assistant's hand should always be cupped under the gait belt to ensure proper grasp and security .Transfers .Maximal Assistance . Place belt around the Patient's waist .