

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER San Gabriel Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 College Park Dr Round Rock, TX 78665	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</p> <p>Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse, neglect, misappropriation of property and exploitation for one (Resident #2) out of three residents reviewed for abuse, in that:</p> <p>The facility failed to ensure Resident #2 was transferred by Hoyer lift from his bed to his wheelchair without being hit in the head by the Hoyer lift and without his right foot being hit against the wall causing resident pain and an abrasion. CNA B did not immediately stoop the Hoyer transfer and request an assessment of the Resident #2 when he cried out, ow. This made Resident #2 feel like, they don't give a crap about him.</p> <p>This failure could place residents that required Hoyer lift transfers and assistance when they express pain at risk for injuries, neglect, harm, pain, and psychosocial injury.</p> <p>This noncompliance was identified as PNC. The incident occurred on 08/21/24 and the facility took corrective action, including terminating CNA B, prior to surveyor entrance. The deficient practice began on 08/21/24 and ended on 08/21/24. The facility had corrected the noncompliance before the survey began.</p> <p>Findings included:</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included alcoholic cirrhosis of the liver with ascites (a condition that occurs when fluid collects in spaces in your belly (abdomen), chronic pain syndrome, anorexia, and altered mental status.</p> <p>Review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 14, indicating cognition was intact. It further reflected that Resident #1 was dependent with transfers.</p> <p>Review of Resident #2's care plan, revised 05/17/23, reflected Resident #2 had an ADL functional status/rehabilitation potential of transfer assist of 2 via mechanical lift.</p> <p>Review of the facility's investigative statement for Resident #2 from CNA B dated 08/26/24 at 1:31 pm reflected the following:</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON spoke with CNA B on 08/26/24 at 3:05 pm. The facility interview with CNA B reflected the DON asked CNA B how the transfer went with Resident #2 and CNA B stated the Hoyer wheel did not work well and the Hoyer was difficult. The DON asked CNA B if CNA C helped CNA B with the transfer and CNA B stated, No he was waiting behind the Hoyer. The</p> <p>DON asked if the Hoyer bar hit Resident #2 in the head and CNA B stated she did not see the bar hit Resident #2's head and she just tried to, move him and fix him. The DON asked if Resident #2's foot hit the wall and CNA B stated, no. The ADON asked if CNA B asked CNA C to help move the Hoyer lift and CNA B stated no, CNA C waited in front of the chair to put Resident #2 in the chair. The ADON asked what CNA B said to Resident #1 before she walked out of room and CNA B stated she told CNA C she was going to go help on the 200 Hall. The ADON asked if Resident #2 said anything to CNA B during the transfer. CNA B stated he said something about, stupid. The ADON asked if CNA C said anything during the transfer and CNA B stated CNA C asked her to let him help put Resident #2 in the chair. The ADON asked is there anything else CNA B wanted to tell them, and CNA replied, I'm sorry.</p> <p>Review of the facility's investigative statement for Resident #2 from CNA C dated 08/26/24 reflected the following:</p> <p>CNA C was in the room when CNA B was transferring Resident #2 with a Hoyer lift. CNA C confirmed he saw Resident #2 get hit in the head with the Hoyer bar. CNA C stated he was trying to give CNA B direction on how to put Resident #2 on the sling and she was not listening and just did, what she wanted to do. CNA C confirmed that once Resident #2 was up in the lift, CNA B moved the Hoyer, so hard that [Resident #2's] right foot hit the wall. CNA C stated CNA B did not say she sorry and, just walked out of room after Resident #2 was transferred into his chair.</p> <p>Review of the facility's investigative statement and summary for Hoyer incident with Resident #2 dated 08/26/24 reflected that, immediately after the incident, Resident #2 received a head-to-toe assessment, the nurse practitioner was notified, an x-ray was ordered that reflected negative findings, and CNA B was immediately suspended.</p> <p>Interview on 09/25/24 at 1:42 pm with Resident #2 reflected CNA B regularly did not want to help him, she did not answer his call light and was rude to him. He stated he let the ADON know that CNA B was not helpful and was rude during the transfer with Resident #2. When asked about what happened with the Hoyer transfer, he revealed CNA B, while he was in the Hoyer lift, jerked his right foot into the wall and he said, ow, ow and CNA B ignored him and, spun him and smacked his head into the back of the Hoyer. Resident #2 said CNA B dragged his foot against the wall he said, ow but CNA B ignored him. He revealed CNA C asked if he could help her, but she did not respond. Resident #2 said that after he was in the wheelchair, CNA B stormed out of the room. Resident #2 revealed his foot was x-rayed and the findings were negative and there were no bruises and no injury. He revealed the incident made him feel like, they don't give a crap about him and you are in a position when you count on people to help you and you don't understand why they don't help you, it deflates any trust you have in the management.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/25/24 at 2:29 pm with CNA C revealed he was with CNA B when she transferred Resident #2 using a Hoyer lift to his wheelchair. CNA C said that CNA B was rough with Resident #2 during the transfer and Resident #2's legs and head were hit against the wall. He revealed he was going to report it to the ADON immediately but Resident #2 spoke to the ADON first. He revealed that facility staff were trained through in-services, and he gets trained every 2 to 3 months on abuse and neglect and transfers.</p> <p>Interview on 09/25/24 at 4:16 pm with the DON revealed when asked if she felt that CNA B's actions or non-actions during the Hoyer transfer with Resident #2 was abuse, she said some people might consider it abuse. CNA B definitely did not do what she should have as a staff member. The DON revealed when she asked CNA B about the incident, she said it was an accident. The DON said CNA B did not take directions very well and when CNA C tried to help, she told him no. She revealed that the DON was ultimately responsible for the staff being trained in the facility.</p> <p>Reviewed staff education/orientation standards of practice Hoyer lift transfer training for CNA C dated 08/22/24 that reflected CNA C met all competency standards for Hoyer transfers.</p> <p>A review of the following facility in-services revealed:</p> <p>in-service on 08/14/24 to the facility clinical staff (this included CNAs) on abuse and neglect.</p> <p>in-service on 08/21/24 to all staff on abuse and neglect and resident transfers.</p> <p>in-service on 09/13/24 to all staff on resident dignity and customer service and abuse and neglect.</p> <p>A review of CNA B's personnel file reflected:</p> <p>Performance feedback dated 06/26/24 - titled opportunity for improvement for the following listed reasons:</p> <p>CNA B was requested to arrive to work on time for every shift or to inform the staff coordinator if she was running late and to notify the charge nurse when she was going on her lunch break and when leaving the hallway.</p> <p>Performance feedback dated 01/31/24 - titled opportunity for improvement for the following listed reasons:</p> <p>01/03/24 - CNA B gave a resident a bed bath after being told the resident was to be showered</p> <p>01/05/24 - CNA B gave a resident their shower late</p> <p>01/08/24 - CNA B did not shower resident prior to wound rounding as instructed</p> <p>01/10/24 - CNA B gave a resident their shower late</p> <p>01/12/24 - CNA B did not follow instructions regarding resident shower schedules</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>01/31/24 - CNA B rolled a resident into the shower room on a shower bed naked except for a sheet placed on the lower portion of resident's body</p> <p>Corrective action form dated 08/21/24 reflected CNA B was suspended pending the investigation of the Hoyer lift incident involving Resident #2.</p> <p>Corrective action form dated 08/22/24 reflected CNA B received a verbal warning for failure to clock out and in clock back in for her 30-minute lunch break.</p> <p>Review on an email dated 08/28/24 from the facility human resources representative to the DON and administrator stated, after her review of the facility investigation involving CNA B's incident with Resident #2 and the Hoyer lift, she agreed with the termination of CNA B's employment with the facility.</p> <p>Review of CNA B's facility annual skills fair training dated 02/09/24 reflected CNA B was trained on facility abuse and neglect policies and successfully passed an abuse and neglect policies quiz and trained in facility transfer techniques.</p> <p>Review of facility abuse, neglect, exploitation, or mistreatment policy dated 2019 reflected abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. An adverse event is untoward, undesirable, and unusually unanticipated event that causes death or serious injury or the risk thereof. Mistreatment means inappropriate treatment or exploitation of a resident. Neglect is the failure of the facility, its employees or service provides to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Review of the facility's self-report to HHSC, dated 08/21/24, reflected the abuse was reported in a timely manner.</p> <p>Review of an in-services on 08/21/24 to the facility clinical staff (this included CNAs) on abuse and neglect reflected staff were educated on the facility abuse, neglect, exploitation, or mistreatment policy dated 2019 regarding:</p> <ol style="list-style-type: none"> 1. the definitions of abuse including the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being, instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish; 2. verbal abuse, sexual abuse, physical abuse, and mental abuse is the willful abuse of an individual who acted deliberately; and <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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** 46708</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for two (Resident #1 and Resident #2) of three residents reviewed, in that:</p> <p>The facility failed to</p> <ol style="list-style-type: none"> 1. utilize a two-person transfer for Resident #1 when transferring her from her bed to her wheelchair; 2. utilize a Hoyer lift when transferring Resident #1 from her bed to her wheelchair; and 3. lock the breaks on Resident #1's wheelchair when transferring her from her bed to her wheelchair <p>causing her wheelchair to roll backwards, resident to slide forward in front of the wheelchair and Resident #1 to fall on top of CNA A. Both Resident #1 and CNA A landed on the floor. As a result of the fall, Resident #1's left knee was bruised and minimally swollen.</p> <p>These failures could place residents that require two person transfers at risk for neglect, harm, pain, and injuries.</p> <p>This noncompliance was identified as PNC. The incident occurred on 08/14/24 and the facility took corrective action, including terminating CNA A. The deficient practice began on 08/14/24 and ended on 08/14/24. The facility had corrected the noncompliance before the survey began.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmission with diagnoses that included nontraumatic intracerebral hemorrhage (a devastating condition whereby a hematoma is formed within the brain parenchyma with or without blood extension into the ventricles), anemia in chronic kidney disease, unspecified fall, lack of coordination, cognitive communication deficit, fracture of left acetabulum (concave surface of the pelvis), closed fracture, and chronic pain.</p> <p>Review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 8, indicating a moderate cognitive impairment. It further reflected that she required extensive assistance with transfers.</p> <p>Review of Resident #1's care plan, revised 11/04/22, reflected Resident #1 had an ADL self-care performance deficit with an intervention of transfer assist of 2 via mechanical lift.</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on ,d+[DATE] with diagnoses that included alcoholic cirrhosis of the liver with ascites (a condition that occurs when fluid collects in spaces in your belly (abdomen), chronic pain syndrome, anorexia, and altered mental status.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's MDS, dated [DATE], reflected a BIMS of 14, indicating cognition was intact. It further reflected that Resident #1 was dependent with transfers.</p> <p>Review of Resident #2's care plan, revised 05/17/23, reflected Resident #2 had an ADL functional status/rehabilitation potential of transfer assist of 2 via mechanical lift.</p> <p>Resident #1</p> <p>Observation of a video provided by a family member reflected Resident #1 lying flat in her bed. CNA rolled Resident #1's wheelchair to align perpendicular to Resident #1's bed. Observation of the video revealed the wheels on the wheelchair kept rolling. CNA A did not engage the brakes on the wheelchair. CNA A walked to the side of Resident #1's bed and raised Resident #1's bed 3/4 length nonrestraint bedrail and pulled Resident #1's legs towards the edge of the bed. CNA A then pulled Resident #1's draw sheet (a small bed sheet placed crosswise over the middle of the bottom sheet of a mattress to cover the area between the person's upper back and thighs, often used move patients) to move more of Resident #1's body closer to the edge of the bed. CNA A moved Resident #1's legs over the edge of the bed which left Resident #1's legs partially hanging off the bed. CNA A raised Resident #1 to a sitting position by placing her left hand on Resident #1's right shoulder (CNA A and Resident #1 were facing each other) and used her right hand to push against the bed for leverage. Resident #1 was then sitting up in bed with her legs hanging over the edge of the bed. CNA A put both of her arms around Resident #1 at Resident #1's lower back and lifted resident to a standing position simultaneously pivoting Resident #1 towards her wheelchair. CNA A attempted to lower Resident #1 into the wheelchair. CNA A missed the seat of Resident #1's wheelchair and Resident #1 and CNA A fell to the floor. CNA A fell on top of Resident #1 and then Resident #1 rolled on top of CNA A.</p> <p>Review of the facility's investigative statement from CNA A dated 08/14/24 reflected CNA A went into Resident #1's room and told her she was getting her up for therapy. CNA A's statement reflected she pulled the wheelchair up to the bed and moved the bed level to the wheelchair and put resident into a sitting position and pivoted Resident #1 to put Resident #1 in the wheelchair. CNA A's statement reflected, I don't know what happened but we both fell and she fell on top of me. I asked her if anything hurt and she said no. I asked her again if she was ok before I went to go get help. When asked by facility if CNA A knew how to transfer her, she stated for shower days, she used a Hoyer, but she transferred her by herself other times. CNA A said she did not use a gait belt for the transfer.</p> <p>Interview on 09/25/24 at 11:14 am with the DON revealed CNA A did not transfer Resident #1 properly. The DON said Resident #1 was a two person assist during a transfer and required a Hoyer lift. The DON revealed Resident #1's knees gave out and she fell on top of CNA A and believed that Resident #1's wheelchair was not locked. The DON revealed that CNA A's employment was terminated.</p> <p>Interview on 09/25/24 at 1:38 pm with Resident #1 through a Spanish speaking interpreter revealed she had no concerns with the facility, but she was not able to answer specific questions about the incident with CNA A.</p> <p>A review of the facility's investigation dated 08/14/24 revealed CNA A was suspended until further investigation; facility staff in-services were conducted on transfer techniques and following plan of care for residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of CNA A's corrective action form, verbal warning, dated 05/01/24 revealed reason for action was insubordination or refusal to perform job assignment and acting rudely or indifferently toward a resident of fell ow employee. Action required: will perform assigned duties, will take direction from supervisors without attitude, will complete rounds every 2 hours, and will clock out for lunch breaks.</p> <p>Review of the corrective action form, discharge, dated 08/16/24 reflected CNA A was told via telephone that her employment with the facility was terminated.</p> <p>Review of an in-service dated 01/14/24 reflected CNA A was trained in facility transfer techniques.</p> <p>Review of Relias (provider of online continuing education for healthcare, senior care, and disabilities professionals) reflected CNA A completed the following education on 01/14/24:</p> <ol style="list-style-type: none"> 1. preventing, recognizing, and reporting abuse and neglect and received a score of 88% 2. slips, trips, and fall prevention and received a score of 80%. <p>Resident #2</p> <p>Interview on 09/25/24 at 1:42 with Resident #2 reflected CNA B regularly did not want to help him, she did not answer his call light and was rude to him. He stated he let the ADON know that CNA B was not helpful and was rude. When asked about what happened with the Hoyer transfer, he revealed CNA B, while he was in the Hoyer lift, jerked his right foot into the wall and he said, ow, ow and CNA B ignored him and, spun him and smacked his head into the back of the Hoyer. Resident #2 said CNA B dragged his foot against the wall he said, ow but CNA B ignored him. He revealed CNA C asked if he could help her, but she did not respond. Resident #2 said that after he was in the wheelchair, CNA B stormed out of the room. Resident #2 revealed his foot was x-rays and the findings were negative and there were no bruises and no injury. He revealed the incident made him feel like, they don't give a crap about him and you are in a position when you count on people to help you and you don't understand why they don't help you, it deflates any trust you have in the management.</p> <p>Interview on 09/25/24 at 2:29 pm with CNA C revealed he was with CNA B when she transferred Resident #2 using a Hoyer lift to his wheelchair. CNA C said that CNA B was rough with Resident #2 during the transfer and Resident #2's legs and head were hit against the wall. He revealed he was going to report it to the ADON immediately but Resident #2 spoke to the ADON first. He revealed that facility staff are trained through in-services, and he gets trained every 2 to 3 months on abuse and neglect and transfers.</p> <p>Review of facility investigative statement from CNA B dated 08/26/24 at 1:31 pm reflected the following:</p> <p>The DON spoke with CNA B on 08/26/24 at 3:05 pm. The facility interview with CNA B reflected the DON asked CNA B how the transfer went with Resident #2 and CNA B stated the Hoyer wheel did not work well and the Hoyer was difficult. The DON asked CNA B if CNA C helped CNA B with the transfer and CNA B stated, No he was waiting behind the Hoyer. The</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DON asked if the Hoyer bar hit Resident #2 in the head and CNA B stated she did not see the bar hit Resident #2's head and she just tried to, move him and fix him. The DON asked if Resident #2's foot hit the wall and CNA B stated, no. The ADON asked if CNA B asked CNA C to help move the Hoyer lift and CNA B stated no, CNA C waited in front of the chair to put Resident #2 in the chair. The ADON asked what CNA B said to Resident #1 before she walked out of room and CNA B stated she told CNA C she was going to go help on the 200 Hall. The ADON asked if Resident #2 said anything to CNA B during the transfer. CNA B stated he said something about, stupid. The ADON asked if CNA C said anything during the transfer and CNA B stated CNA C asked her to let him help put Resident #2 in the chair. The ADON asked is there anything else CNA B wanted to tell them, and CNA replied, I'm sorry.</p> <p>Review of facility investigative statement from CNA C dated 08/26/24 reflected the following:</p> <p>CNA C was in the room when CNA B was transferring Resident #2 with a Hoyer lift. CNA C confirmed he saw Resident #2 get hit in the head with the Hoyer bar. CNA C stated he was trying to give CNA B direction on how to put Resident #2 on the sling and she was not listening and just did, what she wanted to do. CNA C confirmed that once Resident #2 was up in the lift, CNA B moved the Hoyer, so hard that [Resident #2's] right foot hit the wall. CNA C stated CNA B did not say she sorry and, just walked out of room after Resident #2 was transferred into his chair.</p> <p>Review of facility investigative statement and summary for Hoyer incident with Resident #2 dated 08/26/24 reflected that, immediately after the incident, Resident #2 received a head-to-toe assessment, the nurse practitioner was notified, an x-ray was ordered that reflected negative findings, CNA B was immediately suspended.</p> <p>Reviewed staff education/orientation standards of practice Hoyer lift transfer training for CNA C dated 08/22/24 that reflected CNA C met all competency standards for Hoyer transfers.</p> <p>A review of the following facility in-services revealed:</p> <p>Reviewed an 08/14/24 in-service to the facility clinical staff (this included CNAs) on abuse and neglect and falls.</p> <p>Reviewed an 08/21/24 in-service to all staff on abuse and neglect and resident transfers.</p> <p>Reviewed an 09/13/23 in-service to all staff on resident dignity and customer service and abuse and neglect.</p> <p>A review of CNA B's personnel file reflected:</p> <p>Performance feedback dated 06/26/24 - titled opportunity for improvement for the following listed reasons:</p> <p>CNA B was requested to arrive to work on time for every shift or to inform the staff coordinator if she was running late and to notify the charge nurse when she was going on her lunch break and when leaving the hallway.</p> <p>Performance feedback dated 01/31/24 - titled opportunity for improvement for the following listed reasons:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER San Gabriel Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 College Park Dr Round Rock, TX 78665	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>01/03/24 - CNA B gave a resident a bed bath after being told the resident was to be showered</p> <p>01/05/24 - CNA B gave a resident their shower late</p> <p>01/08/24 - CNA B did not shower resident prior to wound rounding as instructed</p> <p>01/10/24 - CNA B gave a resident their shower late</p> <p>01/12/24 - CNA B did not follow instructions regarding resident shower schedules</p> <p>01/31/24 - CNA B rolled a resident into the shower room on a shower bed naked except for a sheet placed on the lower portion of resident's body</p> <p>Corrective action form dated 08/21/24 reflected CNA B was suspended pending the investigation of the Hoyer lift incident involving Resident #2.</p> <p>Corrective action form dated 08/22/24 reflected CNA B received a verbal warning for failure to clock out and in clock back in for her 30-minute lunch break.</p> <p>Review on an email dated 08/28/24 from the facility human resources representative to the DON and administrator stated, after her review of the facility investigation involving CNA B's incident with Resident #2 and the Hoyer lift, she agreed with the termination of CNA B's employment with the facility.</p> <p>Review of CNA B's facility annual skills fair training dated 02/09/24 reflected CNA B was trained on facility abuse and neglect policies and successfully passed an abuse and neglect policies quiz and trained in facility transfer techniques.</p> <p>Review of facility policy restorative nursing policies and procedures dated 2022 reflected moderate to maximum assistance - this resident exhibits an unsteady gait or weakness; one to two staff and an assistive device are necessary to ambulate to transfer.</p> <p>Review of facility nursing policies and procedures, fall management dated 2023 revealed the facility will identify each resident who is at risk for falls and will plan care and implement interventions to manage falls.</p> <p>Review of the facility's self-report to HHSC, dated 08/15/24, reflected the accident and hazard was reported in a timely manner.</p> <p>Review of an in-services on 08/14/24 to the facility clinical staff (this included CNAs) on abuse and neglect reflected staff were educated on the facility abuse, neglect, exploitation, or mistreatment policy dated 2019 regarding:</p> <p>1. the definitions of abuse including the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being, instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER San Gabriel Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 College Park Dr Round Rock, TX 78665	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. verbal abuse, sexual abuse, physical abuse, and mental abuse is the willful abuse of an individual who acted deliberately; and</p> <p>Neglect is the failure of the facility, its employees or service provides to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Review of an in-services on 08/14/24 to the facility clinical staff (this included CNAs) on the facility policy on transfers - ambulation dated 2022 regarding identification of minimum and maximum assistant and transfer techniques and general approaches and guidelines.</p> <p>Review of an in-services on 08/14/24 to the facility clinical staff (this included CNAs) on the facility policy on falls regarding the definition of falls, assistive devices, and procedures.</p>		