STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676344	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacies Nursing and Rehabilitation	355 Fm 83 W Hemphill, TX 75948

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** 40124 Based on observations, interviews, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 2 of 12 residents reviewed for accident hazards. (Resident #50 and #63). 1.The facility failed to develop and implement a policy and procedure to properly handle the care of mechanical lift slings including interventions to inspect the Hoyer sling for signs of damage before each use and not removing damaged slings from service for Resident #50. 2. NA D failed to properly transfer Resident #63 on 01/14/2025. These deficient practices could place residents at risk of falls and injuries during transfers. The findings included: 1.Record review of a facility face sheet dated 01/14/2025 indicated Resident #50 was an [AGE] year-old male that admitted to the facility on [DATE] with cerebral infarction (brain damage due to death of tissue), muscle weakness, and hemiplegia affecting left side (paralysis of the left side). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #50 had a BIMS score of 14 indicating intact cognition, impairment of left extremities, and dependent for all transfers. Record review of a comprehensive care plan revised 11/08/2024 indicated Resident #50 required two staff members for transfers. During an observation on 01/13/2025 at 12:15 p.m. Resident #50 was sitting in sitting in a Geri-chair with a lift sling underneath his buttocks, the sling was frayed on the edges with edging splitting from the body, straps were faded in color, the care tags were illegible, torn, crinkled, and [NAME]. (continued on next page)

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	During an observation and interview on 01/14/2025 at 8:15 a.m., a mechanical lift sling hanging in linen closet 300 hallway was faded and the care tag is illegible. Nurse Aide A said he worked at the facility since November 2024 and was training to become a certified nurse aide. Nurse Aide A was not aware the manufacturer recommended for them to be taken out of service if the sling had a change in color or the label was illegible, that it indicated it had been worn, bleached, or was compromised. Nurse Aide A said that if a sling was not available on the hallway, he would go to the linen storage closet and retrieve one for use. Nurse Aide A said the resident could suffer an injury or could be scared to get up with a lift if they were dropped. Nurse Aide A said he had received training to remove lift slings if they are coming unsewn or had tears. During an observation and interview on 01/14/2025 at 8:30 a.m., of the laundry area revealed Hoyer slings were being actively washed in the laundry room. Laundry staff B said she has worked at the facility for one year and been trained on how to wash the mechanical lift slings. Laundry staff D said she washes them when soiled without bleach and hangs to dry. Laundry staff D was not aware the manufacturer recommended for the Hoyer slings to be taken out of service if the sling had a change in color or the label was illegible, that it indicated it had been worn, bleached, or was compromised. During an interview on 01/14/2025 at 8:30 a.m., CNA C said mechanical lift slings should be taken out of service of service if they have tears, holes signs of coming unsewed. CNA C said she had worked at the facility three years and received training of Hoyer lift safety and when to take Hoyer slings out of service. She said the risk to the resident of a damaged sling was used to transfer a resident could be an injury if dropped from the sling. During an Interview on 01/14/2025 1:00 p.m., the DON said that the staff had received education on when to remove Hoyer. The DON said she had removed two Hoyer slings from service before the survey started and she would find the Hoyer sling that was used for Resident #50 and take it out of service. The DON said the risk to the resident was injury if the Hoyer sling failed during a transfer. During an interview on 01/14/2025 at 3:30 p.m., the Administrator said that lift slings are discarded according to the facility policy and manufacturer's suggested guidelines which is that the slings are discarded when the slings show signs of wear or any tears. The administrator said that the CNAs are to inspect the slings for any signs of rips or tears prior to using the sling. She said that the DON also inspects the slings and replaces any slings with signs of wear and tear with new slings. She said that moving forward staff will be inspecting for rips, tears, and fading. She said that residents are at risk for injury if a sling does not function properly. A record review of Full Body Slings- Medline, Instructions for use www.medline.com accessed 01/14/2025 reflected .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use Sling maintenance best practices .Check condition before each use. If there is any fraying or visible wear and tear, do not use . Reusable slings should be replaced every six months. Follow care instructions on wash tag. If illegible, do not use. Keep at least two reusable slings per patient on hand-one available and one in the laundry. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a facility policy for Lifting Machine, using a Mechanical dated July 2001 indicated .Sling Care: 8. Make that all necessary equipment (slings, hooks, chains, straps, and supports) is on hand and in good condition. A record review of a facility assessment dated [DATE] indicated . Physical Equipment is checked as needed by maintenance department. Nursing department checks medical equipment before use. 2. Record review of Resident #63's face sheet dated 01/14/2025 revealed she was [AGE] year-old female and admitted on [DATE] with diagnoses hypertensive heart disease (heart condition caused by high blood pressure) and Parkinson's (age-related degenerative brain condition). Record review of Resident #63's Quarterly MDS assessment dated [DATE] revealed she scored a 99 on her BIMS and a staff assessment for mental status was completed and indicated moderately impaired cognitive skills for daily decision-making. Record review of Resident #63's comprehensive care plan dated 11/15/2024 revealed she had an ADL Self Care Performance Deficit and required assistance of 2 staff for transfers. During an observation on 01/14/2025 at 8:20 AM, NA D was observed in Resident # 63's room preparing for a transfer. NA D positioned Resident #63 on the side of the bed. NA D then placed her arms under Resident #63's arms and manually lifted her into her wheelchair. During the transfer Resident #63 did not bear weight or pivot and was full weight bearing on NA D. NA D placed Resident #63 in her wheelchair and then placed her arms back under Resident #63's arms and lift again to position in wheelchair. During an interview on 01/14/2025 at 8:36 AM, NA D said she started at the facility in December 2024 and had completed her training for transfers by the therapy department. She said she thought Resident #63 was a 1 person transfer and she could transfer manually or by a gait belt. She said a residents needed care level was on the care plan Kardex and she should have checked her ADLs at the start of her shift. She said if a resident could not bear weight, she should use a gait belt or two people and should have used a gait belt for Resident #63. She said most days the resident could bear weight and not sure why she did not today but had told the nurse. She said by transferring incorrectly it could cause falls or injuries. During an interview on 01/14/2025 at 3:51 pm, LVN E said she was the charge nurse for Resident #63 and responsible for oversight of the nurse aides on the hall. She said Resident #63 required assistance with all ADL's. She said in the past Resident #63 was a one person assist with transfers, but the nurse aides had reported at times that Resident #63 did not stand and bear weight and that her care plan had changed to a two person assist. She said the MDS coordinator updated the care plans and would notify the charge nurses of the changes, but it was the nurses and nurse aides' responsibility to check the care plan every day for any changes. She said if a resident was transferred incorrectly, it could cause falls or injuries. During an interview on 01/14/2025 at 4:00 pm, the MDS Coordinator said she was responsible for updating care plans. She said when Resident #63 had her care plan revised in November 2024 her transfer status had changed from one person to two person. She said the charge nurses and nurse aides should check the care plan Kardex daily as resident care changes could occur daily. She said that residents that are transferred incorrectly could have falls or injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/2025 at 4:05 pm, the DON said all nurse aides were trained on hire how to check the care plan Kardex and properly transfer residents. She said the facility utilizes the therapy department to determine the transfer ability of the resident and if a resident requires a two-person transfer than that was how the resident should be transferred. She said the charge nurses were responsible for oversight of the nurse aides and she and the ADON evaluate their performance through competency checks. She said NA D had completed a transfer training in the last 2 weeks. She said a resident could be injured or fall if incorrectly transferred. During an interview on 01/14/2025 at 4:10 pm, the Administrator said the DON was responsible for oversight of the nursing department. She said the DON and ADON complete competency checks on the nurse aides on hire, as needed and annually. She said the nurses and nurse aides should be following the care plan for ADL's daily and expected each resident receive the care they need and require ensuring safety. She said if a resident was transferred incorrectly a fall or other injury could occur. Record review of a nurse aide proficiency check dated 12/20/24 revealed NA D had demonstrated competency on transfers and ADL care. Record review of an in-service training reported dated 01/03/2025 revealed NA D had received training on transfer technique from therapy department. Record review of a facility policy titled Safe Lifting and Movement of Residents dated July 2017 indicated, .in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents . 46436