

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
NAME OF PROVIDER OR SUPPLIER The Brazos of Waco		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 Market Place Drive Waco, TX 76711	

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** 17141</p> <p>Based on interviews and record reviews the facility failed to ensure each resident receives adequate supervision with assistance devices to prevent accidents for 1 (Resident #1) of 3 residents reviewed for accidents.</p> <p>The facility failed to ensure Resident #1 received assistance, in an appropriately sized space, while being lifted out of her wheelchair using a mechanical lift, as specified in the care plan. CNA B did not ensure Resident #1 was positioned in the center of the lift sling and CNA D failed to stay by Resident #1's side with hand on assistance.</p> <p>The noncompliance was identified as PNC. The IJ began on 11/4/24 and ended on 11/23/24 The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of injuries, falls, and a decline in quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated undated reflected; Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included fracture of the left femur (broken thigh bone), poly osteoarthritis (painful inflammation in five or more joints), cerebral infarction (blocked blood flow to the brain causing brain tissue to die), muscle weakness, hemiplegia (paralysis on one side of the body), hemiparesis (one sided muscle weakness) following unspecified cerebrovascular disease (conditions that affect blood flow to the brain) affecting left dominant side.</p> <p>Record review of Resident #1's annual MDS assessment, dated 1/18/24, section C (Cognitive Patterns) reflected no BIMS score as resident was rarely or never understood. Section GG (Functional Abilities) reflected she was dependent for bed mobility and bed to chair transfers.</p> <p>Record review of Resident #1's comprehensive care plan, revised 11/15/24, reflected in part, Resident has side rails on bed for repositioning. She is at risk for falls. She also has a full torso harness attached to her wheelchair as she has zero trunk control. She will thrust herself forward at times. She is a mechanical (lift brand name) for transfers. Intervention added 11/07/24, Rearrange furniture and bed in (Resident #1's) room to ensure smooth transition for the (lift brand name).</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 progress note dated 11/4/24 reflected, Witnessed Fall RP present. Res being transferred to bed via (mechanical lift brand name) 2 CNAs and grandmother present CNA (CNA B and D's names) stated while positioning (Lift) alongside bed res raised up leaned forward slide out of the sling onto the floor. Standing outside the door I immediately went into the room observed res laying on the floor. Head to toe assessment completed VS:</p> <p>104/70 90 20 97.0 97% RA res is nonverbal assisted onto bed off the floor.</p> <p>Dr notified transported to (Local) Hospital for further evaluation.</p> <p>Record review of Resident #1's Local Hospital Emergency Department Discharge Instructions dated 11/5/24 revealed no new orders. X-ray results were noted to be negative.</p> <p>Record review of Resident #1's progress note dated 11/5/24 reflected, Resident #1 returned from the hospital with no injuries having been found. The nurse documented This nurse was made aware of a hematoma (a collection of blood that pools outside the blood vessels) on the left hip. Residents [family member] requested the area be re-x rayed as it may be a delayed injury related to a fall the week prior.</p> <p>Record review of Resident #1's radiology reports from a mobile x-ray provider (performed at the facility), dated 11/14/24 reflected in part,</p> <p>HIP UNI W OR W/O PELVIS 2-3 V, LEFT</p> <p>Results: The left hip joint is in alignment, but there is narrowing of the joint space due to mild degenerative changes. There is mild degenerative spurring involving acetabular border and femoral head and neck junction. No fracture or dislocation is seen. Pubic rami are intact.</p> <p>Conclusion: Mild osteoarthritis of the left hip.</p> <p>Record review of Resident #1's progress note dated 11/20/24 included additional x-rays were ordered. The nurse documented the x-ray results in her progress note as follows:</p> <p>Acute fracture distal femur with some displacement and impaction noted.</p> <p>Orders received from provider to send resident to ED for further evaluation.</p> <p>Record review of Resident #1's radiology reports from a mobile x-ray provider (performed at the facility), dated 11/20/24 reflected in part, Femur 1 View, Left. Results: Acute fracture distal femur with some displacement and impaction. No acute findings elsewhere. Conclusion: Distal femoral fracture.</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 11/24/24 at 3:58pm LVN C stated she had been in the hallway outside Resident #1's room preparing medications. She heard screaming and ran into Resident #1's room. She stated Resident #1 was on the floor, CNA B and CNA D were standing back on the other side of the lift and Resident #1's FM was behind all of them. LVN C stated the CNA's told her the resident had hit her head in the fall she did an assessment of Resident #1 and did not see any injuries, including on the resident's legs. She called emergency services right away because the resident had hit her head. LVN C stated she did not see the actual lift for Resident #1, but the FM had shown her a video and Resident #1 was leaning to the left and not positioned correctly in the center of the sling.</p> <p>During an interview on 11/24/24 at 4:47pm CNA D stated she had started working at the facility a week before the incident. CNA D stated by the time she got to the room to assist, Resident #1's sling was already hooked up. CNA D stated the fall happened because Resident #1 had leaned forward and to the left. When asked about the positioning of Resident #1 in the sling prior to the fall, CNA D stated everybody keeps talking about this video like it shows something and discontinued the call/interview.</p> <p>During an interview on 11/24/24 at 4:29pm the DON stated all staff receive training on using a mechanical lift upon hire and while shadowing a staff the first three days on the floor. She stated after the fall occurred all staff had been provided an in-service on appropriate use of the lift, including positioning. DON stated prior to Resident #1's fall they had to use the lift between the wall and the bed, making it difficult to maneuver. She stated they rearrange the room so it would not be as difficult to put mechanical lift legs under the bed. DON stated she had seen sections of the video that Resident #1's FM had but not the entire video. She was not aware of Resident #1 leaning to the left but stated they had included in the in-service the correct positioning and sling to be used. DON stated CNA B and CNA D should have positioned Resident #1 better in the sling and kept someone at Resident #1's side. DON stated the outcome of not using lift correctly could be harm to the resident.</p> <p>During an interview on 11/24/24 at 5:31pm the Adm stated she was made aware of Resident #1's having fallen out of the lift at the time it happened. She stated although Resident #1 returned from the hospital without injuries, they did in-services with all staff and rearranged the furniture in Resident #1's room. She stated they had done an additional set of x-rays at the facility after continued expressions of pain. On 11/20 swelling was noted and x-rays were again performed and that set of x-rays showed a fracture. The Administrator stated she wondered if the injury was because of the fall. She stated she had not seen the video of the fall, but the DON had seen parts of the video and planned to look at the entire video. Adm stated they have been and will continue to do monitoring of mechanical lifts.</p> <p>Record review of CNA B's Infection Prevention and Control Boot Camp Class evaluation, dated 2/4/24, includes mechanical lift training and transfer techniques.</p> <p>Record review of CNA D Check off sheet evaluation, dated 10/25/24 includes mechanical lift training and transfer techniques.</p> <p>Record review of the facility Record of Inservice, dated 11/7/24, given to CNAs Band D reflected the following was included, one staff always have a hand on the resident and position patient/resident for maximum comfort.</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 the facility Record of Inservice, dated 11/23/24, given to all staff reflected the following was included, one staff always have a hand on the resident and position patient/resident for maximum comfort. The inservice includes review of policy which includes need for full back support, head support and the residents medically appropriate position.</p> <p>Review of the facility policy dated 3/27/2017 Mechanical Lifts: General Guidelines reflected in part, H. 3) Clear path for the lift device. a) Ensure adequate space for lift to pivot and move freely to receiving area. b) Ensure lift can fit under or around receiving surface and through doorways, as needed.</p>		