STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745017	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge of Saginaw Health and Wellness	848 W McLeroy Blvd Saginaw, TX 76179

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 44937 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 of six residents (Resident #1 and Resident #2) reviewed for accidents. 1. On 12/31/24, CNA F and CNA G failed to safely transfer Resident #1 during the use of the mechanical lift, which resulted in the resident sustaining a scalp hematoma and T12 compression fracture. 2. On 12/18/24 the Van Driver failed to properly restrain Resident #2's wheelchair in the facility transportation van to prevent the wheelchair from tipping over on its side on the way to dialysis. The noncompliance was identified as PNC. The IJ began on 12/18/24 and ended on 01/20/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk for severe injury or harm, decline in health, and decreased quality of life and death. Findings included: 1. Record review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had a BIMS of 00 which indicate her cognition was severely impaired and was not able to respond or complete the Brief Interview for Mental Status. The MDS further reflected Resident #1 was dependent on staff for all functional abilities which included eating, and all transfers. The resident's diagnoses included unsteadiness on feet, muscle wasting atrophy, lack of coordination, bilateral primary osteoarthritis of the knees (degenerative joint condition where the cartilage in both knees breaks down gradually). Record review of Resident #1's undated care plan reflected she had the following care areas: - activities of daily living self-care performance deficit related to dementia and impaired balance. The care plan reflected: Goal Resident #1 will remain at current level of function. Interventions included resident required mechanical lift with two staff assistance for transfers; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- limited physical mobility related to sarcopenia. The care plan reflected: Goal: Resident will demonstrate the appropriate use of Mechanical lift with staff assistance x2 to increase transfers. Intervention: Resident #1 is dependent on two staff for transfers using Mechanical Lift due to inability to bear weight at this time due to generalized weakness. - an actual fall on 12/31/24. The care plan reflected: Goal: Resident will resume usual activities without further incidents. Interventions: Monitor/document/report as needed for 72 hours to physician signs and symptoms of pain, bruises, change in mental status, New Onset, confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks per facility protocol. Provide care staff Inservice training related to Mechanical Lift/Mechanical lift sling utilization. Send to emergency room for evaluation post fall; and - an alteration in musculoskeletal status related to a fracture of the thoracic spine T12 due to a fall from a mechancial life. The care plan reflected: Goal: Resident will remain free from pain or level of discomfort acceptable to resident (specify using pain scale). Interventions included: anticipate and meet needs. Be sure call light within reach and respond promptly to all request for assistance. Give analgesics as ordered by physician. Monitor and document side effects for side effects and effectiveness. Monitor document for risk of falls. Educate resident/family/caregivers on safety measures that need to be taken to reduce the risk of falls. Record review of Resident #1's progress notes entered by LVN L on 12/31/24 at 6:40 PM reflected: Around 5:40 pm when this nurse doing documentation in nursing station shift CNA called to resident room noted resident on the floor with right side lateral position according to shift CNA during Mechanical lift sling are broke from right side of loop that time resident around 4 feet high she fall by right side of head this nurse did head to toe assessment noted resident have right side of upper back bruise with bump and forehead also bump noted resident vitals Blood pressure =109/57, pulse=88, oxygen=98% resident holding her head face scale [NAME] pain level was 5 usually resident are non verbal and confused status called Nurse Practitioner got new order sent emergency room called resident daughter she came facility before transfer to emergency room and notified DON called 911 they too her local hospital. Record review of Resident #1's progress notes entered by LVN L on 12/31/24 6:47 PM reflected: SBAR Summary for Providers. Situation: The Change in Condition reported on this CIC Evaluation are/were: other change in condition. With vitals at the time of evaluation were: Blood Pressure 107/57. Position lying left/arm. Pulse 70. Pulse Type Regular, Respiratory Rate 18 Record review of Resident #1's progress notes entered by LVN Z on 12/31/24 11:45 PM reflected: Resident returned to unit after emergency room visit due to fall. Resident did not have dinner or evening meds. Hospital paperwork indicates she has a Hematoma of the scalp and a compression fracture of T12 vertebra. Zofran and Morphine were give at 9:00 at the hospital. Resident fell asleep shortly after being put to bed Record review of Resident #1's hospital discharge reflected on 12/31/24 at 6:21 PM Resident #1 presented with: fall from Mechanical lift approx. 4ft onto tile flooring; +head strike, -thinner, -LOC, baseline GCS 14; strike to right posterior and side of head; patient is nonverbal due to late-stage dementia; patient grimacing on right hip with moving to stretcher. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The hospital discharge record further reflected: History of Present Illness 6:21 PM Resident #1 is a [AGE] year old female, with history of dementia, COPD, hypertension, and hypercholesteremia, presenting to the emergency department via Emergency Medical Services with fall onset this afternoon. She was brought in from nursing home facility. She was in a mechanical lift in the air when the strap broke and she fell four feet onto tile flooring, landing on her right posterior hip and right side of her head head first. She did not lose consciousness. Her daughter provided a video of the incident. Patient is largely nonverbal, but uttered ow after the event. She is able to say words, but does not answer questions, GCS 14, This is her baseline per family, but she states the patient seems like she is in pain. Emergency Medical Services notes that she grimaced when her right hip was handled. She is not anticoagulated. No further complaints raised at this time. Record review of the radiology report for Resident #1 reflected: Suspected acute compression fracture of the T12 vertebral body with approximately 10% vertebral body height loss. No bony retropulsion. Record review of the facility's Provider Investigation Report dated 01/07/25 reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Head to toe skin assessment, pain assessment and pain monitoring. Assessment included bruising to the upper back and forehead hematoma. Both CNAs that were involved with the transfer were suspended pending an investigation. The resident was immediately sent to the hospital for further evaluation and treatment. The resident's family and physician were notified of the incident. On 12/31/24 CNA F, and CNA G went to [Resident #1's] room to transfer her from her bed to her wheelchair so she could sit up and assisted while eating dinner. Both aides helped position Resident in the sling and hooked the sling loops to the mechanical lift arm, one aide on each side of the bed. CNA F was on [Resident #1's] right side and secured the right side sling straps inside the hooks of the mechanical lift arm, while CNA G was on [Resident #1's] left side and secured the left-side sling straps inside the hooks of the mehancial lift arm. CNA G then proceeded to operate the mechanical lift, raising resident in the air off the bed from the left side of the A bed into the space between the A and B beds. While this occurred, CNA F had moved from the right side of the bed to move [Resident #1's] wheelchair around to the left side of the bed (this side the lift was being operated from) and she was standing behind the wheelchair waiting fo the lift to lower resident into the wheelchair. Before CNA G could lower the resident in the lift, the right side sling strap loop broke, causing [Resident #1] to fall backwards toward her right shoulder and then to the ground on her right side. CNA F being towards the foot of the bed and closest to the door, immediately left the room to get the nurse who was right outside the resident's room by the nurse substation. The nurse came into the room, assessed [Resident #1] and called 911 for her to be sent out. [Resident #1] was transferred out by Emergency Medical Services around 7pm and taken to the hospital. She was diagnosed with a scalp hematoma with no intercranial hemorrhage and a T12 compression fracture. She returned to the nursing home facility around 11:45 PM the same evening with no new orders. [Resident #1] is being monitored continually for and adverse effects of the fall. Upon further investigation CNA F stated there were multiple loops on each of the 4 straps and at least 1 broken loop on one of the straps. However, the other loop(s) were intact and looked okay. She stated during interview, she didn't want to try and find another sling because she was in a hurry to get Resident #1 up for dinner. Since the green loops were not ripped or torn, CNA F felt they would be safe to use and told CNA G during the setup for the transfer to use the green loops. Staff have been in-serviced/re-educated on sling safety, ensuring the slings are not ripped or torn, and how to properly secure the loops on the mehanical lift, and the process of taking slings out of service. Nursing staff have also completed observation checkoffs on proper mechanical lift transfers with a one-on-one return demonstration. All slings in the building were inspected and any that were frayed, torn , or deemed unsafe have been discarded. Supply of replacement slings were ordered, and additional slings were ordered as backups. CNA G has received one-on-one training with return demonstration as well, and has returned to work after suspension. The facility has terminated CNA F, because she noticed the slings did not meet safe standards. And decided to continue to use the sling at resulted in an injury to [Resident #1]. Interview on 01/23/25 at 9:44 AM with Resident #1 was attempted; however, due to the resident's severe cognitive deficits the resident did not respond. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations on 01/23/25 between 9:50 AM and 10:44 AM of two additional transfers with ADON and Treatment Nurse observing CNA A, CNA B, CNA C and CNA D revealed each CNA inspecting the mechanical lift battery, sling connectors, ability to lift and lower, lock, legs to open and close. Each CNA held the mechanical lift sling in their hands looking down the seams and material for any worn, torn or thin spots in the material. Each CNA was observed checking and tugging the loops looking for cuts, open seams, or loose threads. CNAs were observed talking through their inspection of both the machine and the inspection of the mechanical lift slings. Observation revealed they worked together as a team to ensure throughout the transfer the resident felt secure and safe. Staff was heard stating what color loops they were using and double checked to ensure the hooks were secure with the loops. Communicated when to lift, lower, and when to reposition. Observation of the ADON and Treatment Nurse to step in with moving furniture if needed. Interview on 01/23/25 at 10:36 AM with ADON and Treatment Nurse revealed all nursing management were trained, then management trained nursing staff to include nurses and certified nursing assistants. The Treatment Nurse stated staff was inserviced and trained on mechanical lift maintenance, sling maintenance, safe transfers, and completed a check off list step by step on transferring residents. The ADON stated monitoring was still ongoing, spot checks were completed by management staff daily. The ADON and the Treatment Nurse stated during their observations of transfers there has not been any resident concerns when a mechanical Lift was used. Record review of CNA F statement dated 12/31/24 reflected: We were using the mechanical lift on [Resident #1]to get her up for dinner. I was on the side of the bed closest to the wall and CNA G was on the other side controlling the mechanical lift remote. We put the sling under her and fastened the loops on the green loop at her shoulders. Both of us used the green loop. The mechanical sling had a loop that were already ripped, I think it was the blue loop, and that is why we used the green loop. I knew the sling had a broken loop, but I did not go try to find another mechanical lift sling because I was in a hurry to get [Resident #1] to dinner. I stood by the side of the bed and assisted the lift into the air until CNA G moved the resident over to the middle of the beds. I came around to the middle of the room to push the wheelchair underneath the resident and the right shoulder loop snapped causing the sling to release from the clamp and the resident fell out of the sling onto the floor. She landed on the leg of the mechanical lift's closest to the window. I went and got the nurse at that time. The statement was signed by CNA F. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/23/25 at 1:04 PM with CNA F revealed she worked with Resident #1 on 12/31/24 as her aide on 2:00-10:00 PM shift when she was told by LVN L to get Resident #1 up and in the dining room for lunch. CNA F stated LVN L refused to assist with the transfer, and she had to find someone to assist her with the mechanical lift transfer. CNA F stated it had taken her 15 minutes to locate help and they nurse was yelling to get Resident #1 to the dining room. CNA F stated Resident #1 had a sling in her room that had been used that morning, CNA F stated she informed LVN L that they sling was damaged but she acted as if she did not care, Obviously the prior shift used the mechanical lift sling for breakfast, and they knew the loops were broken and they still used it. CNA F stated she proceeded with preparing Resident #1 for the transfer with the mechanical sling that was damaged at the loops. CNA F stated I hooked Resident #1 to the mechanical lift on the right side and CNA G hooked the left side. CNA F stated, after connecting Resident #1 to the mechanical lift CNA G lifted her and was pulling her out, I got the wheelchair, about to roll it under Resident #1 and the sling broke, it took me by surprise there was no pop or anything. CNA F stated, CNA G had control of the mechanical lift and I was guiding Resident #1, when I stepped away to grab the wheelchair, she came down headfirst towards me,. CNA F stated the transfer was staged in the middle of both beds A and B, the wheelchair was parked at the end of Bed B. CNA F stated by the time I had my hand on the wheelchair rolling it in front of her the loops broke on the right side, at her right shoulder, Resident #1 came down head first hitting the floor CNA F stated she then alerted LVN L. CNA F stated she observed swelling to Resident #1's forehead from the impact of the fall. CNA F stated she completed interview with the DON, re-enacted the incident, trained on mechanical lift transfers and was suspended, was later terminated. CNA F stated we used the same sling as the morning shift; we knew going into it that there were broken loops and there were no other slings available and the nurse was yelling at us to get her up CNA F stated she was responsible for inspecting and using properly working equipment, and that she was expected to report any broken equipment or when they did not have adequate supplies. CNA F stated not doing so placed Resident #1 at risk for accident and injury to happen. Record review of CNA G statement dated 12/31/24 I was in the room with CNA F, and we were trying to get Resident #1 into the wheelchair for dinner. The sling was under her, and I was controlling the control to the mechanical lift. I attached the green loop on my side of the patient after asking CNA F which color of loop to use. I was in the middle of the two beds when I started to move the patient toward the center of the room with the mechanical lift controller. I opened the mechanical lift's legs out wide, as the mechanical lift came out from underneath the bed and pushed the patient in the mechanical lift toward CNA F and the wheelchair. The mechanical lift's loop snapped that was on her right shoulder and she fell out of the sling and onto the ground. CNA F went to get the nurse to help get the patient looked at. Signed CNA G (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/23/25 at 1:34 PM CNA G revealed she was working the front hall while CNA F worked the back, she stated CNA F asked her to assist with mechanical lift transfer for Resident #1. CNA G stated, when I entered the room the mechanical lift sling was already under her, and we just needed to hook her to the machine. CNA G stated because I was new, I was asking her questions about the process, I was asking her what color loops we were using. CNA G stated they used green for the upper body and purple for the lower body. CNA G stated she checked her side to ensure the mechanical lift sling was hooked properly to the mechanical lift. CNA G stated she pulled the mechanical to align with the bed, lifted Resident #1 and opened the mechanical lift's legs. CNA G stated CNA F went for the wheelchair and as soon as she was about to put the wheelchair in front of Resident #1 I heard a snap and a bump, I was shocked Resident #1 was on the floor, I could see a bump forming on her forehead resulting from her falling head first. CNA F went to get the nurse. The sling was good, it was in good condition, I did not see anything wrong with the sling or straps. I looked at the colors to ensure I was using the right ones. CNA G stated she was inserviced by the DON and she reenacted the incident to show how the mechanical lift was used. CNA G stated she was suspended and upon return continued training to include mechanical lift transfers, inspecting machine and the sling yourself prior to use. CNA G stated it was her responsibility to look at the straps to ensure they were in good condition, and if not do not use the sling and to report it to the nurse or the DON. CNA G stated not doing so placed residents at risk of injury. Interview on 01/23/25 at 2:30 PM with LVN L revealed she was the nurse on duty during Resident #1's incident on 12/31/24. LVN L stated Resident #1 was a two person assist with use of a mechanical lift for transfers, she stated she was not in the room during the fall, however, was notified by CNA F that Resident #1 had fallen from the mechanical lift. LVN L stated she walked into the room and found Resident #1 on the floor laying on top of the mechanical lift machine legs, LVN L stated she could see that Resident #1 had an injury to the forehead, contacted DON, completed assessment, and called emergency services. LVN L stated she had not yelled or rushed aides to complete a transfer for Resident #1, she was not informed there was issues with the mechanical lift machine or the sling. LVN L stated she expected staff to alert her if there was any issues or concerns with resident transfers, she would not expect staff to use slings that were not in good condition. LVN L stated she was inserviced on mechanical lift transfers, inspecting mechanical lift slings, and demonstrated competency, LVN L further stated there should be two persons at all times to ensure the safety of resident during transfers especially with mechanical lift use. LVN L stated it was the responsibility of the aides or anyone doing a transfer to inspect the mechanical lift machine, mechanical lift slings to ensure its not damaged and if so, the sling should be reported to DON to have it replaced. LVN L stated if aides thought there was a problem she should be notified immediately, not doing so placed residents at risk of a fall or injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/23/25 at 1:40 PM Laundry Aide H revealed the mechanical lift slings were gathered with laundry off the halls in a barrel, sorted, washed and air dried in the dryer machine. Laundry Aide H stated after they air dry, she folded and delivered the slings to the linen closets on each hall. According to the Laundry Aide H it was the responsibility of the aides to check the sling prior to use, she stated before the incident she would just wash, and air dry in the machine, and delivered them to the floor. Laundry Aide did not address surveyor questions on having any responsibility to inspect, remove or report to management . Laundry Aide H stated she had been inserviced on mechanical lift sling inspection, the facility purchased new slings and created a numbering system to include all mechanical lift slings, the wash and dry system is the same however now the Laundry Aides were responsible for inspecting slings when they come through laundry. Laundry Aides were now responsible for inspecting and documenting the condition of each numbered sling, if one is damaged, frayed or not in good working condition the aide was to report it to the supervisor and the DON taking the damaged sling out of commission and replace it with a new sling. Record review of a form titled Transfer Safety dated 12/06/24 reflected: It is a requirement of your job to ensure we are always putting resident safety first. This is to include during transfers with a mechanical lift or gait belt. Ensure that all limbs (upper and lower) are in a safe place to prevent bruising, skin tears or general discomfort. If you are unsure of where placement should be, speak with the nurse or ADON's before proceeding with the transfer. If you have any further questions, please see the DON or ADON's. Signed by both CNA F and CNA G. Record review of facility policy dated 2024 titled Transfer Equipment/Devices - Includes Use of Slings Guidance reflected: Purpose: To promote safe resident transfers from one surface to another with proper functioning equipment/devices and attachments. Responsible Disciplines: Administrator, Director of Nursing, Maintenance Department staff, laundry staff, Therapy Department staff, Department head and Director Care (Licensed & Non-licensed) staff. Guidance: Slings should be entered into TELS [maintenance management application] system by Director of Maintenance, Administrator or designee when put into use. Slings should be tagged in some way/format with a number. Slings should then be entered into TELS or onto excel spreadsheet in the same process. When a sling is put into use: It should be tagged numerically and dated when it went into service, and this should be noted. Slings should be checked monthly by the maintenance staff. Slings should be checked for wear, tear, rips, broken straps, loose stitching, and the condition of where the sling is hooked to by the transfer lift. If any is worn, damage, it should be taken out of commission and new sling put into use. When a sling is noted with tears, rips, loose threads, broken straps it is to be taken out of commission and immediately reported/brought to Administrator, DON, Maintenance. 2. Record review of Resident #2's MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had a BIMS of 10 which indicate his cognition was moderately impaired. The MDS further reflected Resident #2 had functional limitation in range of motion on one side for both upper and lower extremities. Resident #2 had use of a wheelchair. Resident #2 required partial/moderate assistance with chair/bed-to-chair transfer. Diagnoses include dependence on Renal Dialysis (treatment used for kidney failure, helps remove extra fluid and waste from the blood when kidney is not able to function properly), and Type 1 Diabetes Mellitus. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's undated care plan reflected he had activities of daily living self-care performance deficit related to activity intolerance, Dementia, Impaired balance, Shortness of breath, weakness, Unsteadiness, Goal: Resident #2 will remain at current level of function. Interventions included resident uses wheelchair for mobility, able to use walker for short distances. Resident sometimes require two person assist due to fatigue or weakness. Resident requires one staff assist to move between surfaces. Resident #2 has Diabetes Mellitus, Type1 with the potential for abnormal blood sugar levels, poor wound healing and pain. Goal: The resident will have no complications related to diabetes. Interventions included Check all of body for breaks in skin and treat promptly as ordered by doctor. Diabetes medication/ insulin as ordered by doctor. Monitor/document for side effects and effectiveness. Dietary consult for nutritional regimen and ongoing monitoring. Record review of Resident #2's progress note dated 12/18/24 at 1:38 PM reflected: Fall Details : Date / Time of Fall: 12/18/2024 1:15 PM Fall was not witnessed. Fall occurred elsewhere. Other fall location: facility transportation van Activity at the time of fall: riding in the van The reason for the fall was not evident. Did an injury occur as a result of the fall:No. Did fall result in an ER visit/hospitalization : No. Provider Time notified: 12/18/2024 Notified of: Resident fall Fall Details Note:This nurse was notified of the resident's fall . The van driver states that the resident's wheelchair tipped over while he was driving , he and the resident states that the wheelchair was locked down and do not know how it fell over. Other furniture involved: No. Wheelchair was involved in fall. Wheelchair was not unlocked at time of fall. Were the wheelchair footrest(s) in the way: N/A. Resident was wearing oxygen as prescribed at time of fall. Resident was using incontinence supplies at the time of the fall. Record review of Resident #2's progress note dated 12/18/24 at 1:42 PM reflected: Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Falls At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 118/44 - 12/18/2024 13:38 Position: Lying r/arm - Pulse: P 70 - 12/18/2024 13:38 Pulse Type: Regular - RR: R 18.0 - 12/18/2024 13:38 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER: The Lodge of Saginaw Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE: 848 W McLeroy Blvd Saginaw, TX 76179	

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	- Temp: T 98.6 - 12/18/2024 13:38 Route: Forehead (non-contact) - Weight: W 281.0 lb - 12/17/2024 03:20 Scale: Mechanical Lift - Pulse Oximetry: O2 97.0 % - 12/18/2024 06:36 Method: Oxygen via Nasal Cannula - Blood Glucose: BS 119.0 - 12/18/2024 11:27 Outcomes of Physical Assessment : Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: No changes observed - Functional Status Evaluation: Fall Nursing observations, evaluation, and recommendations are: monitor resident's neuro checks. Primary Care Provider Feedback : Primary Care Provider responded with the following feedback: A. Recommendations: monitor resident Emergency Medical Services were not interviewed during the investigation. Observation and interview on 01/23/25 at 9:20 AM with with the Maintenance Director revealed the van was big enough for two passengers and demonstrated his expectations of the van driver when transporting residents. The Maintenance Director went to the back of the van and opened the two back doors and locked them in place to secure the doors would remain open while operating the ramp. He then lowered the ramp to the ground and locked it in place, then he pulled a strap from the right side of the ramp to the left side of the ramp. He stated, This strap was to keep residents from rolling off the ramp while the ramp is lifted. The Maintenance Director then walked around the van to the passenger section of the van, stating once in the van, you will roll resident inside the passenger section and hook them to the tie downs on the floor board. The Maintenance Director then pick up a tie down and hooked it into the floor board and turning the spindle and pulling it to show it is locked into place. The Maintenance Director then explained that once the tie downs were secure in the floor the straps were hooked to the wheelchair. According to the Maintenance Director, 4 tie downs per wheelchair, he then pulled and demonstrated the seat belt will then hook to the tie down and pull across the resident keeping them secure during the transport. The Maintenance Director stated after the incident with Resident #2 the Van Driver was inserviced and retrained on safely and transporting residents on 01/02/25. The Maintenance Director stated the facility purchased eight new straps, he inspected the van, regional staff came to inspect the van and after review there were no findings as to what happened to cause Resident #2 to tilt during the turn. The Maintenance Director stated the van was checked monthly by himself, the driver and the shop if needed. This document was requested however not provided prior to exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge of Saginaw Health and Wellness	848 W McLeroy Blvd Saginaw, TX 76179

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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 - Some	Interview on 01/23/25 at 9:34 AM with Resident #2 revealed he was headed to dialysis on 12/18/25 when he tilted out of the wheelchair and ended on the floor of the transportation van. Resident #2 stated he could not recall anything specific that would have caused him to tilt out of his wheelchair. Resident #2 stated after the fall he did not have any injuries or pain, he was checked by emergency medical providers on the side of the road, the facility and eventually went to the hospital for an evaluation. Resident #2 stated the Van Driver was a safe driver, and he had gone on the van since the incident and felt safe to do so. Observation on 01/23/25 at 10:00 AM of the Van Driver prepared to transport Resident #3 to an appointment revealed he followed the expectation of the Maintenance Director by ensuring Resident #3 was secure in the wheelchair, when rolled onto the ramp the straps were secure in keeping her from rolling off the ramp. The Van Driver then rolled Resident #3 to the front of the van, ensured she was in secure spot to administer four straps from the tie-down locks in the floorboard. The Van Driver then administered the seat belt across Resident #3 and then attempted to rock the wheelchair and pull-on straps to ensure safety for the resident. Interview on 01/23/25 at 1:48 PM with the Van Driver revealed he had been driving for at least an hour heading to his stop taking Resident #2 to his dialysis appointment. The Van Driver stated he heard a loud popping noise, and when he looked back he saw Resident #2 and his chair moving. The Van Driver stated he attempted to grab Resident #2 to prevent him from falling over but could not grab him and maintain the vehicle so he pulled over to the side of the road. The Van Driver stated he saw Resident #2 fall over on the floor of the van with his wheelchair on top of his feet. The Van Driver stated The seat belt had came off; however the straps were still locked and in place, connected to the wheelchair, they had him pinned under the wheelchair. The Van Driver stated I could only assume something went wrong with the straps. The Van Driver stated he asked if Resident #2 was ok and called 911. The Van Driver stated Resident #2 replied he was ok. Emergency Medical Services and the police came to the van while parked on the side of the road and evaluated Resident #2, at this time Resident #2 refused to transport to the hospital, therefore was transported back to the facility. The Van Driver stated I always checked the spindle, the strap and always shake the wheelchair to ensure it can not move. The Van Driver stated he was inserviced on checking the tie downs and straps prior to transporting residents. The Van Driver stated it was his responsibility to ensure residents are transported safely and that meant to make sure all equipment worked properly, not doing so placed residents at risk of accidents. Interview on 01/23/25 at 2:40 PM with the DON revealed she was notified by nursing staff Resident #1 had fallen from the mechanical lift and was injured. The DON stated she responded by sending Resident #1 out to the hospital. The DON stated investig [TRUNCATED]