Printed: 05/18/2024 Form Approved OMB No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER Slaton Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 630 S 19th Slaton, TX 79364 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | | | en policies and procedures that five residents whose records were distration when CNA A and CNA B und sustaining a fracture. The portable allegations are not experienced by the procedure of the effort. Resident does none as was required for the resident to the resident to the procedure of the effort. Resident does none as was required for the resident to the procedure of the effort. |

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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Facility ID: 675496

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 | |
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| NAME OF PROVIDER OR SUPPLIER Slaton Care Center | | STREET ADDRESS, CITY, STATE, ZI 630 S 19th Slaton, TX 79364 | P CODE | |
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| (X4) ID PREFIX TAG | X TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | on) | |
| F 0607 Level of Harm - Minimal harm or potential for actual harm | -Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: further decline in function, anxiety, and immobility. Resident requires total dependance for mobility. | | | |
| Residents Affected - Few | Record Review of Resident #1's Pt 1/10/23-2/8/23, revealed: | nysical Therapy Evaluation, dated 1/10 | /23 for certification period: | |
| | -Clinical Impressions: Pt with recer and safety. | at UTI with need for antibiotics. Pt with | noted deficits in strength, balance, | |
| | -Reason for Skilled Services: Skille | d PT services are warranted to assess | functional abilities, promote safety | |
| | awareness, enhance rehab potenti abilities, | al, increase coordination, improve dyna | amic balance, enhance fall recovery | |
| | increase functional activity tolerance, increase LE ROM and strength and minimize falls in order to e patient's | | | |
| | quality of life by improving ability to | perform functional mobility w/less risk | for falls. | |
| | -Risk Factors: Due to the documen at risk for: | ted physical impairments and associat | ed functional deficits, the patient is | |
| | falls, further decline in function and | immobility. | | |
| | -Skilled Intervention Focus = Resto | oration, Compensation | | |
| | Record review of Resident #1's care plan dated 02/13/23 indicated she had a Focus are Performance Deficit with weakness and poor safety awareness. The goals included, will current level of function in bed mobility transfers, eating, dressing, toilet use, and Persor the review date. Interventions for Resident #1 included: Transfer: The resident requires aid for transfers. The resident requires mechanical lift and 2 CNAs for transfer. | | | |
| | nurse name, revealed that the resid | led Resident #1's Nurses note on 3/11, dent had a fall on 3/10/23 when 2 facilit ower chair; and Resident #1 had bruisir | y staff members were transferring | |
| | (continued on next page) | | | |
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| | | | 110. 0736-0371 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | on) |
| Evel of Harm - Minimal harm or potential for actual harm Residents Affected - Few | during a transfer by CNA A, CNA B required during the transfer. The Al staff involved (CNA A, CNA B, MA are required to report all falls to the The ADM stated that all staff, includincluding Hospice staff are aware a The ADM stated that on 3/11/23, R ankle and an x-ray revealed a right investigate how the resident fractur resident was transferred on 3/10/23 performed by CNA A, CNA B, MA areported immediately and staff faile using the Hoyer lift as required. During an interview on 3/28/23 at 9 after she began investigating Resident #1 had a fracture on her resident #1. The DON stated Resistated there were Hoyer lifts availal Resident #1. The DON stated Resistated there were Hoyer lifts availal Resident #1. The DON stated CNA Hoyer, Resident #1 went to the grostated she was told by CNA B Resisted she was told by CNA B Resisted she was told by CNA B Resisted the told was also in the room by one of the CNAs. The DON stated Resisted she was told by CNA B Resisted the revealed as fractur to the ground, they should have not lift went to the ground, they should have after the nurse assessed Resident had bruises and swelling to her right was ordered that revealed a fractur Hospice and the physician ordered she questioned Resident #1 about said it occurred during the transfer. the Hoyer lift and to report any incic witnessed, or not witnessed. The Dresident was a Hoyer lift and they we staff (CNA A, CNA B and MA) were During an observation and attempte in her bed with a blanket covering | n interview on 3/28/23 at 9:30 a.m. the ADM stated that on 3/10/23 Resident #1 had an assistant and transfer by CNA A, CNA B, MA and the Hospice CNA and that they did not use a Hoyer lift during the transfer. The ADM stated that the fall was not reported to the nurse on shift by an lived (CNA A, CNA B, MA and Hospice CNA). The ADM stated that all staff, including Hospice to report all falls to the nurse and not to move a resident until a nurse assesses the Rest stated that all staff, including Hospice staff are trained to report falls to the nurse and all st Hospice staff are aware and trained that Resident #1 requires a two person assist with Hoy I stated that on 3/11/23, Resident #1 was found with bruising and swelling on Resident #1's d an x-ray revealed a right heel fracture. The ADM stated that the DON immediately started the how the resident fractured her right heel and during that investigation it was determined to was transferred on 3/10/23 without a Hoyer lift and had an assisted fall during the transfer d by CNA A, CNA B, MA and the Hospice CNA. The ADM stated that the fall should have be immediately and staff failed to follow their training by not notifying the nurse immediately are | |

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(continued on next page)

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| | .a.a 50.7.665 | | No. 0938-0391 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
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| (X4) ID PREFIX TAG | REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | on) |
| F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Resident #1's room. The CNA A staroom stating she needed to shower Resident #1 from her wheelchair to think it was a good idea, but she as the ground when they stood Reside The CNA A stated the Hospice CNA transfer. The CNA A stated the Hos MA came into the room and all 4 of to lift Resident #1 into the shower of shower and Resident #1 had stated report the assisted fall to the nurse was outside Resident #1's room and CNA A stated Resident #1's room and CNA A stated Resident #1 required A the Hoyer lift provides a safe med weight on her legs for a long time a not using the Hoyer lift could result she has been trained on reporting for resident falls which could turn into it to report it and she has injuries. During an interview on 3/28/23 at 1 lift due to safety and that Resident Rehab stated that when the rehabilit down to stand up movements with stated staff are trained to use the Hehabilitation stated that the risk of The Director of Rehabilitation stated that it is possible Rehabilitation stated that it is possible Rehabilitation stated that if a staff resident if a | 1:25 a.m. with CNA A stated on 3/10/2 ated Resident #1 was in her wheelchair Resident #1. The CNA A stated CNA the shower chair without the Hoyer lift esisted CNA B. The CNA A stated during and both CNA A and CNA B. A was prepping for Resident #1's show spice CNA called out in the hall to the N them (CNA A, CAN B, MA, and Hospichair. The CNA A stated the Hospice C is she was really tired after the transfer. because she didn't think to notify anyod she had been trained Resident #1 with a Hoyer lift because staff cannot lift he hod to lift and transfer Resident #1 beind was unable to walk or transfer hers in a resident having a fall that could refalls, Hoyer lifts, transfers, and Resident in a resident having a fall that could refalls, Hoyer lifts, transfers, and Resident in a resident having a fall that could refalls, Hoyer lifts are refalls, Hoyer lifts are an experienced with the Director of Rehab; set and there are 2 Hoyer lifts avait on the using a Hoyer lift included falls, fraction department worked with Reside two rehabilitation department staff assistely. The Director of Rehabilitation state in the fracture occurred during transformember witnesses another staff not using diately report to the charge nurse, Director it. | r and the Hospice CNA entered the B stated they would transfer. The CNA A stated she did not ag the transfer Resident #1 went to assisted the resident to the ground. Her and did not assist with the MA for help. The CNA A stated the ce CNA) each grabbed onto a limb NA then took Resident #1 for a The CNA A stated the Hoyer lift as a 2-person life with a Hoyer. The er properly without the lift. The CNA cause Resident #1 cannot bare left. The CNA A stated the risk of sult in an injury. The CNA A stated the risk of sult in an injury. The CNA A stated the risk of sult in an injury. The CNA A stated in eglected Resident #1; we failed that the Resident #1 is a Hoyer is not stand well. The Director of ant #1, she had a hard time doing sit sting. The Director of Rehabilitation illable in the facility. The Director of actures, tears, or employee injuries. In the staff involved in the erson transfer with the use of the fer or fall. The Director of and Hoyer lift on a resident who |

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| streets for Medicale & Medicala Sci vices | | No. 0938-0391 | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC | EFICIENCIES d by full regulatory or LSC identifying information) | |
| F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | #1's room with CNA A assisting Recame in and stated she needed to CNA B stated Resident #1 was in In the shower chair. The CNA B state arms to lift her while the hospice Cl during that transfer, Resident #1 m ground and she and CNA A assiste hallway and asked the MA to come Hospice CNA, and the MA all grabil stated that the shower chair moved that Resident #1 requires two peoplift in the hallway and they were in a use the Hoyer, I know it was wrong shower and bathe her. The CNA B the MA took Resident #1 to bathe. to the ground and did not have a reshould have reported to the nurse, to move a resident during an assist that she has been trained on Resid Hoyer lift. The CNA B stated that R bathing. The CNA B stated that R bathing. The CNA B stated that on she attempted incontinence care at the nurse about the fall the previou or using a Hoyer lift. I don't know w We didn't want that to happen to be got hurt. It makes me cry to know v During an interview on 3/28/23 at 1 hallway and heard someone call ou Resident #1's room he observed R room. The MA stated he knew that #1 on the floor and he assisted CN attempted to put her in the shower was assisted by them again to the shower chair for the Hospice CNA notify the nurse if a resident has a fassesses the resident. The MA stated has assesses the resident. The MA stated has a sasesses the resident. | During an interview on 3/28/23 at 1:31 p.m. with CNA B; stated that on 3/10/23 she was working in Resis #1's room with CNA A assisting Resident #1's roommate to bed. The CNA B stated that the Hospice CN came in and stated she needed to shower Resident #1 and entered the room with the shower chair. The CNA B stated that she needed to shower Resident #1 and entered the room with the shower chair. The CNA B stated that she and CNA A and CNA B decided to transfer Resident # the shower chair. The CNA B stated that she and CNA A stood behind Resident #1 and used Resident # arms to lift her while the hospice CNA attempted to pull down Resident #1's pants. The CNA B stated that during that transfer, Resident #1 must have gotten tired being in a standing position and started going to ground and she and CNA A assisted Resident #1 to the ground. The CNA B stated she then stepped into hallway and asked the MA to come and assist with Resident #1, stating that then they CNA A, CNA B, Hospice CNA, and the MA all grabbed one of Resident #1's limbs to transfer her to the shower chair. CNA stated that the shower chair moved but they were able to get Resident #1 in the shower chair. CNA B stated that the shower chair word but they were able to get Resident #1 in the shower chair. CNA B stated there was a Hilfi in the hallway and they were in a hurry and chose not to use it. CNA B stated, I don't know why we die use the Hoyer, I know it was wrong. We were just trying to hurry up and help the hospice lady so she cool shower and bathe her. The CNA B stated after Resident #1 was in the shower chair, she left the room, a the MA took Resident #1 to bathe. The CNA B stated she never reported to the nurse that Resident #1 was halved have reported to the nurse, and she is trained to do so. The CNA B stated that staff are not suppto move a resident during an assisted fall because the nurse needs to assess for injuries. The CNA B stated that Resident #1's care plan and did not follow the plan when she did not use a Hoyer lift. I don't know | |

(continued on next page)

notify the nurse after a fall and to use the Hoyer lift.

During an interview on 3/28/23 at 2:06 p.m., Corporate nurse stated staff should have used a Hoyer and 2 people assist with Resident #1. Corporate nurse stated that staff should have reported when Resident #1 went to the ground. Corporate nurse stated that CNA A, CNA B, and MA were trained during orientation to

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|---------------------------------------|---|--|--|--|
| AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | A. Building | COMPLETED | |
| | 675496 | B. Wing | 03/28/2023 | |
| NAME OF PROVIDER OR SUPPLIE | ER | STREET ADDRESS, CITY, STATE, ZI | P CODE | |
| Slaton Care Center | | 630 S 19th Slaton, TX 79364 | | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey a | agency. | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC | EFICIENCIES If by full regulatory or LSC identifying information) | | |
| F 0607 | During a phone interview on 4/4/23 | at 9:41 a.m. the Hospice CNA stated t | hat she was working at the facility | |
| | | nt #1's room to prepare her for a show | | |
| Level of Harm - Minimal harm or | | CNA A and CNA B in the room assisti | • | |
| ootential for actual harm | | ed with Resident #1 five times before 3 | | |
| | | nd 2 persons for all transfers and lifting | | |
| Residents Affected - Few | | he lift and the CNA A and CNA B lifted | | |
| | and she attempted to pull down Resident #1's pants before they transferred her to the shower chair. The | | | |
| | | ent went to the ground, and they assiste | | |
| | I . | ah sound when she was on the ground. | • | |
| | | ney (CNA A, CNA B, MA, and herself) li | | |
| | | in the shower chair. The Hospice CNA | | |
| | | not remember the resident going to the #1 to bathe and during the bathing, Re | | |
| | | called her supervisor and notified her t | · · | |
| | · | • | | |
| | about heel pain, and she was advised to check for pressure sores. The Hospice CNA stated that she did not observe any pressure sores and Resident #1 stated her heel hurt on the inside, not on the skin. The Hospice | | | |
| | CNA stated she did not report the fall to any one at the facility and waited several days before reporting to | | | |
| | her agency. The Hospice CNA stated that she thought she told a facility charge nurse that Resident #1 | | | |
| | complained about her heal hurting but does not remember who or when she notified someone at the facility. | | | |
| | The Hospice CNA stated she had been trained to immediately notify a nurse when a resident has a fall or | | | |
| | goes to the ground because a nurse has to assess a resident for injuries. The Hospice CNA stated that she | | | |
| | also knew Resident #1 required a Hoyer lift but went under the direction of the facility CNAs during the | | | |
| | | that by not following the care plan that s | | |
| | person transfer with Hoyer lift, it placed the resident at risk of falls and injuries. The Hospice CNA stated she | | | |
| | was not aware that Resident #1 fractured her right ankle until the facility contacted the hospice agency and notified them of the incident. | | | |
| | During a phone interview on 4/4/23 | with Hospice LVN; stated that the Hos | pice CNA called her on 3/10/23 t | |
| | , , | nat her right heel was hurting, and she(| • | |
| | | | | |
| | for pressure ulcers or sores. The Hospice LVN stated she never got back with the Hospice CNA to determine if there were any pressure ulcers or sores. The Hospice LVN stated that the Hospice CNA never informed | | | |
| | | • | • | |
| | her that Resident #1 had an assiste | ed fall during a transfer, nor did the Hos | spice CNA inform her that a trans | |
| | her that Resident #1 had an assiste was done without the Hoyer lift. The | • | spice CNA inform her that a trans CNA has been trained that | |

-Employees must report suspected abuse, neglect, mistreatment, or injury of unknown origin of a potential

Record review of the facility's Abuse, Neglect policy dated 05/2017 indicated neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that is necessary to

Hospice CNA should not have participated in a transfer of Resident #1 without utilizing the Hoyer lift as required. The Hospice LVN stated she was notified of the incident that occurred on 3/10/23 by the facility and that Resident #1 had a fractured right heel. The Hospice LVN stated that the Hospice CNA was trained prior to 3/10/23 that Resident #1 required a 2 person transfer and Hoyer lift, to notify both the facility nurse and the

victim immediately to the DON and Administrator.

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hospice agency of any resident falls and not to move a resident who has had a fall.

avoid physical harm, pain, mental anguish, or emotional distress.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | ion) |
| F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | | | the allegation: Failure to follow unknown origin. A X 4 cm, dark purple bruising rt B and Hospice CNA transferred nsfer they struggled, and resident ower chair. Stigation. Written disciplinary action coaching for not reporting the ers, mechanical lift,. In-services on buse, neglect and injury of A revealed the following completed Bed to Wheelchair using a transfer nsferring; Abuse, Neglect and B revealed the following completed traint Alternatives; Lifting Machine, ion; Transferring from a Bed to ad Transferring revealed the following completed traint Alternatives. |

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| | EK | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| Slaton Care Center | | 630 S 19th Slaton, TX 79364 | | |
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| (X4) ID PREFIX TAG | (4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENT (Each deficiency must be preceded by full | | on) | |
| F 0609 | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. | | | |
| Level of Harm - Minimal harm or potential for actual harm | **NOTE- TERMS IN BRACKETS H | IAVE BEEN EDITED TO PROTECT C | ONFIDENTIALITY** 43849 | |
| Residents Affected - Few | Based on observation, interview and record review, the facility failed to ensure an allegation of negle reported immediately but not later than 24 hours after the allegation was made for 1 of 5 residents (F #1) reviewed for reporting. | | | |
| | | port an allegation of neglect when CNA loyer lift and the resident fell to the gro | | |
| | This failure could affect residents b reported timely after they are disco | y placing them at risk of abuse if the revered. | eportable allegations are not | |
| | Findings included: | | | |
| | Record review of a face sheet dated indicated Resident #1 was an [AGE] year-old female admitted facility initially on 01/20/2021. Her diagnoses were Type 2 diabetes, Unspecified dementia, Hypoth Major Depressive disorder, and Hypertension. Record review of a Resident #1's quarterly MDS dated [DATE] indicated a BIMS of 4 indicating a s cognitive impairment. Her bathing self-performance indicates a score of 4 indicating total depender chair/bed to chair mobility: the ability to transfer to and from bed to chair (or wheelchair) indicated a 01 and documents that she was dependent: Dependent - Helper does ALL of the effort. Resident of the effort to complete the activity. Or the assistance of 2 or more helpers was required for the recomplete the activity. | | | |
| | | | | |
| | Record Review of Resident #1's Occupational Therapy Evaluation, dated: 1/12/23 for certification period: 1/12/23-2/10/23, revealed: | | | |
| | -Clinical Impressions: Decreased mobility and function | | | |
| | -Reason for Skilled Services: Patient requires skilled OT services to assess safety and (I) with ADLs, increase safety | | | |
| | awareness and minimize safety hazards/barriers. | | | |
| | -Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: further decline in function, anxiety, and immobility. Resident requires total dependance for mobility. | | | |
| | Record Review of Resident #1's Physical Therapy Evaluation, dated 1/10/23 for certification period: 1/10/23-2/8/23, revealed: | | | |
| | -Clinical Impressions: Pt with recent UTI wiht need for antibiotics. Pt with noted deficits in strength, balance, and safety. | | | |
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| F 0609 | -Reason for Skilled Services: Skille | ed PT services are warranted to assess | functional abilities, promote safety | |
| Level of Harm - Minimal harm or potential for actual harm | awareness, enhance rehab potential, increase coordination, improve dynamic balance, enhance fall recovery abilities, | | | |
| Residents Affected - Few | increase functional activity tolerand patient's | ee, increase LE ROM and strength and | minimize falls in order to enhance | |
| | quality of life by improving ability to | perform functional mobility w/less risk | for falls. | |
| | -Risk Factors: Due to the documen at risk for: | ted physical impairments and associate | ed functional deficits, the patient is | |
| | falls, further decline in function and | immobility. | | |
| | -Skilled Intervention Focus = Resto | oration, Compensation | | |
| | Record review of Resident #1's care plan dated 02/13/23 indicated she had a Focus area ADL Self-Care Performance Deficit with weakness and poor safety awareness. The goals included, will maintain, or improcurrent level of function in bed mobility transfers, eating, dressing, toilet use, and Personal hygiene throug the review date. Interventions for Resident #1 included: Transfer: The resident requires use of a mechanic aid for transfers. The resident requires mechanical lift and 2 CNAs for transfer. | | | |
| | nurse name, revealed that the resid | ded Resident #1's Nurses note on 3/11/ dent had a fall on 3/10/23 when 2 facilit ower chair; and Resident #1 had bruisir | y staff members were transferring | |
| | during a transfer by CNA A, CNA B required during the transfer. The Al staff involved (CNA A, CNA B, MA are required to report all falls to the The ADM stated that all staff, including Hospice staff are aware a The ADM stated that on 3/11/23, R ankle and an x-ray revealed a right investigate how the resident fracturesident was transferred on 3/10/23 performed by CNA A, CNA B, MA a | | | |
| | | | | |

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| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | P CODE |
| Slaton Care Center | | 630 S 19th Slaton, TX 79364 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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) | | on) |
| F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | after she began investigating Resic Resident #1 had a fracture on her resident #1 had a fracture on her resident #1. The DON stated Stated She felt Resident #1. The DON stated Resistated there were Hoyer lifts availa Resident #1. The DON stated CNA Hoyer, Resident #1 went to the grostated she was told by CNA B Resishospice aide was also in the room by one of the CNAs. The DON state Resident #1 into the shower chair at the staff involved should have not I went to the ground, they should ha after the nurse assessed Resident had bruises and swelling to her right was ordered that revealed a fractur Hospice and the physician ordered she questioned Resident #1 about said it occurred during the transfer. the Hoyer lift and to report any inciewitnessed, or not witnessed. The Direction of the control of the contro | 2.55 a.m., the DON stated when she be dent #1's right ankle fracture on 3/11/23 right ankle. The DON stated that during a transferring Resident #1 without the hat along with it. The DON stated this incit they were okay to not use Hoyer and it dent #1 is heavy set and cannot bare whole and there was no reason not to use ble and there was no reason not to use ble and after when they attempted to und and CNA A and CNA B assisted the dent #1 yelled out after she went to the and after the resident went to the grouned she was told by CNA A, CNA B, and and the Hospice CNA took Resident #1 without a Hoye called immediately for a nurse and with an analysis of the control of the tone of the tone of the state of the tone of the | 8. when she was notified that her investigation, CNA A told her doyer lift and CNA A had stated to dent occurred on 3/10/23. The would be easier not to use lift with weight during transfers. The DON a Hoyer lift as required with the transfer Resident #1 without the resident to the ground. The DON a ground. The DON stated the nd, the MA was called into the room of the MA then they assisted for her bath. The DON stated all of loyer lift and when Resident #1 waited to move Resident #1 until a reported on 3/11/23 Resident #1 ange. The DON stated an X-ray N stated Resident #1 was on of for Resident #1. The DON stated e hit her foot on the floor and also the MA all have been trained to use regardless of if it was assisted, and the Hospice CNA knew the N stated that all 3 of the facility |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIE Slaton Care Center | NAME OF PROVIDER OR SUPPLIER Slaton Care Center | | P CODE |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | on) |
| F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Resident #1's room. The CNA A staroom stating she needed to shower Resident #1 from her wheelchair to think it was a good idea, but she as the ground when they stood Reside The CNA A stated the Hospice CNA transfer. The CNA A stated the Hos MA came into the room and all 4 of to lift Resident #1 into the shower as shower and Resident #1 had stated report the assisted fall to the nurse was outside Resident #1's room an CNA A stated Resident #1's room an county in the Hoyer lift provides a safe met weight on her legs for a long time a not using the Hoyer lift could result she has been trained on reporting for resident falls which could turn into it to report it and she has injuries. During an interview on 3/28/23 at 1 lift due to safety and that Resident Rehab stated that when the rehabilit down to stand up movements with stated staff are trained to use the Hehabilitation stated that the risk of the Director of Rehabilitation stated that it is possible Rehabilitation stated that it is possible Rehabilitation stated that if a staff resident if a staff r | 1:25 a.m. with CNA A stated on 3/10/2 ated Resident #1 was in her wheelchair Resident #1. The CNA A stated CNA the shower chair without the Hoyer lift esisted CNA B. The CNA A stated during and both CNA A and CNA B. A was prepping for Resident #1's show spice CNA called out in the hall to the N them (CNA A, CAN B, MA, and Hospichair. The CNA A stated the Hospice C is she was really tired after the transfer. because she didn't think to notify anyod she had been trained Resident #1 with a Hoyer lift because staff cannot lift he hod to lift and transfer Resident #1 beind was unable to walk or transfer hers in a resident having a fall that could refalls, Hoyer lifts, transfers, and Resident in a resident having a fall that could refalls, Hoyer lifts, transfers, and Resident in a resident having a fall that could refalls, Hoyer lifts are refalls, Hoyer lifts are an experienced with the Director of Rehab; set and there are 2 Hoyer lifts avait on the using a Hoyer lift included falls, fraction department worked with Reside two rehabilitation department staff assistely. The Director of Rehabilitation state in the fracture occurred during transformember witnesses another staff not using diately report to the charge nurse, Director it. | r and the Hospice CNA entered the B stated they would transfer. The CNA A stated she did not ag the transfer Resident #1 went to assisted the resident to the ground. Her and did not assist with the MA for help. The CNA A stated the ce CNA) each grabbed onto a limb NA then took Resident #1 for a The CNA A stated the Hoyer lift as a 2-person life with a Hoyer. The er properly without the lift. The CNA cause Resident #1 cannot bare left. The CNA A stated the risk of sult in an injury. The CNA A stated the risk of sult in an injury. The CNA A stated the risk of sult in an injury. The CNA A stated in eglected Resident #1; we failed that the Resident #1 is a Hoyer is not stand well. The Director of ant #1, she had a hard time doing sit sting. The Director of Rehabilitation illable in the facility. The Director of actures, tears, or employee injuries. In the staff involved in the erson transfer with the use of the fer or fall. The Director of and Hoyer lift on a resident who |

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| | | | NO. 0938-0391 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
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| Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | came in and stated she needed to CNA B stated Resident #1 was in I the shower chair. The CNA B state arms to lift her while the hospice C during that transfer, Resident #1 m ground and she and CNA A assiste hallway and asked the MA to come Hospice CNA, and the MA all grabl stated that the shower chair moved that Resident #1 requires two peoplift in the hallway and they were in a use the Hoyer, I know it was wrong shower and bathe her. The CNA B the MA took Resident #1 to bathe. to the ground and did not have a reshould have reported to the nurse, to move a resident during an assist that she has been trained on Resid Hoyer lift. The CNA B stated that R bathing. The CNA B stated that R bathing. The CNA B stated that on she attempted incontinence care at the nurse about the fall the previou or using a Hoyer lift. I don't know w We didn't want that to happen to be got hurt. It makes me cry to know v During an interview on 3/28/23 at 1 hallway and heard someone call ou Resident #1's room he observed R room. The MA stated he knew that #1 on the floor and he assisted CN attempted to put her in the shower was assisted by them again to the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower was a stated the same continuous in the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower chair for the Hospice CNA notify the nurse if a resident has a state of the continuous in the shower chair for the Hospice CNA notify th | sident #1's roommate to bed. The CNA shower Resident #1 and entered the roler wheelchair and CNA A and CNA B d that she and CNA A stood behind Re NA attempted to pull down Resident #1 ust have gotten tired being in a standing the Resident #1 to the ground. The CNA and assist with Resident #1, stating the and assist with Resident #1, stating the done of Resident #1's limbs to trans a but they were able to get Resident #1 let to transfer and the use of a Hoyer lift a hurry and chose not to use it. CNA B we were just trying to hurry up and h stated after Resident #1 was in the shaften that have the stated after Resident #1 was in the shaften that have the stated after that have the nurse needs to assent #1's care plan and did not follow the esident #1 relies on staff to do all trans 3/11/23 she observed bruising and swind that is when she notified the nurse of so day. The CNA B stated that neglect is hy we didn't use the Hoyer. I feel bad. For Every time I think about it, I feel awfive did that, and she got hurt. 150 p.m. with the MA, stated that he was this name to Resident #1's room. The esident #1 on the floor and CNA A, CNA Resident #1 was a Hoyer lift but didn't A A, CNA B and the Hospice CNA lift if chair. The MA stated that the shower of floor. The MA stated that the shower of floor is on the ground and not be worted by the stated that the power of the balliance are after that the shower of the properties of the stated that the worted the balliance are after that the shower of the properties of the stated that the shower of the properties of the stated that the shower of the properties of the stated that the shower of the s | som with the shower chair. The decided to transfer Resident #1 to esident #1 and used Resident #1's 's pants. The CNA B stated that g position and started going to the B stated she then stepped into the at then they CNA A, CNA B, fer her to the shower chair. CNA B in the shower chair. CNA B stated there was a Hoyer stated, I don't know why we didn't elp the hospice lady so she could ower chair, she left the room, and to the nurse that Resident #1 went a cCNA B stated she knows that she a stated that staff are not supposed to the nurse that Resident #1 went elpin when she did not use a sters, incontinence care and elling to Resident #1's ankle when of her observations but did not tell is not following a resident care plan thurt me to see Resident #1 hurt. The that we didn't use the lift and she working on 3/10/23 in the AB and Hospice CNA were in the think of that when he saw Resident #1 off the floor and chair slid back, and Resident #1 esident #1 up and placed her in the MA stated he has been trained to the resident until a nurse |

are any injuries.

(continued on next page)

notify the nurse after a fall and to use the Hoyer lift.

assesses the resident. The MA stated he believed one of the CNAs would have notified the nurse. The MA stated that the purpose of having a nurse assess a resident after a fall is for the nurse to determine if there

During an interview on 3/28/23 at 2:06 p.m., Corporate nurse stated staff should have used a Hoyer and 2 people assist with Resident #1. Corporate nurse stated that staff should have reported when Resident #1 went to the ground. Corporate nurse stated that CNA A, CNA B, and MA were trained during orientation to

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLII Slaton Care Center For information on the nursing home's (X4) ID PREFIX TAG F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by an 3/10/23 and walked into Resider walked into the room and observed Hospice CNA stated she had worked the Resident required a Hoyer lift a staff told her that they didn't need they and she attempted to pull down Resider CNA stated that the reside CNA stated that the reside CNA stated Resident #1 made a as MA was called into the room and the holding onto a limb and placed her back several inches, but she does a stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advis observe any pressure sores and Resident she was advisored to the stated that she was advisored to the stated she was ad | <u> </u> | agency. that she was working at the facility er. The Hospice CNA stated she ing another resident to bed. The 1/10/23 and had been trained that g. The Hospice CNA stated that Resident #1 from her wheelchair ed her to the shower chair. The ed her to the ground. The Hospice CNA stated that the ifted Resident #1 by each of them a stated the shower chair did go be ground again. The Hospice CNA stated that the right heel that the resident was complaining ospice CNA stated that she did not nside, not on the skin. The Hospice several days before reporting to |
|--|--|--|---|
| Slaton Care Center For information on the nursing home's (X4) ID PREFIX TAG F 0609 Level of Harm - Minimal harm or potential for actual harm | SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by an 3/10/23 and walked into Resider walked into the room and observed Hospice CNA stated she had worked the Resident required a Hoyer lift a staff told her that they didn't need they and she attempted to pull down Resider CNA stated that the reside CNA stated that the reside CNA stated Resident #1 made a as MA was called into the room and the holding onto a limb and placed her back several inches, but she does a stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advis observe any pressure sores and Resident she was advisored to the stated that she was advisored to the stated she was ad | 630 S 19th Slaton, TX 79364 tact the nursing home or the state survey of the state of the sta | agency. that she was working at the facility er. The Hospice CNA stated she ing another resident to bed. The 1/10/23 and had been trained that g. The Hospice CNA stated that Resident #1 from her wheelchair ed her to the shower chair. The ed her to the ground. The Hospice CNA stated that the ifted Resident #1 by each of them a stated the shower chair did go be ground again. The Hospice CNA stated that the right heel that the resident was complaining ospice CNA stated that she did not nside, not on the skin. The Hospice several days before reporting to |
| For information on the nursing home's (X4) ID PREFIX TAG F 0609 Level of Harm - Minimal harm or potential for actual harm | SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by During a phone interview on 4/4/23 on 3/10/23 and walked into Resider walked into the room and observed Hospice CNA stated she had worke the Resident required a Hoyer lift a staff told her that they didn't need the and she attempted to pull down Resident CNA stated Resident #1 made a as MA was called into the room and the holding onto a limb and placed her back several inches, but she does in stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advisionserve any pressure sores and Resident she was advisionserve any pressure sores and Resident she was advisionserved. | Slaton, TX 79364 tact the nursing home or the state survey. CIENCIES full regulatory or LSC identifying information of the state of | that she was working at the facility er. The Hospice CNA stated she ing another resident to bed. The 1/10/23 and had been trained that g. The Hospice CNA stated that Resident #1 from her wheelchair ed her to the shower chair. The ed her to the ground. The Hospice of the Hospice CNA stated that the ifted Resident #1 by each of them a stated the shower chair did go be ground again. The Hospice CNA esident #1 stated that her right heel that the resident was complaining ospice CNA stated that she did not niside, not on the skin. The Hospice several days before reporting to |
| (X4) ID PREFIX TAG F 0609 Level of Harm - Minimal harm or potential for actual harm | SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by During a phone interview on 4/4/23 on 3/10/23 and walked into Resider walked into the room and observed Hospice CNA stated she had worke the Resident required a Hoyer lift a staff told her that they didn't need the and she attempted to pull down Resident CNA stated Resident #1 made a as MA was called into the room and the holding onto a limb and placed her back several inches, but she does in stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advisionserve any pressure sores and Resident she was advisionserve any pressure sores and Resident she was advisionserved. | ciencies full regulatory or LSC identifying information at 9:41 a.m. the Hospice CNA stated to the first and the Hospice CNA stated to the first and CNA B in the room assisting at the first and the CNA B in the room assisting the lift and the CNA A and CNA B lifted the first and the CNA A and CNA B lifted the first and the ground, and they assisted the first and the ground, and they assisted the first and the ground, and they assisted the first and the first and the ground and they assisted the first and the first | that she was working at the facility er. The Hospice CNA stated she ing another resident to bed. The 1/10/23 and had been trained that g. The Hospice CNA stated that Resident #1 from her wheelchair ed her to the shower chair. The ed her to the ground. The Hospice of the Hospice CNA stated that the ifted Resident #1 by each of them a stated the shower chair did go be ground again. The Hospice CNA esident #1 stated that her right heel that the resident was complaining ospice CNA stated that she did not niside, not on the skin. The Hospice several days before reporting to |
| F 0609 Level of Harm - Minimal harm or potential for actual harm | During a phone interview on 4/4/23 on 3/10/23 and walked into Resider walked into the room and observed Hospice CNA stated she had worked the Resident required a Hoyer lift and she attempted to pull down Resident CNA stated Resident #1 made a as MA was called into the room and the holding onto a limb and placed her back several inches, but she does not stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advisionserve any pressure sores and Resident she was advisions. | full regulatory or LSC identifying information of the state of the sta | that she was working at the facility er. The Hospice CNA stated she ing another resident to bed. The 1/10/23 and had been trained that g. The Hospice CNA stated that Resident #1 from her wheelchair ed her to the shower chair. The ed her to the ground. The Hospice of the Hospice CNA stated that the ifted Resident #1 by each of them a stated the shower chair did go be ground again. The Hospice CNA stated that he right heel that the resident was complaining ospice CNA stated that she did not niside, not on the skin. The Hospice several days before reporting to |
| Level of Harm - Minimal harm or potential for actual harm | on 3/10/23 and walked into Resider walked into the room and observed Hospice CNA stated she had worked the Resident required a Hoyer lift at staff told her that they didn't need the and she attempted to pull down Resident CNA stated Resident #1 made a at MA was called into the room and the holding onto a limb and placed her back several inches, but she does a stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advis observe any pressure sores and Resident walked into the room and the stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advis observe any pressure sores and Resident. | nt #1's room to prepare her for a showed CNA A and CNA B in the room assistived with Resident #1 five times before 3 and 2 persons for all transfers and lifting he lift and the CNA A and CNA B lifted resident #1's pants before they transferred to went to the ground, and they assisted as sound when she was on the ground ney (CNA A, CNA B, MA, and herself) in the shower chair. The Hospice CNA not remember the resident going to the #1 to bathe and during the bathing, Recalled her supervisor and notified her tipsed to check for pressure sores. The Hoesident #1 stated her heel hurt on the interest with the sound sale was a shown to be some time to be seed to check for pressure sores. | er. The Hospice CNA stated she ing another resident to bed. The i/10/23 and had been trained that g. The Hospice CNA stated that Resident #1 from her wheelchair ed her to the shower chair. The ed her to the ground. The Hospice . The Hospice CNA stated that the ifted Resident #1 by each of them a stated the shower chair did go a ground again. The Hospice CNA esident #1 stated that her right heel that the resident was complaining ospice CNA stated that she did not nside, not on the skin. The Hospice several days before reporting to |
| | her agency. The Hospice CNA state complained about her heal hurting I The Hospice CNA stated she had be goes to the ground because a nurse also knew Resident #1 required a Heransfer. The Hospice CNA stated the person transfer with Hoyer lift, it play was not aware that Resident #1 francified them of the incident. During a phone interview on 4/4/23 notify her that Resident #1 stated the for pressure ulcers or sores. The Heif there were any pressure ulcers on her that Resident #1 had an assisted was done without the Hoyer lift. The Resident #1 requires a two-person Hospice CNA should not have partice required. The Hospice LVN stated stated that Resident #1 had a fractured right to 3/10/23 that Resident #1 required hospice agency of any resident falls. Record review of the facility's Abus facility, its employees, or service pavoid physical harm, pain, mental and service in the state of the service pavoid physical harm, pain, mental and service particles. | ted that she thought she told a facility of but does not remember who or when so been trained to immediately notify a nurse has to assess a resident for injuries. Hoyer lift but went under the direction of that by not following the care plan that saced the resident at risk of falls and injuried the right ankle until the facility of the work of the tright ankle until the facility of the work of the w | the notified someone at the facility. It is when a resident has a fall or The Hospice CNA stated that she of the facility CNAs during the stated that Resident #1 was a 2 uries. The Hospice CNA stated she contacted the hospice agency and spice CNA called her on 3/10/23 to (Hospice LVN) advised her to check with the Hospice CNA never informed spice CNA inform her that a transfer at CNA has been trained that The Hospice LVN stated that the thout utilizing the Hoyer lift as curred on 3/10/23 by the facility and the Hospice CNA was trained prior notify both the facility nurse and the had a fall. |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIER Slaton Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 630 S 19th Slaton, TX 79364 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | | | the allegation: Failure to follow unknown origin. X 4 cm, dark purple bruising rt B and Hospice CNA transferred asfer they struggled, and resident wer chair. Itigation. Written disciplinary action coaching for not reporting the rs, mechanical lift,. In-services on buse, neglect and injury of A revealed the following completed Bed to Wheelchair using a transfer sferring; Abuse, Neglect and B revealed the following completed raint Alternatives; Lifting Machine, on; Transferring from a Bed to d Transferring evealed the following completed raint Alternatives. |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by | CIENCIES full regulatory or LSC identifying informati | on) |
| F 0689 Level of Harm - Actual harm Residents Affected - Few | Ensure that a nursing home area is accidents. **NOTE- TERMS IN BRACKETS In Based on interview and record revisupervision and assistance devices. The facility failed to use a Hoyer lift in a fracture. This failure could result in decrease devices. Findings include: Record review of a face sheet date facility initially on 01/20/2021. Her of Major Depressive disorder, and Hy Record review of a Resident #1's of cognitive impairment. Her bathing is chair/bed to chair mobility: the ability of the effort to complete the activity complete the activity. Record Review of Resident #1's Of 1/12/23-2/10/23, revealed: -Clinical Impressions: Decreased in -Reason for Skilled Services: Patie increase safety awareness and minimize safety had -Risk Factors: Due to the document at risk for: further decline in function mobility. Record Review of Resident #1's Pf 1/10/23-2/8/23, revealed: | s free from accident hazards and provided AVE BEEN EDITED TO PROTECT Context, the facility failed to ensure each rest to prevent injuries for 1 of 5 residents at as indicated in Resident #1's care planted quality of life and risk of injury due to diagnoses were Type 2 diabetes, Unspected performance indicates a score of 4 ty to transfer to and from bed to chair (rependent: Dependent - Helper does ALI). Or the assistance of 2 or more helper accupational Therapy Evaluation, dated: | les adequate supervision to prevent ONFIDENTIALITY** 43849 sident received adequate (Resident #1) reviewed for injuries. In, during a transfer which resulted o lack of supervision and assistance year-old female admitted to the ecified dementia, Hypothyroidism, a BIMS of 4 indicating a severe indicating total dependence. Her or wheelchair) indicated a score of L of the effort. Resident does none as was required for the resident to 1/12/23 for certification period: es safety and (I) with ADLs, ed functional deficits, the patient is quires total dependance for /23 for certification period: |
| | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 | | |
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| NAME OF PROVIDED OR SUPPLIES | | CTREET ADDRESS CITY STATE 71 | D CODE | | |
| NAME OF PROVIDER OR SUPPLIE Slaton Care Center | ± κ | STREET ADDRESS, CITY, STATE, ZI 630 S 19th | PCODE | | |
| Staton Care Center | | Slaton, TX 79364 | | | |
| For information on the nursing home's | 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 | -Reason for Skilled Services: Skille | d PT services are warranted to assess | functional abilities, promote safety | | |
| Level of Harm - Actual harm | awareness, enhance rehab potenti abilities, | al, increase coordination, improve dyna | amic balance, enhance fall recovery | | |
| Residents Affected - Few | increase functional activity tolerand patient's | ee, increase LE ROM and strength and | minimize falls in order to enhance | | |
| | quality of life by improving ability to | perform functional mobility w/less risk | for falls. | | |
| | -Risk Factors: Due to the documen at risk for: | ted physical impairments and associate | ed functional deficits, the patient is | | |
| | falls, further decline in function and immobility. | | | | |
| | -Skilled Intervention Focus = Restoration, Compensation | | | | |
| | Record review of Resident #1's care plan dated 02/13/23 indicated she had a Focus area ADL Self-Care Performance Deficit with weakness and poor safety awareness. The goals included, will maintain, or improve current level of function in bed mobility transfers, eating, dressing, toilet use, and Personal hygiene through the review date. Interventions for Resident #1 included: Transfer: The resident requires use of a mechanical aid for transfers. The resident requires mechanical lift and 2 CNAs for transfer. | | | | |
| | Record Review of the facility provided Resident #1's Nurses note on 3/11/23 at 21:30, with no documented nurse name, revealed that the resident had a fall on 3/10/23 when 2 facility staff members were transferring resident from a wheelchair to a shower chair; and Resident #1 had bruising and a fracture to the right ankle. | | | | |
| | during a transfer by CNA A, CNA B required during the transfer. The Al staff involved (CNA A, CNA B, MA are required to report all falls to the The ADM stated that all staff, including Hospice staff are aware a The ADM stated that on 3/11/23, R ankle and an x-ray revealed a right investigate how the resident fracturesident was transferred on 3/10/23 performed by CNA A, CNA B, MA | 1:30 a.m. the ADM stated that on 3/10/28, MA and the Hospice CNA and that the DM stated that the fall was not reported and Hospice CNA). The ADM stated the nurse and not to move a resident until ding Hospice staff are trained to report and trained that Resident #1 requires a resident #1 was found with bruising and heel fracture. The ADM stated that the red her right heel and during that invest without a Hoyer lift and had an assistent the Hospice CNA. The ADM stated and to follow their training by not notifying | ey did not use a Hoyer lift as I to the nurse on shift by any of the at all staff, including Hospice staff a nurse assesses the Resident. falls to the nurse and all staff, two person assist with Hoyer lift. I swelling on Resident #1's right DON immediately started to igation it was determined that the ed fall during the transfer that the fall should have been | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
|--|--|--|--|
| | 675496 | A. Building B. Wing | 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | P CODE |
| Slaton Care Center | | 630 S 19th Slaton, TX 79364 | |
| For information on the nursing home's pla | an to correct this deficiency, please conf | tact 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) | | on) |
| | after she began investigating Reside Resident #1 had a fracture on her resident #1 had a fracture on her resident #1. The DON, she knew better but went DON stated CNA B stated she felt to Resident #1. The DON stated Resident #1. The DON stated CNA Hoyer, Resident #1 went to the growth the growth was to by CNA B Resident #1 went to the growth was also in the room aby one of the CNAs. The DON state Resident #1 into the shower chair at the staff involved should have not like went to the ground, they should have after the nurse assessed Resident had bruises and swelling to her right was ordered that revealed a fracture Hospice and the physician ordered she questioned Resident #1 about said it occurred during the transfer. The Hoyer lift and to report any incide witnessed, or not witnessed. The Doresident was a Hoyer lift and they we staff (CNA A, CNA B and MA) were During an observation and attempte in her bed with a blanket covering in the control of the covering in the covering in the covering in the covering in the position of the covering in the position and attempte in her bed with a blanket covering in the position and attempte in her bed with a blanket covering in the covering | 255 a.m., the DON stated when she be leint #1's right ankle fracture on 3/11/25 ight ankle. The DON stated that during a transferring Resident #1 without the let along with it. The DON stated this incitive were okay to not use Hoyer and it dent #1 is heavy set and cannot bare vole and there was no reason not to use B had told her when they attempted to und and CNA A and CNA B assisted the dent #1 yelled out after she went to the ground after the resident went to the ground she was told by CNA A, CNA B, and the Hospice CNA took Resident #1 fred or moved Resident #1 without a Hoye called immediately for a nurse and with an and the went of a resident #1's right ankle. The DO a soft splint and brace and pain control the injury and Resident #1 reported show the tofall and the ground, ON stated all 3 (CNA A, CNA B, MA) a vere required to report the fall. The DO witten up and in-serviced. The definition of the ground in-serviced interview on 3/28/23 at 10:52 a.m.; her torso and lower body. Resident #1 ond to verbal questions regarding her to the service of the province of the ground in the province of the ground in the province of the ground in the province of the provi | 8. when she was notified that her investigation, CNA A told her doyer lift and CNA A had stated to dent occurred on 3/10/23. The would be easier not to use lift with weight during transfers. The DON a Hoyer lift as required with the transfer Resident #1 without the resident to the ground. The DON a ground. The DON stated the nd, the MA was called into the room of the MA then they assisted for her bath. The DON stated all of loyer lift and when Resident #1 until a reported on 3/11/23 Resident #1 ange. The DON stated an X-ray N stated Resident #1 was on of for Resident #1. The DON stated e hit her foot on the floor and also the MA all have been trained to use regardless of if it was assisted, and the Hospice CNA knew the N stated that all 3 of the facility |

Printed: 05/18/2024 Form Approved OMB No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 | |
|--|--|---|--|--|
| NAME OF PROVIDED OR CURRUIT | | CTDEET ADDRESS CITY STATE 71 | D CODE | |
| NAME OF PROVIDER OR SUPPLIE | = R | STREET ADDRESS, CITY, STATE, ZI | PCODE | |
| Slaton Care Center | | 630 S 19th Slaton, TX 79364 | | |
| 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 DEFIC (Each deficiency must be preceded by | CIENCIES full regulatory or LSC identifying informati | on) | |
| F 0689 | 1 | 1:25 a.m. with CNA A stated on 3/10/2 | Š . | |
| Level of Harm - Actual harm | room stating she needed to showe | ated Resident #1 was in her wheelchair Resident #1. The CNA A stated CNA | B stated they would transfer | |
| Residents Affected - Few | | the shower chair without the Hoyer lift sisted CNA B. The CNA A stated durir | | |
| | the ground when they stood Reside The CNA A stated the Hospice CN transfer. The CNA A stated the Hos MA came into the room and all 4 of to lift Resident #1 into the shower of shower and Resident #1 had stated report the assisted fall to the nurse was outside Resident #1's room an CNA A stated Resident #1's room an CNA A stated Resident #1 required A the Hoyer lift provides a safe med weight on her legs for a long time a not using the Hoyer lift could result she has been trained on reporting the resident falls which could turn into the report it and she has injuries. During an interview on 3/28/23 at 1 | ent #1 up and both CNA A and CNA B A was prepping for Resident #1's show spice CNA called out in the hall to the fithem (CNA A, CAN B, MA, and Hospichair. The CNA A stated the Hospice Cd she was really tired after the transfer. because she didn't think to notify anyod she had been trained Resident #1 w I a Hoyer lift because staff cannot lift his thod to lift and transfer Resident #1 beind was unable to walk or transfer hers in a resident having a fall that could refalls, Hoyer lifts, transfers, and Resider injuries. CNA A stated that I believe we will the same with the Director of Rehab; s #1 can become very confused and doe | assisted the resident to the ground. For and did not assist with the MA for help. The CNA A stated the ce CNA) each grabbed onto a limb NA then took Resident #1 for a The CNA A stated she did not one. The CNA A stated the Hoyer lift as a 2-person life with a Hoyer. The erroperly without the lift. The CNA cause Resident #1 cannot bare elff. The CNA A stated the risk of sult in an injury. The CNA A stated at #1's care plan. She stated eneglected Resident #1; we failed entated that Resident #1 is a Hoyer | |
| | Rehab stated that when the rehabil down to stand up movements with stated staff are trained to use the Rehabilitation stated that the risk of the Director of Rehabilitation state trained to notify the nurse immedia incident with Resident #1 neglected Hoyer and stated that it is possible Rehabilitation stated that if a staff resident #1 neglected Rehabilitation stated that if a staff resident #1 neglected Rehabilitation stated that if a staff resident #1 neglected Rehabilitation stated that if a staff resident #1 neglected Rehabilitation stated that if a staff resident #1 neglected Rehabilitation stated that if a staff resident #1 neglected Rehabilitation stated that if a staff resident #1 neglected Rehabilitation stated that it is a staff resident #1 neglected Rehabilitation stated that it is a staff resident #1 neglected Rehabilitation stated that it is a staff resident #1 neglected Rehabilitation stated that it is neglected Rehabilitation stated Rehabilitation Rehabilitation stated Rehabilitation stated Rehabilitation stated Rehabilitation stated Reh | itation department worked with Reside two rehabilitation department staff assiloyer lift and there are 2 Hoyer lifts avaif not using a Hoyer lift included falls, fract that if a resident has a fall, or an assitely. The Director of Rehabilitation stated to follow her care plan requiring a 2 path that the fracture occurred during transformers witnesses another staff not usignately report to the charge nurse, Director of the | nt #1, she had a hard time doing sit sting. The Director of Rehabilitation ilable in the facility. The Director of actures, tears, or employee injuries. sted fall staff are required and ed that the staff involved in the erson transfer with the use of the fer or fall. The Director of ng a Hoyer lift on a resident who | |
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FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 675496

If continuation sheet Page 18 of 22

| | | | NO. 0936-0391 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIER Slaton Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 630 S 19th Slaton, TX 79364 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | (4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | on) |
| F 0689 Level of Harm - Actual harm Residents Affected - Few | #1's room with CNA A assisting Recame in and stated she needed to CNA B stated Resident #1 was in high the shower chair. The CNA B state arms to lift her while the hospice C during that transfer, Resident #1 m ground and she and CNA A assiste hallway and asked the MA to come Hospice CNA, and the MA all grabh stated that the shower chair moved that Resident #1 requires two peoplift in the hallway and they were in use the Hoyer, I know it was wrong shower and bathe her. The CNA B the MA took Resident #1 to bathe. to the ground and did not have a reshould have reported to the nurse, to move a resident during an assist that she has been trained on Resid Hoyer lift. The CNA B stated that Resident #1. The CNA B stated that Resident #1 to bathing. The CNA B stated that Resident #1 to happen to he got hurt. It makes me cry to know we didn't want that to happen to he got hurt. It makes me cry to know we make the makes me cry to know we come the following an interview on 3/28/23 at 1 hallway and heard someone call on Resident #1's room he observed Resident #1's room he observed Resident #1's room he observed Resident #1's room he assisted CN attempted to put her in the shower was assisted by them again to the shower chair for the Hospice CNA notify the nurse if a resident. The MA stated that the purpose of having a are any injuries. During an interview on 3/28/23 at 2 people assist with Resident #1. Co | :50 p.m. with the MA, stated that he want his name to Resident #1's room. The esident #1 on the floor and CNA A, CN Resident #1 was a Hoyer lift but didn't A A, CNA B and the Hospice CNA lift Fichair. The MA stated that the shower of floor. The MA stated then they lifted Reform to bathe her and he left the room. The fall or is on the ground and not to move ted he believed one of the CNAs would nurse assess a resident after a fall is for the control of | A B stated that the Hospice CNA com with the shower chair. The decided to transfer Resident #1 to esident #1 and used Resident #1's 's pants. The CNA B stated that g position and started going to the a B stated she then stepped into the last then they CNA A, CNA B, fer her to the shower chair. CNA B in the shower chair. CNA B stated there was a Hoyer stated, I don't know why we didn't elp the hospice lady so she could lower chair, she left the room, and to the nurse that Resident #1 went e CNA B stated she knows that she B stated that staff are not supposed less for injuries. The CNA B stated e plan when she did not use a sters, incontinence care and elling to Resident #1's ankle when of her observations but did not tell s not following a resident care plan It hurt me to see Resident #1 hurt. Lul that we didn't use the lift and she was working on 3/10/23 in the AB and Hospice CNA were in the think of that when he saw Resident #2 sident #1 up and placed her in the AB stated he has been trained to be the resident until a nurse I have notified the nurse. The MA or the nurse to determine if there |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 | |
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| NAME OF PROVIDER OR SUPPLIE | -D | STREET ADDRESS, CITY, STATE, ZI | P CODE | |
| Slaton Care Center | | 630 S 19th Slaton, TX 79364 | . 6052 | |
| 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 DEFIC (Each deficiency must be preceded by | | CIENCIES full regulatory or LSC identifying informati | on) | |
| F 0689 Level of Harm - Actual harm Residents Affected - Few | During a phone interview on 4/4/23 on 3/10/23 and walked into Reside walked into the room and observed Hospice CNA stated she had work the Resident required a Hoyer lift a staff told her that they didn't need the and she attempted to pull down Resided CNA stated Resident #1 made a as MA was called into the room and the holding onto a limb and placed her back several inches, but she does stated that she then took Resident hurt. The Hospice CNA stated she about heel pain, and she was advist observe any pressure sores and R. CNA stated she did not report the form agency. The Hospice CNA stated she had to goes to the ground because a nurse also knew Resident #1 required a litransfer. The Hospice CNA stated she had to goes to the ground because a nurse also knew Resident #1 required a litransfer. The Hospice CNA stated for preson transfer with Hoyer lift, it plasms not aware that Resident #1 fra notified them of the incident. During a phone interview on 4/4/23 notify her that Resident #1 had an assiste was done without the Hoyer lift. The Resident #1 requires a two-person Hospice CNA should not have part required. The Hospice LVN stated that Resident #1 had a fractured right of 3/10/23 that Resident #1 require hospice agency of any resident fall Record review of the facility's Abus facility, its employees, or service pavoid physical harm, pain, mental and stated that mental and stated that mental harm, pain, mental and stated that the stated that mental harm, pain, mental and stated that the stated that mental harm. | at 9:41 a.m. the Hospice CNA stated in t#1's room to prepare her for a shown to CNA and CNA B in the room assistive dwith Resident #1 five times before 3 and 2 persons for all transfers and lifting the lift and the CNA A and CNA B lifted is ident #1's pants before they transferred the went to the ground, and they assisted a sound when she was on the ground they (CNA A, CNA B, MA, and herself) I in the shower chair. The Hospice CNA not remember the resident going to the #1 to bathe and during the bathing, Recalled her supervisor and notified her the sed to check for pressure sores. The Hesident #1 stated her heel hurt on the in ital to any one at the facility and waited ed that she thought she told a facility could be a sound the work of the search that it is all to any one at the facility and waited ed that she thought she told a facility could be a sound that she thought she told a facility could be a sound that the search trained to immediately notify a number has to assess a resident for injuries. Hoyer lift but went under the direction of that by not following the care plan that acced the resident at risk of falls and injurient the right heel was hurting, and she lospice LVN stated she never got back or sores. The Hospice LVN stated that | that she was working at the facility er. The Hospice CNA stated she ng another resident to bed. The /10/23 and had been trained that g. The Hospice CNA stated that Resident #1 from her wheelchair ed her to the shower chair. The ed her to the ground. The Hospice compared that the fitted Resident #1 by each of them estated the shower chair did go a ground again. The Hospice CNA sident #1 stated that her right heel hat the resident was complaining ospice CNA stated that she did not enside, not on the skin. The Hospice several days before reporting to the hard that resident #1 he notified someone at the facility. The Hospice CNA stated that she fit the facility CNAs during the stated that Resident #1 was a 2 tries. The Hospice CNA stated she ontacted the hospice agency and spice CNA called her on 3/10/23 to Hospice LVN) advised her to check with the Hospice CNA to determine the Hospice CNA never informed spice CNA inform her that a transfer CNA has been trained that The Hospice LVN stated that the thout utilizing the Hoyer lift as curred on 3/10/23 by the facility and the Hospice CNA was trained prior notify both the facility nurse and the hoad a fall. | |
| | (continued on next page) | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. Building | (X3) DATE SURVEY COMPLETED | |
| | 675496 | B. Wing | 03/28/2023 | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | P CODE | |
| Slaton Care Center 630 S 19th Slaton, TX 79364 | | | | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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 - Actual harm | Record review of the facility provided Provider Investigation Report, report date to HHSC 3/11/23 revealed the following: | | | |
| Residents Affected - Few | | in Resident #1's room. Description of illure to report an assisted fall. Injury of | | |
| | -Description of injury: Right and lat | eral fracture of right malleolus. | | |
| | -Assessment on 3/11/23 at 11:12 a ankle. Rt elbow 1 cm x 2.4 cm skin | n.m.: Green bruise to lower shin 7.4 cm tear. | X 4 cm, dark purple bruising rt | |
| | Investigation Summary: It was determined that on 3/10/23, CNA A, CNA B and Hospice CNA transferred resident without a mechanical lift from w/c to shower chair. During the transfer they struggled, and resident was assisted to floor. MA went in room and all 4 assisted residents to shower chair. -Investigation Findings: Confirmed -Provider Action Taken Post-Investigation: Suspended CNAs during investigation. Written disciplinary actior against CNA A and CNA B involved in transfer. MA received one on one coaching for not reporting the incident to the charge nurse. Training/In-services for CNAs/MA on transfers, mechanical lift, In-services on transfers, mechanical lifts, notifying supervisor of accidents and events, abuse, neglect and injury of unknown origin. | | | |
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| | | | | |
| | In-services signed by CNA A, CNA | B and MA on 3/11/23. | | |
| | Record review of the facility provided, undated, Hydraulic Lift policy indicated: The hydraulic lift mechanical device used to transfer a resident from and to the bed and chair. It is reserved for t paralyzed, obese, or too weak to transfer without complete assistance. The number of staff to passistance with the transfer should be determined by the manufacturer's recommendations. | | air. It is reserved for those who are number of staff to provide | |
| | 1 | nieve safe transfer to bed or chair via a d correct transfer of the resident to the | | |
| | Record Review of facility provided SNFCLINIC training transcript for CNA A revealed the following completed training: | | | |
| | | nat is Abuse; Lifting Machine, Using a Mechanical; Transferring from a Bed to Wheelchair using a transfer it; Using a Hydraulic Lift; CNA-Safely Moving residents-Lifting and Transferring; Abuse, Neglect and ploitation Fall Prevention | | |
| | Record Review of facility provided training: | SNFCLINIC training transcript for CNA | B revealed the following completed | |
| | (continued on next page) | | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2023 |
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| NAME OF PROVIDER OR SUPPLIER Slaton Care Center | | STREET ADDRESS, CITY, STATE, ZI | P CODE |
| For information on the nursing home's plan to correct this deficiency, please or | | Slaton, TX 79364 | ogopov |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC | CIENCIES | |
| F 0689 Level of Harm - Actual harm | (Each deficiency must be preceded by full regulatory or LSC identifying information) Fall Prevention, Slip, Trip and Fall Prevention, What is Abuse; Using Restraint Alternatives; Lifting Machine, Using a Mechanical; Using a Hydraulic Lift; Abuse, Neglect and Exploitation; Transferring from a Bed to Wheelchair using a Transfer Belt; CNA Safely Moving residents-Lifting and Transferring | | |
| Residents Affected - Few | Record Review of facility provided training: | SNFCLINIC training transcript for MA r | evealed the following completed |
| | Fall Prevention, Slip, Trip and Fall | Prevention, What is Abuse, Using Rest | raint Alternatives. |
| | Lifting Machine, Using a Mechanica | al; Using a Hydraulic Lift; Abuse, Negle | ect and Exploitation. |
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