STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675496	A. Building B. Wing	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on interview and record review the facility failed to implement written policies and procedures that prohibit and prevent resident neglect for 1 of 5 residents (Resident #1) of five residents whose records were reviewed for neglect. Facility staff did not implement facility policy and immediately notify administration when CNA A and CNA B transferred Resident #1 without a hoyer lift and the resident fell to the ground sustaining a fracture. This failure could affect residents by placing them at risk of neglect if the reportable allegations are not reported timely after they are discovered. Findings included: Record review of a face sheet dated indicated Resident #1 was an [AGE] year-old female admitted to the facility initially on 01/20/2021. Her diagnoses were Type 2 diabetes, Unspecified dementia, Hypothyroidism, Major Depressive disorder, and Hypertension. Record review of a Resident #1's quarterly MDS dated [DATE] indicated a BIMS of 4 indicating a severe cognitive impairment. Her bathing self-performance indicates a score of 4 indicating total dependence. Her chair/bed to chair mobility: the ability to transfer to and from bed to chair (or wheelchair) indicated a score of 01 and documents that she was dependent: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers was required for the resident to complete 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. (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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 with need for antibiotics. Pt with noted deficits in strength, balance, and safety. -Reason for Skilled Services: Skilled PT services are warranted to assess functional abilities, promote safety awareness, enhance rehab potential, increase coordination, improve dynamic balance, enhance fall recovery abilities, increase functional activity tolerance, increase LE ROM and strength and minimize falls in order to enhance patient's quality of life by improving ability to perform functional mobility w/less risk for falls. -Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: 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. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/23 at 9:30 a.m. the ADM stated that on 3/10/23 Resident #1 had an assisted fall during a transfer by CNA A, CNA B, MA and the Hospice CNA and that they did not use a Hoyer lift as required during the transfer. The ADM stated that the fall was not reported to the nurse on shift by any of the staff involved (CNA A, CNA B, MA and Hospice CNA). The ADM stated that all staff, including Hospice staff are required to report all falls to the nurse and not to move a resident until a nurse assesses the Resident. The ADM stated that all staff, including Hospice staff are trained to report falls to the nurse and all staff, including Hospice staff are aware and trained that Resident #1 requires a two person assist with Hoyer lift. The ADM stated that on 3/11/23, Resident #1 was found with bruising and swelling on Resident #1's right ankle and an x-ray revealed a right heel fracture. The ADM stated that the DON immediately started to investigate how the resident fractured her right heel and during that investigation it was determined that the resident was transferred on 3/10/23 without a Hoyer lift and had an assisted fall during the transfer performed by CNA A, CNA B, MA and the Hospice CNA. The ADM stated that the fall should have been reported immediately and staff failed to follow their training by not notifying the nurse immediately and by not using the Hoyer lift as required. During an interview on 3/28/23 at 9:55 a.m., the DON stated when she became aware of the unreported fall after she began investigating Resident #1's right ankle fracture on 3/11/23. when she was notified that Resident #1 had a fracture on her right ankle. The DON stated that during her investigation, CNA A told her that CNA B asked her to assist with transferring Resident #1 without the Hoyer lift and CNA A had stated to the DON, she knew better but went along with it. The DON stated this incident occurred on 3/10/23. The DON stated CNA B stated she felt they were okay to not use Hoyer and it would be easier not to use lift with Resident #1. The DON stated Resident #1 is heavy set and cannot bare weight during transfers. The DON stated there were Hoyer lifts available and there was no reason not to use a Hoyer lift as required with Resident #1. The DON stated CNA B had told her when they attempted to transfer Resident #1 without the Hoyer, Resident #1 went to the ground and CNA A and CNA B assisted the resident to the ground. The DON stated she was told by CNA B Resident #1 yelled out after she went to the ground. The DON stated the hospice aide was also in the room and after the resident went to the ground, the MA was called into the room by one of the CNAs. The DON stated she was told by CNA A, CNA B, and the MA then they assisted Resident #1 into the shower chair and the Hospice CNA took Resident #1 for her bath. The DON stated all of the staff involved should have not lifted or moved Resident #1 without a Hoyer lift and when Resident #1 went to the ground, they should have called immediately for a nurse and waited to move Resident #1 until after the nurse assessed Resident #1 for injuries. The DON stated CNA B reported on 3/11/23 Resident #1 had bruises and swelling to her right ankle when she performed a brief change. The DON stated an X-ray was ordered that revealed a fracture to Resident #1's right ankle. The DON stated Resident #1 was on Hospice and the physician ordered a soft splint and brace and pain control for Resident #1. The DON stated she questioned Resident #1 about the injury and Resident #1 reported she hit her foot on the floor and also said it occurred during the transfer. The DON stated CNA A, CNA B, and the MA all have been trained to use the Hoyer lift and to report any incident of a resident going to the ground, regardless of if it was assisted, witnessed, or not witnessed. The DON stated all 3 (CNA A, CNA B, MA) and the Hospice CNA knew the resident was a Hoyer lift and they were required to report the fall. The DON stated that all 3 of the facility staff (CNA A, CNA B and MA) were written up and in-serviced. During an observation and attempted interview on 3/28/23 at 10:52 a.m.; Resident #1 was observed sleeping in her bed with a blanket covering her torso and lower body. Resident #1 opened her eyes and looked at the HHSC Investigator but did not respond to verbal questions regarding her treatment, fall history, or current injury to her right heel. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/23 at 11:25 a.m. with CNA A stated on 3/10/23 she was working with CNA B in Resident #1's room. The CNA A stated Resident #1 was in her wheelchair and the Hospice CNA entered the room stating she needed to shower Resident #1. The CNA A stated CNA B stated they would transfer Resident #1 from her wheelchair to the shower chair without the Hoyer lift. The CNA A stated she did not think it was a good idea, but she assisted CNA B. The CNA A stated during the transfer Resident #1 went to the ground when they stood Resident #1 up and both CNA A and CNA B assisted the resident to the ground. The CNA A stated the Hospice CNA was prepping for Resident #1's shower and did not assist with the transfer. The CNA A stated the Hospice CNA called out in the hall to the MA for help. The CNA A stated the MA came into the room and all 4 of them (CNA A, CAN B, MA, and Hospice CNA) each grabbed onto a limb to lift Resident #1 into the shower chair. The CNA A stated the Hospice CNA then took Resident #1 for a shower and Resident #1 had stated she was really tired after the transfer. The CNA A stated she did not report the assisted fall to the nurse because she didn't think to notify anyone. The CNA A stated the Hoyer lift was outside Resident #1's room and she had been trained Resident #1 was a 2-person life with a Hoyer. The CNA A stated Resident #1 required a Hoyer lift because staff cannot lift her properly without the lift. The CNA A the Hoyer lift provides a safe method to lift and transfer Resident #1 because Resident #1 cannot bare weight on her legs for a long time and was unable to walk or transfer herself. The CNA A stated the risk of not using the Hoyer lift could result in a resident having a fall that could result in an injury. The CNA A stated she has been trained on reporting falls, Hoyer lifts, transfers, and Resident #1's care plan. She stated resident falls which could turn into injuries. CNA A stated that I believe we neglected Resident #1; we failed to report it and she has injuries. During an interview on 3/28/23 at 11:48 a.m. with the Director of Rehab; stated that Resident #1 is a Hoyer lift due to safety and that Resident #1 can become very confused and does not stand well. The Director of Rehab stated that when the rehabilitation department worked with Resident #1, she had a hard time doing sit down to stand up movements with two rehabilitation department staff assisting. The Director of Rehabilitation stated staff are trained to use the Hoyer lift and there are 2 Hoyer lifts available in the facility. The Director of Rehabilitation stated that the risk of not using a Hoyer lift included falls, fractures, tears, or employee injuries. The Director of Rehabilitation stated that if a resident has a fall, or an assisted fall staff are required and trained to notify the nurse immediately. The Director of Rehabilitation stated that the staff involved in the incident with Resident #1 neglected to follow her care plan requiring a 2 person transfer with the use of the Hoyer and stated that it is possible that the fracture occurred during transfer or fall. The Director of Rehabilitation stated that if a staff member witnesses another staff not using a Hoyer lift on a resident who requires a Hoyer, they should immediately report to the charge nurse, Director of Nurses, or the Rehabilitation department to address it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Resident #1's room with CNA A assisting Resident #1's roommate to bed. The CNA B stated that the Hospice CNA came in and stated she needed to shower Resident #1 and entered the room with the shower chair. The CNA B stated Resident #1 was in her wheelchair and CNA A and CNA B decided to transfer Resident #1 to the shower chair. The CNA B stated that she and CNA A stood behind Resident #1 and used Resident #1's 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 the ground and she and CNA A assisted Resident #1 to the ground. The CNA B stated she then stepped into the 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 B stated that the shower chair moved but they were able to get Resident #1 in the shower chair. CNA B stated that Resident #1 requires two people to transfer and the use of a Hoyer lift. CNA B stated there was a Hoyer lift in the hallway and they were in a hurry and chose not to use it. CNA B stated, I don't know why we didn't use the Hoyer, I know it was wrong. We were just trying to hurry up and help the hospice lady so she could shower and bathe her. The CNA B stated after Resident #1 was in the shower chair, she left the room, and the MA took Resident #1 to bathe. The CNA B stated she never reported to the nurse that Resident #1 went to the ground and did not have a reason for not reporting to the nurse. The CNA B stated she knows that she should have reported to the nurse, and she is trained to do so. The CNA B stated that staff are not supposed to move a resident during an assisted fall because the nurse needs to assess for injuries. The CNA B stated that she has been trained on Resident #1's care plan and did not follow the plan when she did not use a Hoyer lift. The CNA B stated that Resident #1 relies on staff to do all transfers, incontinence care and bathing. The CNA B stated that on 3/11/23 she observed bruising and swelling to Resident #1's ankle when she attempted incontinence care and that is when she notified the nurse of her observations but did not tell the nurse about the fall the previous day. The CNA B stated that neglect is not following a resident care plan or using a Hoyer lift. I don't know why we didn't use the Hoyer. I feel bad. It hurt me to see Resident #1 hurt. We didn't want that to happen to her. Every time I think about it, I feel awful that we didn't use the lift and she got hurt. It makes me cry to know we did that, and she got hurt. During an interview on 3/28/23 at 1:50 p.m. with the MA, stated that he was working on 3/10/23 in the hallway and heard someone call out his name to Resident #1's room. The MA stated that when he entered Resident #1's room he observed Resident #1 on the floor and CNA A, CNA B and Hospice CNA were in the room. The MA stated he knew that Resident #1 was a Hoyer lift but didn't think of that when he saw Resident #1 on the floor and he assisted CNA A, CNA B and the Hospice CNA lift Resident #1 off the floor and attempted to put her in the shower chair. The MA stated that the shower chair slid back, and Resident #1 was assisted by them again to the floor. The MA stated then they lifted Resident #1 up and placed her in the shower chair for the Hospice CNA to bathe her and he left the room. The MA stated he has been trained to notify the nurse if a resident has a fall or is on the ground and not to move the resident until a nurse 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 are any injuries. 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 notify the nurse after a fall and to use the Hoyer lift. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/4/23 at 9:41 a.m. the Hospice CNA stated that she was working at the facility on 3/10/23 and walked into Resident #1's room to prepare her for a shower. The Hospice CNA stated she walked into the room and observed CNA A and CNA B in the room assisting another resident to bed. The Hospice CNA stated she had worked with Resident #1 five times before 3/10/23 and had been trained that the Resident required a Hoyer lift and 2 persons for all transfers and lifting. The Hospice CNA stated that staff told her that they didn't need the lift and the CNA A and CNA B lifted Resident #1 from her wheelchair and she attempted to pull down Resident #1's pants before they transferred her to the shower chair. The Hospice CNA stated that the resident went to the ground, and they assisted her to the ground. The Hospice CNA stated Resident #1 made a aah sound when she was on the ground. The Hospice CNA stated that the MA was called into the room and they (CNA A, CNA B, MA, and herself) lifted Resident #1 by each of them holding onto a limb and placed her in the shower chair. The Hospice CNA stated the shower chair did go back several inches, but she does not remember the resident going to the ground again. The Hospice CNA stated that she then took Resident #1 to bathe and during the bathing, Resident #1 stated that her right heel hurt. The Hospice CNA stated she called her supervisor and notified her that the resident was complaining 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 transfer. The Hospice CNA stated that by not following the care plan that stated that Resident #1 was a 2 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 Hospice CNA called her on 3/10/23 to notify her that Resident #1 stated that her right heel was hurting, and she(Hospice LVN) advised her to check 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 assisted fall during a transfer, nor did the Hospice CNA inform her that a transfer was done without the Hoyer lift. The Hospice LVN stated that the Hospice CNA has been trained that Resident #1 requires a two-person lift and a Hoyer lift during all transfers. The Hospice LVN stated that the 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 hospice agency of any resident falls and not to move a resident who has had a fall. 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 avoid physical harm, pain, mental anguish, or emotional distress. -Employees must report suspected abuse, neglect, mistreatment, or injury of unknown origin of a potential victim immediately to the DON and Administrator. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility provided Provider Investigation Report, report date to HHSC 3/11/23 revealed the following: -Incident date: 3/10/23 at 3:30 p.m. in Resident #1's room. Description of the allegation: Failure to follow resident care plan for transfers. Failure to report an assisted fall. Injury of unknown origin. -Description of injury: Right and lateral fracture of right malleolus. -Assessment on 3/11/23 at 11:12 a.m.: Green bruise to lower shin 7.4 cm X 4 cm, dark purple bruising rt ankle. Rt elbow 1 cm x 2.4 cm skin tear. 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 action 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. In-services signed by CNA A, CNA B and MA on 3/11/23. Record Review of facility provided SNFCLINIC training transcript for CNA A revealed the following completed training: What is Abuse; Lifting Machine, Using a Mechanical; Transferring from a Bed to Wheelchair using a transfer belt; Using a Hydraulic Lift; CNA-Safely Moving residents-Lifting and Transferring; Abuse, Neglect and Exploitation Fall Prevention Record Review of facility provided SNFCLINIC training transcript for CNA B revealed the following completed training: 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 Record Review of facility provided SNFCLINIC training transcript for MA revealed the following completed training: 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on observation, interview and record review, the facility failed to ensure an allegation of neglect was reported immediately but not later than 24 hours after the allegation was made for 1 of 5 residents (Resident #1) reviewed for reporting. Facility staff did not immediately report an allegation of neglect when CNA A and CNA B inappropriately transferred Resident #1 without a hoyer lift and the resident fell to the ground sustaining a fracture This failure could affect residents by placing them at risk of abuse if the reportable allegations are not reported timely after they are discovered. Findings included: Record review of a face sheet dated indicated Resident #1 was an [AGE] year-old female admitted to the facility initially on 01/20/2021. Her diagnoses were Type 2 diabetes, Unspecified dementia, Hypothyroidism, Major Depressive disorder, and Hypertension. Record review of a Resident #1's quarterly MDS dated [DATE] indicated a BIMS of 4 indicating a severe cognitive impairment. Her bathing self-performance indicates a score of 4 indicating total dependence. Her chair/bed to chair mobility: the ability to transfer to and from bed to chair (or wheelchair) indicated a score of 01 and documents that she was dependent: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers was required for the resident to complete 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Reason for Skilled Services: Skilled PT services are warranted to assess functional abilities, promote safety awareness, enhance rehab potential, increase coordination, improve dynamic balance, enhance fall recovery abilities, increase functional activity tolerance, increase LE ROM and strength and minimize falls in order to enhance patient's quality of life by improving ability to perform functional mobility w/less risk for falls. -Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: 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 an interview on 3/28/23 at 9:30 a.m. the ADM stated that on 3/10/23 Resident #1 had an assisted fall during a transfer by CNA A, CNA B, MA and the Hospice CNA and that they did not use a Hoyer lift as required during the transfer. The ADM stated that the fall was not reported to the nurse on shift by any of the staff involved (CNA A, CNA B, MA and Hospice CNA). The ADM stated that all staff, including Hospice staff are required to report all falls to the nurse and not to move a resident until a nurse assesses the Resident. The ADM stated that all staff, including Hospice staff are trained to report falls to the nurse and all staff, including Hospice staff are aware and trained that Resident #1 requires a two person assist with Hoyer lift. The ADM stated that on 3/11/23, Resident #1 was found with bruising and swelling on Resident #1's right ankle and an x-ray revealed a right heel fracture. The ADM stated that the DON immediately started to investigate how the resident fractured her right heel and during that investigation it was determined that the resident was transferred on 3/10/23 without a Hoyer lift and had an assisted fall during the transfer performed by CNA A, CNA B, MA and the Hospice CNA. The ADM stated that the fall should have been reported immediately and staff failed to follow their training by not notifying the nurse immediately and by not using the Hoyer lift as required. (continued on next page)

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	675496	A. Building B. Wing	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Slaton Care Center	630 S 19th Slaton, TX 79364

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/23 at 9:55 a.m., the DON stated when she became aware of the unreported fall after she began investigating Resident #1's right ankle fracture on 3/11/23. when she was notified that Resident #1 had a fracture on her right ankle. The DON stated that during her investigation, CNA A told her that CNA B asked her to assist with transferring Resident #1 without the Hoyer lift and CNA A had stated to the DON, she knew better but went along with it. The DON stated this incident occurred on 3/10/23. The DON stated CNA B stated she felt they were okay to not use Hoyer and it would be easier not to use lift with Resident #1. The DON stated Resident #1 is heavy set and cannot bare weight during transfers. The DON stated there were Hoyer lifts available and there was no reason not to use a Hoyer lift as required with Resident #1. The DON stated CNA B had told her when they attempted to transfer Resident #1 without the Hoyer, Resident #1 went to the ground and CNA A and CNA B assisted the resident to the ground. The DON stated she was told by CNA B Resident #1 yelled out after she went to the ground. The DON stated the hospice aide was also in the room and after the resident went to the ground, the MA was called into the room by one of the CNAs. The DON stated she was told by CNA A, CNA B, and the MA then they assisted Resident #1 into the shower chair and the Hospice CNA took Resident #1 for her bath. The DON stated all of the staff involved should have not lifted or moved Resident #1 without a Hoyer lift and when Resident #1 went to the ground, they should have called immediately for a nurse and waited to move Resident #1 until after the nurse assessed Resident #1 for injuries. The DON stated CNA B reported on 3/11/23 Resident #1 had bruises and swelling to her right ankle when she performed a brief change. The DON stated an X-ray was ordered that revealed a fracture to Resident #1's right ankle. The DON stated Resident #1 was on Hospice and the physician ordered a soft splint and brace and pain control for Resident #1. The DON stated she questioned Resident #1 about the injury and Resident #1 reported she hit her foot on the floor and also said it occurred during the transfer. The DON stated CNA A, CNA B, and the MA all have been trained to use the Hoyer lift and to report any incident of a resident going to the ground, regardless of if it was assisted, witnessed, or not witnessed. The DON stated all 3 (CNA A, CNA B, MA) and the Hospice CNA knew the resident was a Hoyer lift and they were required to report the fall. The DON stated that all 3 of the facility staff (CNA A, CNA B and MA) were written up and in-serviced. During an observation and attempted interview on 3/28/23 at 10:52 a.m.; Resident #1 was observed sleeping in her bed with a blanket covering her torso and lower body. Resident #1 opened her eyes and looked at the HHSC Investigator but did not respond to verbal questions regarding her treatment, fall history, or current injury to her right heel. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/23 at 11:25 a.m. with CNA A stated on 3/10/23 she was working with CNA B in Resident #1's room. The CNA A stated Resident #1 was in her wheelchair and the Hospice CNA entered the room stating she needed to shower Resident #1. The CNA A stated CNA B stated they would transfer Resident #1 from her wheelchair to the shower chair without the Hoyer lift. The CNA A stated she did not think it was a good idea, but she assisted CNA B. The CNA A stated during the transfer Resident #1 went to the ground when they stood Resident #1 up and both CNA A and CNA B assisted the resident to the ground. The CNA A stated the Hospice CNA was prepping for Resident #1's shower and did not assist with the transfer. The CNA A stated the Hospice CNA called out in the hall to the MA for help. The CNA A stated the MA came into the room and all 4 of them (CNA A, CAN B, MA, and Hospice CNA) each grabbed onto a limb to lift Resident #1 into the shower chair. The CNA A stated the Hospice CNA then took Resident #1 for a shower and Resident #1 had stated she was really tired after the transfer. The CNA A stated she did not report the assisted fall to the nurse because she didn't think to notify anyone. The CNA A stated the Hoyer lift was outside Resident #1's room and she had been trained Resident #1 was a 2-person life with a Hoyer. The CNA A stated Resident #1 required a Hoyer lift because staff cannot lift her properly without the lift. The CNA A the Hoyer lift provides a safe method to lift and transfer Resident #1 because Resident #1 cannot bare weight on her legs for a long time and was unable to walk or transfer herself. The CNA A stated the risk of not using the Hoyer lift could result in a resident having a fall that could result in an injury. The CNA A stated she has been trained on reporting falls, Hoyer lifts, transfers, and Resident #1's care plan. She stated resident falls which could turn into injuries. CNA A stated that I believe we neglected Resident #1; we failed to report it and she has injuries. During an interview on 3/28/23 at 11:48 a.m. with the Director of Rehab; stated that Resident #1 is a Hoyer lift due to safety and that Resident #1 can become very confused and does not stand well. The Director of Rehab stated that when the rehabilitation department worked with Resident #1, she had a hard time doing sit down to stand up movements with two rehabilitation department staff assisting. The Director of Rehabilitation stated staff are trained to use the Hoyer lift and there are 2 Hoyer lifts available in the facility. The Director of Rehabilitation stated that the risk of not using a Hoyer lift included falls, fractures, tears, or employee injuries. The Director of Rehabilitation stated that if a resident has a fall, or an assisted fall staff are required and trained to notify the nurse immediately. The Director of Rehabilitation stated that the staff involved in the incident with Resident #1 neglected to follow her care plan requiring a 2 person transfer with the use of the Hoyer and stated that it is possible that the fracture occurred during transfer or fall. The Director of Rehabilitation stated that if a staff member witnesses another staff not using a Hoyer lift on a resident who requires a Hoyer, they should immediately report to the charge nurse, Director of Nurses, or the Rehabilitation department to address it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Resident #1's room with CNA A assisting Resident #1's roommate to bed. The CNA B stated that the Hospice CNA came in and stated she needed to shower Resident #1 and entered the room with the shower chair. The CNA B stated Resident #1 was in her wheelchair and CNA A and CNA B decided to transfer Resident #1 to the shower chair. The CNA B stated that she and CNA A stood behind Resident #1 and used Resident #1's 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 the ground and she and CNA A assisted Resident #1 to the ground. The CNA B stated she then stepped into the 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 B stated that the shower chair moved but they were able to get Resident #1 in the shower chair. CNA B stated that Resident #1 requires two people to transfer and the use of a Hoyer lift. CNA B stated there was a Hoyer lift in the hallway and they were in a hurry and chose not to use it. CNA B stated, I don't know why we didn't use the Hoyer, I know it was wrong. We were just trying to hurry up and help the hospice lady so she could shower and bathe her. The CNA B stated after Resident #1 was in the shower chair, she left the room, and the MA took Resident #1 to bathe. The CNA B stated she never reported to the nurse that Resident #1 went to the ground and did not have a reason for not reporting to the nurse. The CNA B stated she knows that she should have reported to the nurse, and she is trained to do so. The CNA B stated that staff are not supposed to move a resident during an assisted fall because the nurse needs to assess for injuries. The CNA B stated that she has been trained on Resident #1's care plan and did not follow the plan when she did not use a Hoyer lift. The CNA B stated that Resident #1 relies on staff to do all transfers, incontinence care and bathing. The CNA B stated that on 3/11/23 she observed bruising and swelling to Resident #1's ankle when she attempted incontinence care and that is when she notified the nurse of her observations but did not tell the nurse about the fall the previous day. The CNA B stated that neglect is not following a resident care plan or using a Hoyer lift. I don't know why we didn't use the Hoyer. I feel bad. It hurt me to see Resident #1 hurt. We didn't want that to happen to her. Every time I think about it, I feel awful that we didn't use the lift and she got hurt. It makes me cry to know we did that, and she got hurt. During an interview on 3/28/23 at 1:50 p.m. with the MA, stated that he was working on 3/10/23 in the hallway and heard someone call out his name to Resident #1's room. The MA stated that when he entered Resident #1's room he observed Resident #1 on the floor and CNA A, CNA B and Hospice CNA were in the room. The MA stated he knew that Resident #1 was a Hoyer lift but didn't think of that when he saw Resident #1 on the floor and he assisted CNA A, CNA B and the Hospice CNA lift Resident #1 off the floor and attempted to put her in the shower chair. The MA stated that the shower chair slid back, and Resident #1 was assisted by them again to the floor. The MA stated then they lifted Resident #1 up and placed her in the shower chair for the Hospice CNA to bathe her and he left the room. The MA stated he has been trained to notify the nurse if a resident has a fall or is on the ground and not to move the resident until a nurse 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 are any injuries. 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 notify the nurse after a fall and to use the Hoyer lift. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/4/23 at 9:41 a.m. the Hospice CNA stated that she was working at the facility on 3/10/23 and walked into Resident #1's room to prepare her for a shower. The Hospice CNA stated she walked into the room and observed CNA A and CNA B in the room assisting another resident to bed. The Hospice CNA stated she had worked with Resident #1 five times before 3/10/23 and had been trained that the Resident required a Hoyer lift and 2 persons for all transfers and lifting. The Hospice CNA stated that staff told her that they didn't need the lift and the CNA A and CNA B lifted Resident #1 from her wheelchair and she attempted to pull down Resident #1's pants before they transferred her to the shower chair. The Hospice CNA stated that the resident went to the ground, and they assisted her to the ground. The Hospice CNA stated Resident #1 made a aah sound when she was on the ground. The Hospice CNA stated that the MA was called into the room and they (CNA A, CNA B, MA, and herself) lifted Resident #1 by each of them holding onto a limb and placed her in the shower chair. The Hospice CNA stated the shower chair did go back several inches, but she does not remember the resident going to the ground again. The Hospice CNA stated that she then took Resident #1 to bathe and during the bathing, Resident #1 stated that her right heel hurt. The Hospice CNA stated she called her supervisor and notified her that the resident was complaining 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 transfer. The Hospice CNA stated that by not following the care plan that stated that Resident #1 was a 2 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 Hospice CNA called her on 3/10/23 to notify her that Resident #1 stated that her right heel was hurting, and she(Hospice LVN) advised her to check 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 assisted fall during a transfer, nor did the Hospice CNA inform her that a transfer was done without the Hoyer lift. The Hospice LVN stated that the Hospice CNA has been trained that Resident #1 requires a two-person lift and a Hoyer lift during all transfers. The Hospice LVN stated that the 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 hospice agency of any resident falls and not to move a resident who has had a fall. 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 avoid physical harm, pain, mental anguish, or emotional distress. -Employees must report suspected abuse, neglect, mistreatment, or injury of unknown origin of a potential victim immediately to the DON and Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility provided Provider Investigation Report, report date to HHSC 3/11/23 revealed the following: -Incident date: 3/10/23 at 3:30 p.m. in Resident #1's room. Description of the allegation: Failure to follow resident care plan for transfers. Failure to report an assisted fall. Injury of unknown origin. -Description of injury: Right and lateral fracture of right malleolus. -Assessment on 3/11/23 at 11:12 a.m.: Green bruise to lower shin 7.4 cm X 4 cm, dark purple bruising rt ankle. Rt elbow 1 cm x 2.4 cm skin tear. 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 action 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. In-services signed by CNA A, CNA B and MA on 3/11/23. Record Review of facility provided SNFCLINIC training transcript for CNA A revealed the following completed training: What is Abuse; Lifting Machine, Using a Mechanical; Transferring from a Bed to Wheelchair using a transfer belt; Using a Hydraulic Lift; CNA-Safely Moving residents-Lifting and Transferring; Abuse, Neglect and Exploitation Fall Prevention Record Review of facility provided SNFCLINIC training transcript for CNA B revealed the following completed training: 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 Record Review of facility provided SNFCLINIC training transcript for MA revealed the following completed training: 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.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent injuries for 1 of 5 residents (Resident #1) reviewed for injuries. The facility failed to use a Hoyer lift as indicated in Resident #1's care plan, during a transfer which resulted in a fracture. This failure could result in decreased quality of life and risk of injury due to lack of supervision and assistance devices. Findings include: Record review of a face sheet dated indicated Resident #1 was an [AGE] year-old female admitted to the facility initially on 01/20/2021. Her diagnoses were Type 2 diabetes, Unspecified dementia, Hypothyroidism, Major Depressive disorder, and Hypertension. Record review of a Resident #1's quarterly MDS dated [DATE] indicated a BIMS of 4 indicating a severe cognitive impairment. Her bathing self-performance indicates a score of 4 indicating total dependence. Her chair/bed to chair mobility: the ability to transfer to and from bed to chair (or wheelchair) indicated a score of 01 and documents that she was dependent: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers was required for the resident to complete 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 with need for antibiotics. Pt with noted deficits in strength, balance, and safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Reason for Skilled Services: Skilled PT services are warranted to assess functional abilities, promote safety awareness, enhance rehab potential, increase coordination, improve dynamic balance, enhance fall recovery abilities, increase functional activity tolerance, increase LE ROM and strength and minimize falls in order to enhance patient's quality of life by improving ability to perform functional mobility w/less risk for falls. -Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: 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 an interview on 3/28/23 at 9:30 a.m. the ADM stated that on 3/10/23 Resident #1 had an assisted fall during a transfer by CNA A, CNA B, MA and the Hospice CNA and that they did not use a Hoyer lift as required during the transfer. The ADM stated that the fall was not reported to the nurse on shift by any of the staff involved (CNA A, CNA B, MA and Hospice CNA). The ADM stated that all staff, including Hospice staff are required to report all falls to the nurse and not to move a resident until a nurse assesses the Resident. The ADM stated that all staff, including Hospice staff are trained to report falls to the nurse and all staff, including Hospice staff are aware and trained that Resident #1 requires a two person assist with Hoyer lift. The ADM stated that on 3/11/23, Resident #1 was found with bruising and swelling on Resident #1's right ankle and an x-ray revealed a right heel fracture. The ADM stated that the DON immediately started to investigate how the resident fractured her right heel and during that investigation it was determined that the resident was transferred on 3/10/23 without a Hoyer lift and had an assisted fall during the transfer performed by CNA A, CNA B, MA and the Hospice CNA. The ADM stated that the fall should have been reported immediately and staff failed to follow their training by not notifying the nurse immediately and by not using the Hoyer lift as required. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/28/23 at 9:55 a.m., the DON stated when she became aware of the unreported fall after she began investigating Resident #1's right ankle fracture on 3/11/23. when she was notified that Resident #1 had a fracture on her right ankle. The DON stated that during her investigation, CNA A told her that CNA B asked her to assist with transferring Resident #1 without the Hoyer lift and CNA A had stated to the DON, she knew better but went along with it. The DON stated this incident occurred on 3/10/23. The DON stated CNA B stated she felt they were okay to not use Hoyer and it would be easier not to use lift with Resident #1. The DON stated Resident #1 is heavy set and cannot bare weight during transfers. The DON stated there were Hoyer lifts available and there was no reason not to use a Hoyer lift as required with Resident #1. The DON stated CNA B had told her when they attempted to transfer Resident #1 without the Hoyer, Resident #1 went to the ground and CNA A and CNA B assisted the resident to the ground. The DON stated she was told by CNA B Resident #1 yelled out after she went to the ground. The DON stated the hospice aide was also in the room and after the resident went to the ground, the MA was called into the room by one of the CNAs. The DON stated she was told by CNA A, CNA B, and the MA then they assisted Resident #1 into the shower chair and the Hospice CNA took Resident #1 for her bath. The DON stated all of the staff involved should have not lifted or moved Resident #1 without a Hoyer lift and when Resident #1 went to the ground, they should have called immediately for a nurse and waited to move Resident #1 until after the nurse assessed Resident #1 for injuries. The DON stated CNA B reported on 3/11/23 Resident #1 had bruises and swelling to her right ankle when she performed a brief change. The DON stated an X-ray was ordered that revealed a fracture to Resident #1's right ankle. The DON stated Resident #1 was on Hospice and the physician ordered a soft splint and brace and pain control for Resident #1. The DON stated she questioned Resident #1 about the injury and Resident #1 reported she hit her foot on the floor and also said it occurred during the transfer. The DON stated CNA A, CNA B, and the MA all have been trained to use the Hoyer lift and to report any incident of a resident going to the ground, regardless of if it was assisted, witnessed, or not witnessed. The DON stated all 3 (CNA A, CNA B, MA) and the Hospice CNA knew the resident was a Hoyer lift and they were required to report the fall. The DON stated that all 3 of the facility staff (CNA A, CNA B and MA) were written up and in-serviced. During an observation and attempted interview on 3/28/23 at 10:52 a.m.; Resident #1 was observed sleeping in her bed with a blanket covering her torso and lower body. Resident #1 opened her eyes and looked at the HHSC Investigator but did not respond to verbal questions regarding her treatment, fall history, or current injury to her right heel. (continued on next page)

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	675496	A. Building B. Wing	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Slaton Care Center	630 S 19th Slaton, TX 79364

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/28/23 at 11:25 a.m. with CNA A stated on 3/10/23 she was working with CNA B in Resident #1's room. The CNA A stated Resident #1 was in her wheelchair and the Hospice CNA entered the room stating she needed to shower Resident #1. The CNA A stated CNA B stated they would transfer Resident #1 from her wheelchair to the shower chair without the Hoyer lift. The CNA A stated she did not think it was a good idea, but she assisted CNA B. The CNA A stated during the transfer Resident #1 went to the ground when they stood Resident #1 up and both CNA A and CNA B assisted the resident to the ground. The CNA A stated the Hospice CNA was prepping for Resident #1's shower and did not assist with the transfer. The CNA A stated the Hospice CNA called out in the hall to the MA for help. The CNA A stated the MA came into the room and all 4 of them (CNA A, CAN B, MA, and Hospice CNA) each grabbed onto a limb to lift Resident #1 into the shower chair. The CNA A stated the Hospice CNA then took Resident #1 for a shower and Resident #1 had stated she was really tired after the transfer. The CNA A stated she did not report the assisted fall to the nurse because she didn't think to notify anyone. The CNA A stated the Hoyer lift was outside Resident #1's room and she had been trained Resident #1 was a 2-person life with a Hoyer. The CNA A stated Resident #1 required a Hoyer lift because staff cannot lift her properly without the lift. The CNA A the Hoyer lift provides a safe method to lift and transfer Resident #1 because Resident #1 cannot bare weight on her legs for a long time and was unable to walk or transfer herself. The CNA A stated the risk of not using the Hoyer lift could result in a resident having a fall that could result in an injury. The CNA A stated she has been trained on reporting falls, Hoyer lifts, transfers, and Resident #1's care plan. She stated resident falls which could turn into injuries. CNA A stated that I believe we neglected Resident #1; we failed to report it and she has injuries. During an interview on 3/28/23 at 11:48 a.m. with the Director of Rehab; stated that Resident #1 is a Hoyer lift due to safety and that Resident #1 can become very confused and does not stand well. The Director of Rehab stated that when the rehabilitation department worked with Resident #1, she had a hard time doing sit down to stand up movements with two rehabilitation department staff assisting. The Director of Rehabilitation stated staff are trained to use the Hoyer lift and there are 2 Hoyer lifts available in the facility. The Director of Rehabilitation stated that the risk of not using a Hoyer lift included falls, fractures, tears, or employee injuries. The Director of Rehabilitation stated that if a resident has a fall, or an assisted fall staff are required and trained to notify the nurse immediately. The Director of Rehabilitation stated that the staff involved in the incident with Resident #1 neglected to follow her care plan requiring a 2 person transfer with the use of the Hoyer and stated that it is possible that the fracture occurred during transfer or fall. The Director of Rehabilitation stated that if a staff member witnesses another staff not using a Hoyer lift on a resident who requires a Hoyer, they should immediately report to the charge nurse, Director of Nurses, or the Rehabilitation department to address it. (continued on next page)

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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 - Actual harm Residents Affected - Few	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 Resident #1's room with CNA A assisting Resident #1's roommate to bed. The CNA B stated that the Hospice CNA came in and stated she needed to shower Resident #1 and entered the room with the shower chair. The CNA B stated Resident #1 was in her wheelchair and CNA A and CNA B decided to transfer Resident #1 to the shower chair. The CNA B stated that she and CNA A stood behind Resident #1 and used Resident #1's 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 the ground and she and CNA A assisted Resident #1 to the ground. The CNA B stated she then stepped into the 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 B stated that the shower chair moved but they were able to get Resident #1 in the shower chair. CNA B stated that Resident #1 requires two people to transfer and the use of a Hoyer lift. CNA B stated there was a Hoyer lift in the hallway and they were in a hurry and chose not to use it. CNA B stated, I don't know why we didn't use the Hoyer, I know it was wrong. We were just trying to hurry up and help the hospice lady so she could shower and bathe her. The CNA B stated after Resident #1 was in the shower chair, she left the room, and the MA took Resident #1 to bathe. The CNA B stated she never reported to the nurse that Resident #1 went to the ground and did not have a reason for not reporting to the nurse. The CNA B stated she knows that she should have reported to the nurse, and she is trained to do so. The CNA B stated that staff are not supposed to move a resident during an assisted fall because the nurse needs to assess for injuries. The CNA B stated that she has been trained on Resident #1's care plan and did not follow the plan when she did not use a Hoyer lift. The CNA B stated that Resident #1 relies on staff to do all transfers, incontinence care and bathing. The CNA B stated that on 3/11/23 she observed bruising and swelling to Resident #1's ankle when she attempted incontinence care and that is when she notified the nurse of her observations but did not tell the nurse about the fall the previous day. The CNA B stated that neglect is not following a resident care plan or using a Hoyer lift. I don't know why we didn't use the Hoyer. I feel bad. It hurt me to see Resident #1 hurt. We didn't want that to happen to her. Every time I think about it, I feel awful that we didn't use the lift and she got hurt. It makes me cry to know we did that, and she got hurt. During an interview on 3/28/23 at 1:50 p.m. with the MA, stated that he was working on 3/10/23 in the hallway and heard someone call out his name to Resident #1's room. The MA stated that when he entered Resident #1's room he observed Resident #1 on the floor and CNA A, CNA B and Hospice CNA were in the room. The MA stated he knew that Resident #1 was a Hoyer lift but didn't think of that when he saw Resident #1 on the floor and he assisted CNA A, CNA B and the Hospice CNA lift Resident #1 off the floor and attempted to put her in the shower chair. The MA stated that the shower chair slid back, and Resident #1 was assisted by them again to the floor. The MA stated then they lifted Resident #1 up and placed her in the shower chair for the Hospice CNA to bathe her and he left the room. The MA stated he has been trained to notify the nurse if a resident has a fall or is on the ground and not to move the resident until a nurse 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 are any injuries. 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 notify the nurse after a fall and to use the Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 4/4/23 at 9:41 a.m. the Hospice CNA stated that she was working at the facility on 3/10/23 and walked into Resident #1's room to prepare her for a shower. The Hospice CNA stated she walked into the room and observed CNA A and CNA B in the room assisting another resident to bed. The Hospice CNA stated she had worked with Resident #1 five times before 3/10/23 and had been trained that the Resident required a Hoyer lift and 2 persons for all transfers and lifting. The Hospice CNA stated that staff told her that they didn't need the lift and the CNA A and CNA B lifted Resident #1 from her wheelchair and she attempted to pull down Resident #1's pants before they transferred her to the shower chair. The Hospice CNA stated that the resident went to the ground, and they assisted her to the ground. The Hospice CNA stated Resident #1 made a aah sound when she was on the ground. The Hospice CNA stated that the MA was called into the room and they (CNA A, CNA B, MA, and herself) lifted Resident #1 by each of them holding onto a limb and placed her in the shower chair. The Hospice CNA stated the shower chair did go back several inches, but she does not remember the resident going to the ground again. The Hospice CNA stated that she then took Resident #1 to bathe and during the bathing, Resident #1 stated that her right heel hurt. The Hospice CNA stated she called her supervisor and notified her that the resident was complaining 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 transfer. The Hospice CNA stated that by not following the care plan that stated that Resident #1 was a 2 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 Hospice CNA called her on 3/10/23 to notify her that Resident #1 stated that her right heel was hurting, and she(Hospice LVN) advised her to check 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 assisted fall during a transfer, nor did the Hospice CNA inform her that a transfer was done without the Hoyer lift. The Hospice LVN stated that the Hospice CNA has been trained that Resident #1 requires a two-person lift and a Hoyer lift during all transfers. The Hospice LVN stated that the 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 hospice agency of any resident falls and not to move a resident who has had a fall. 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 avoid physical harm, pain, mental anguish, or emotional distress. -Employees must report suspected abuse, neglect, mistreatment, or injury of unknown origin of a potential victim immediately to the DON and Administrator. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility provided Provider Investigation Report, report date to HHSC 3/11/23 revealed the following: -Incident date: 3/10/23 at 3:30 p.m. in Resident #1's room. Description of the allegation: Failure to follow resident care plan for transfers. Failure to report an assisted fall. Injury of unknown origin. -Description of injury: Right and lateral fracture of right malleolus. -Assessment on 3/11/23 at 11:12 a.m.: Green bruise to lower shin 7.4 cm X 4 cm, dark purple bruising rt ankle. Rt elbow 1 cm x 2.4 cm skin tear. 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 action 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. 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 is a mechanical device used to transfer a resident from and to the bed and chair. It is reserved for those who are paralyzed, obese, or too weak to transfer without complete assistance. The number of staff to provide assistance with the transfer should be determined by the manufacturer's recommendations. Goals include: The resident will achieve safe transfer to bed or chair via a mechanical lift device. The caregiver will demonstrate safe and correct transfer of the resident to the bed or chair via the hydraulic lift. (see training record) Record Review of facility provided SNFCLINIC training transcript for CNA A revealed the following completed training: What is Abuse; Lifting Machine, Using a Mechanical; Transferring from a Bed to Wheelchair using a transfer belt; Using a Hydraulic Lift; CNA-Safely Moving residents-Lifting and Transferring; Abuse, Neglect and Exploitation Fall Prevention Record Review of facility provided SNFCLINIC training transcript for CNA B revealed the following completed training: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 Record Review of facility provided SNFCLINIC training transcript for MA revealed the following completed training: 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.