STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455800	A. BUILDING ______ B. WING _____	**09/15/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHASE HEALTH AND REHABILITATION CENTER	**8820 TOWN PARK DR HOUSTON, TX 77036**

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 0224 **Level of harm -** Actual harm **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary services to prohibit neglect of one of seven residents (CR#1) reviewed for abuse and neglect: CR# 1 incurred a fall while two aides were utilizing a Hoyer lift in transferring him from a bed in his room to a shower bed (stretcher) in the hallway. The Hoyer lift tilted and caused CR #1 to fall and sustain an acute [MEDICAL CONDITION] tibia and fibula on [DATE]. CR #1 was transferred to the hospital following the fall where he died on [DATE]. This failure affected CR# 1 who sustained fractures and placed 51 residents at risk of not receiving safe assistance with Hoyer lift transfers which could lead to injuries. Intake # 1 and # 0 Findings include: Record review of CR# 1's face sheet revealed a [AGE] year old year male admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Record review of CR# 1's care plan not dated revealed CR#1 had self-care performance deficit related to [MEDICAL CONDITION]. Goal was to maintain current level of function on ADLs through review date. Approach include: transfer- the resident requires mechanical lift (Hoyer) with two staff assistance for transfer. Record review of CR # 1's MDS dated [DATE] revealed a cognition score of zero which meant the resident was severely impaired. CR#1 required extensive assistance with bed mobility, transfer, dressing, eating, personal hygiene and was dependent on staff for toilet use and bathing. Record review of CR # 1's nursing notes dated [DATE] at 10:53 a.m., revealed Resident was being transferred from his bed to the shower bed via Hoyer lift. Due to the improper positioning of the Hoyer base the Hoyer lift began to tilt. The resident was lowered to the floor by the two aides present. Upon assessment by RN, a reddened area (possible bruising) was noted to the left knee. Resident did not display any sign and symptoms of distress. MD was notified of the incident and orders for X-Ray were received . Record review of CR # 1's nursing notes dated [DATE] at 2:50 p.m., revealed Resident X-Ray result returned post fall acute fracture in proximal tibia and fibula; called MD and gave order to transfer resident to ER . Record review of CR # 1's X-ray result dated [DATE] revealed acute fracture in proximal tibia and fibula. Record review of facility ' s incident report for CR#1 dated [DATE] revealed Resident was being transferred from the shower bed to his bed. The resident was wheeled out from the bed and when the caregivers were about to wheel him back to his bed , the wheel of the Hoyer tilted over and they lowered the resident to the floor. resident sustained [REDACTED]. Record review of facility investigation report revealed a fracture of unknown origin. The incident date was [DATE] at 10:30 a.m. Further review of the incident description revealed the resident was being transferred by two CNAs from his bed to the shower bed. During the transfer the Hoyer lift tilted and the CNAs had to lower the resident to the floor. Upon initial head to toe assessment a bruise was noted on the resident ' s left knee. The physician was notified and an order was given for an X-Ray which indicated an acute fracture in the proximal tibia and fibula. Summary revealed written statements were obtained from the two CNAs and both individuals were trained on proper transfer procedure with Hoyer lift. Fracture was likely caused by lowering of the resident to the floor and his history of brittle bones. Further review of the investigation report dated [DATE] revealed post action taken post investigation- the two CNAs transferring the resident at the time of the incident were given additional training in transferring with a Hoyer lift. A nursing in-service was given on [DATE] for nursing department on lift and transfers. Record review of witness statement written by CNA#1 dated [DATE] revealed I was assisting CR#1 with a shower along with co-worker CNA#2. As we began to lift him in the air my co-worker guided the sling and I had the Hoyer lift. As he was in the air, I turned to the shower bed and the whole lift fell over . I have never seen anything like it. Prior to the lift I checked to make sure the weight was correct which 500 pounds was . Record review of witness statement written by CNA#2 dated [DATE] revealed CNA#2 would like to state the day of the fall of CR#1 was very tragic. I was helping another aide to put CR#1 onto the shower bed, when we hooked CR#1 onto the Hoyer lift. We pulled him close to the shower bed but before we could put him on it, somehow the Hoyer lift tilted over . It was an accident but both of us did everything correct due to my knowledge of the lift and transferring . Record review of facility training after the incident dated ,[DATE]-[DATE] revealed proper lift and transfer and reporting any broken sling or lift. CNA#1 and #2 were the only attendants. Further review of training details provided revealed Both CNAs were in-serviced and watched video on lift transferring , they were also verbally in serviced on proper alignment of a resident prior to turning , repositioning or transferring . No other staff education or in-services were provided at that time. Two attempts to interview CNA#1 on [DATE] were unsuccessful. He was a part time staff of the facility, and calls made to his phone were not returned. Interview on [DATE] at 11:20 a.m., CNA#2 stated she was called to assist CNA#1 in transferring CR#1 from the bed to the shower bed. Both aides placed a shower bed outside of the resident ' s room entrance because there was not enough space for the long shower bed in the room. She said they put the resident on the Hoyer lift and pulled the lift backward out of the room to the hallway where the shower bed was. CNA #2 held the resident and the sling while CNA#1 controlled the Hoyer and the remote. As CNA#1 was about to turn the Hoyer lift to be in a parallel position with the shower bed, the Hoyer lift tilted over and the resident came down with his back to the ground. She said she was trained on how to use the Hoyer lift but stated they did everything right and did not know what happened. CNA#2 said she received no one on one demonstration after the incident but was asked to watch a video on how to use the Hoyer lift. Interview on [DATE] about 12:20 p.m., CNA#3 said the Hoyer lifts in the facility have acceptable weights allowed. She explained that some of Hoyer lifts will tilt over if the weight was not evenly distributed. She illustrated with a 400 pound maximum Hoyer lift would shake and could tilt over if used on residents of 314 LBS despite the manufactures instruction. She further stated staff had to know which one to use on certain residents to be safe. Interview on [DATE] at 3:40 p.m., the DON said the facility determined the aides did not properly use the Hoyer lift during the transfer of CR#1 which resulted in the Hoyer lift tilting over. She said she was of the opinion that the aides lowered the resident to the floor and the fall occurred while the resident was being transferred back to bed from the shower bed. The DON further said the aides should not use the Hoyer lift as a mode of transportation. She said it was determined the base of the Hoyer lift was closed instead of open which caused the lift to tilt over. The DON agreed there were lots of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455800**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/15/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHASE HEALTH AND REHABILITATION CENTER	**8820 TOWN PARK DR HOUSTON, TX 77036**

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 0224

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
inconsistent documentation regarding the incident which the facility should have identified during their investigation. The DON said the two aides were re-educated and she would continue to educate staff on proper use of the lift. She explained the two aides were given verbal education and they watched a video on Hoyer lift use. The DON was asked why other facility staff were not trained and if a return demonstration was conducted with the staff using the facility Hoyer lifts, and she said no.
Interview on [DATE] at 4:35 p.m., the facility Administrator agreed the incident could have been avoided if staff used the right technique during CR#1 ' s transfer. She further said the facility identified the staff needed additional training which was given. The Administrator agreed the facility did not ensure the safety of the residents dependent on Hoyer lift for transfer when they failed to train staff on the proper use of the Hoyer lifts in the facility instead of a video and also to ensure understanding of training with return demonstration.
Record review of facility policy on abuse and neglect prohibition dated [DATE] revealed each resident has the right to free from mistreatment , neglect , abuse , involuntary seclusion, injuries of unknown origin and misappropriation of property .
Facility census dated [DATE] listed 51 residents required the use of the Hoyer lift for transfers.

F 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation , interview and record review, the facility failed to implement their written policies and procedures concerning the timely investigation and reporting of neglect for two of seven residents (CR# 1 and Resident #5) reviewed for abuse and neglect
The facility failed to timely report to state office when CR# 1 incurred a fall while two aides were utilizing a Hoyer lift in transferring him from a bed in his room to a shower bed (stretcher) in the hallway. The Hoyer lift tilted and caused CR #1 to fall and sustain an acute [MEDICAL CONDITION] tibia and fibula on [DATE]. CR #1 was transferred to the hospital following the fall where he died on [DATE]. The facility reported the incident on [DATE].
The facility failed to investigate and report to the state agency when Resident #5 was diagnosed with [REDACTED].
This failure affected two residents who suffered fractures and placed 17 residents who had a history of [REDACTED].
Findings include:
Intake # 1 and # 0
Record review of CR# 1's face sheet revealed a [AGE] year old year male admitted to the facility on [DATE]. [DIAGNOSES REDACTED].
Record review of facility investigation report revealed a fracture of unknown origin. The incident date was [DATE] at 10:30 a.m. Further review of the incident description revealed the resident was being transferred by two CNAs from his bed to the shower bed. During the transfer the Hoyer lift tilted and the CNAs had to lower the resident to the floor. Upon initial head to toe assessment a bruise was noted on the resident ' s left knee. The physician was notified and an order was given for an X-Ray which indicated an acute fracture in the proximal tibia and fibula. Summary revealed written statements were obtained from the two CNAs and both individuals were trained on proper transfer procedure with Hoyer lift. Fracture was likely caused by lowering of the resident to the floor and his history of brittle bones.
Interview on [DATE] at 3:40 p.m., the DON said the facility determined the aides did not properly use the Hoyer lift during the transfer of CR#1 which resulted in the Hoyer lift tilting over. She said she was of the opinion that the aides lowered the resident to the floor and the fall occurred while the resident was being transferred back to bed from the shower bed. The DON further said the aides should not use the Hoyer lift as a mode of transportation. She said it was determined the base of the Hoyer lift was closed instead of open which caused the lift to tilt over. The DON agreed there were lots of inconsistent documentation regarding the incident which the facility should have identified during their investigation. The DON said the two aides were re-educated and she would continue to educate staff on proper use of the lift. She explained the two aides were given verbal education and they watched a video on Hoyer lift use. The DON was asked why other facility staff were not trained and if a return demonstration was conducted with the staff using the facility Hoyer lifts, and she said no.
Interview on [DATE] at 4:35 p.m., the facility Administrator agreed the incident could have been avoided if staff used the right technique during CR#1 ' s transfer. She further said the facility identified the staff needed additional training which was given. The Administrator agreed the facility did not ensure the safety of the residents dependent on Hoyer lift for transfer when they failed to train staff on the proper use of the Hoyer lifts in the facility instead of a video and also to ensure understanding of training with return demonstration.
Further Interview on [DATE] at 4:35p.m., the facility Administrator said the facility reported the incident to state agency on [DATE]. She further said the facility was aware of how the injury was sustained and therefore did not think it was reportable incident. She however said after the facility ' s investigation, it was determined the CNAs did not use the appropriate technique during transfer and required additional training.
Resident #5
Record review of Resident # 5 ' s face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED].
Record review of Resident # 5 ' s MDS dated [DATE] revealed a cognitive score of one which meant the resident's cognition was severely impaired. The resident required extensive assistance from staff for bed mobility, transfer, dressing, eating, and personal hygiene. Ambulation did not occur during the assessment period and she was dependent on staff for toilet use and bathing.
Record review of Resident # 5 ' s left knee X-Ray dated [DATE] revealed the reason for the X-ray was the resident had pain for two days. Further review of the result revealed a fracture mid-portion of patella was seen.
Record review of facility ' s incident/accident log revealed Resident # 5 had falls on [DATE]-no incident report, [DATE]-fall in resident ' s room; Resident ' s outcome was fracture and action taken - hospitalization . State notified (checked) [DATE], and [DATE].
Observation and interview on [DATE] at 9:38 a.m., revealed Resident #5 in bed, alert but very confused. Resident # 5 was Spanish speaking and did not speak English. She was noted with brace to her left leg. Unit manger #1 reported the resident had an injury (left knee fracture) from a fall.
Interview on [DATE] at 1:36 p.m., RN#1 said she was not aware of how Resident #5 sustained a fracture. She stated the resident was a fall risk and had multiple falls. The resident had complained of pain to left knee and the X-ray showed she had fractures.
Interview on [DATE] at 3:40 p.m., the DON said did not know why Resident #5 ' s fracture of unknown origin was not reported. She said the Administrator handle the issue because she was on vacation.
Interview on [DATE] at 4:40 p.m., the facility Administrator said she did not think Resident# 5 ' s fracture of unknown origin was a reportable. She said the facility believed it must have been caused by one of her numerous falls. She said the resident was constantly attempting to ambulate and staff could not restrain her. She said the facility did not feel it had anything to do with abuse or neglect.
Record review of facility policy on abuse and neglect prohibition dated [DATE] revealed each resident has the right to free from mistreatment, neglect, abuse , involuntary seclusion, injuries of unknown origin and misappropriation of property. The facility will report all allegations and substantiated occurrence of abuse , neglect , injuries of unknown origin, and misappropriation of property to the state agency and law enforcement officials as designated by the state law.
The facility DON reported 18 residents had historys of falls.

F 0226

Level of harm - Actual harm

Residents Affected - Few

Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHASE HEALTH AND REHABILITATION CENTER	**8820 TOWN PARK DR HOUSTON, TX 77036**

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 0226 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation , interview and record review, the facility failed to implement their written policies and procedures concerning the reporting of neglect for two of seven residents (CR# 1 and Resident #5) reviewed for abuse and neglect The facility failed to timely report to state office when CR# 1 incurred a fall while two aides were utilizing a Hoyer lift in transferring him from a bed in his room to a shower bed (stretcher) in the hallway. The Hoyer lift tilted and caused CR #1 to fall and sustain an acute [MEDICAL CONDITION] tibia and fibula on [DATE]. CR #1 was transferred to the hospital following the fall where he died on [DATE]. The facility reported the incident on [DATE]. The facility failed to investigate and report to the state agency when Resident #5 was diagnosed with [REDACTED]. This failure affected two residents who suffered fractures and placed 17 residents who had a history of [REDACTED]. Findings include: Intake # 1 and # 0 Record review of facility policy on abuse and neglect prohibition dated [DATE] revealed each resident has the right to free from mistreatment , neglect , abuse , involuntary seclusion, injuries of unknown origin and misappropriation of property . Further review of policy revealed the facility would report all allegations and substantiated occurrence of abuse, neglect, injuries of unknown origin, and misappropriation of property to the state agency and law enforcement officials as designated by the state law. Record review of CR# 1's face sheet revealed a [AGE] year old year male admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Record review of CR# 1's care plan not dated revealed CR#1 had self-care performance deficit related to [MEDICAL CONDITION]. Goal was to maintain current level of function on ADLs through review date. Approach include: transfer- the resident requires mechanical lift (Hoyer) with two staff assistance for transfer. Record review of CR # 1's MDS dated [DATE] revealed a cognition score of zero which meant the resident was severely impaired. CR#1 required extensive assistance with bed mobility, transfer, dressing, and eating, personal hygiene and was dependent on staff for toilet use and bathing. Record review of CR # 1's nursing notes dated [DATE] at 10:53 a.m., revealed Resident was being transferred from his bed to the shower bed via Hoyer lift. Due to the improper positioning of the Hoyer base the Hoyer lift began to tilt. The resident was lowered to the floor by the two aides present. Upon assessment by RN, a reddened area (possible bruising) was noted to the left knee. Resident did not display any sign and symptoms of distress. MD was notified of the incident and orders for X-Ray were received . Record review of CR # 1's X-ray result dated [DATE] revealed acute fracture in proximal tibia and fibula. Record review of facility investigation report dated [DATE] revealed fracture of unknown origin; incident date was [DATE] at 10:30a.m. Further review of incident description revealed the resident was being transferred by two CNAs from his bed to the shower bed. During the transfer the Hoyer lift tilted and the CNAs had to lower the resident to the floor. Upon initial head to toe assessment a bruise was noted on the resident ' s left knee, physician was notified and order was given for X-Ray which indicated an acute fracture in proximal tibia and fibula. Summary revealed written statements were obtained from the two CNAs and both individuals were trained on proper transfer procedure with Hoyer lift. Fracture was likely caused by lowering of the resident to the floor and his history of bristle bones. Investigation finding was confirmed. Interview on [DATE] at 4:35 p.m., the facility Administrator said the facility reported the incident to the state agency on [DATE]. She further said the facility was aware of how the injury was sustained and therefore did not think it was reportable incident. She however said after the facility ' s investigation, it was determined the CNAs did not use the appropriate technique during transfer and required additional training. Resident #5 Record review of Resident # 5 ' s face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident # 5 ' s MDS dated [DATE] revealed cognitive score of one, and required extensive assistance for bed mobility, transfer, dressing, eating, and personal hygiene. Ambulation did not occur and she was dependent with toilet use and bathing. Record review of Resident # 5 ' s left knee X-Ray dated [DATE] revealed reason for X-ray was pain for 2 days. Further review of result revealed fracture mid-portion of patella was seen. Record review of facility ' s incident/accident log revealed Resident # 5 had falls on [DATE]-no incident report, [DATE]-fall in resident ' s room; Resident ' s outcome was fracture and action taken - hospitalization . State notified (checked). [DATE], and [DATE]. Further review of incidents reports revealed on [DATE] at 2:30p.m., resident was sitting in a Geri chair outside of room, the resident appears to have gotten out and attempted to walk towards shower room, and she was observed on the floor , upon assessment, no injury and complaint of pain was noted. Observation and interview on [DATE] at 9:38 a.m., revealed Resident #5 in bed, alert but very confused. Resident # 5 was Spanish speaking and did not speak English .She was noted with brace to left leg. Unit manger #1 reported the resident had injury (left knee fracture) from a fall. Interview on [DATE] at 3:40 p.m., the DON said she did not know why Resident #5 ' s fracture of unknown origin was not reported. She said the Administrator handled the issue because she was on vacation. Interview on [DATE] at 4:40 p.m., The facility Administrator said she did not think Resident# 5 ' s fracture of unknown origin was reportable. She said the facility believed it must have been caused by one of her numerous falls. She said the resident was constantly attempting to ambulate and staff cannot restrain her. She said the facility did not think it had anything to do with abuse or neglect. The facility DON reported 17 residents had historys of falls.
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to emsure resident's environment remained as free of accident hazards as was possible, and each resident received adequate supervision and assistance devices to prevent an accident for one of seven residents (CR#1) reviewed for accidents and supervision. CR# 1 incurred a fall while two aides were utilizing a Hoyer lift in transferring him from a bed in his room to a shower bed (stretcher) in the hallway. The Hoyer lift tilted and caused CR #1 to fall and sustain an acute fracture of the proximal tibia and fibula on [DATE]. CR #1 was transferred to the hospital following the fall where he died on [DATE]. This failure affected CR# 1 who sustained fractures and placed 51 residents at risk of not receiving safe assistance with Hoyer lift transfers which could lead to injuries. Intake # 1 and # 0 Findings include: Record review of CR# 1's face sheet revealed a [AGE] year old year male admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Record review of CR# 1's care plan not dated revealed CR#1 had self-care performance deficit related to [DIAGNOSES REDACTED]. Goal was to maintain current level of function on ADLs through review date. Approach include: transfer- the resident requires mechanical lift (Hoyer) with two staff assistance for transfer. Record review of CR # 1's MDS dated [DATE] revealed a cognition score of zero which meant the resident was severely impaired. CR#1 required extensive assistance with bed mobility, transfer, dressing, eating, personal hygiene and was dependent on staff for toilet use and bathing. Record review of CR # 1's nursing notes dated [DATE] at 10:53 a.m., revealed Resident was being transferred from his bed to the shower bed via Hoyer lift. Due to the improper positioning of the Hoyer base the Hoyer lift began to tilt. The resident was lowered to the floor by the two aides present. Upon assessment by RN, a reddened area (possible bruising) was noted to

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NAME OF PROVIDER OF SUPPLIER **WESTCHASE HEALTH AND REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **8820 TOWN PARK DR HOUSTON, TX 77036**	

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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 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) the left knee. Resident did not display any sign and symptoms of distress. MD was notified of the incident and orders for X-Ray were received . Record review of CR # 1's nursing notes dated [DATE] at 2:50 p.m., revealed Resident X-Ray result returned post fall acute fracture in proximal tibia and fibula; called MD and gave order to transfer resident to ER . Record review of CR # 1's X-ray result dated [DATE] revealed acute fracture in proximal tibia and fibula. Record review of facility ' s incident report for CR#1 dated [DATE] revealed Resident was being transferred from the shower bed to his bed. The resident was wheeled out from the bed and when the caregivers were about to wheel him back to his bed , the wheel of the Hoyer tilted over and they lowered the resident to the floor. resident sustained [REDACTED]. Record review of facility investigation report revealed a fracture of unknown origin. The incident date was [DATE] at 10:30 a.m. Further review of the incident description revealed the resident was being transferred by two CNAs from his bed to the shower bed. During the transfer the Hoyer lift tilted and the CNAs had to lower the resident to the floor. Upon initial head to toe assessment a bruise was noted on the resident ' s left knee. The physician was notified and an order was given for an X-Ray which indicated an acute fracture in the proximal tibia and fibula. Summary revealed written statements were obtained from the two CNAs and both individuals were trained on proper transfer procedure with Hoyer lift. Fracture was likely caused by lowering of the resident to the floor and his history of brittle bones. Further review of the investigation report dated [DATE] revealed post action taken post investigation- the two CNAs transferring the resident at the time of the incident were given additional training in transferring with a Hoyer lift. A nursing in-service was given on [DATE] for nursing department on lift and transfers. Record review of witness statement written by CNA#1 dated [DATE] revealed I was assisting CR#1 with a shower along with co-worker CNA#2. As we began to lift him in the air my co-worker guided the sling and I had the Hoyer lift. As he was in the air, I turned to the shower bed and the whole lift fell over . I have never seen anything like it. Prior to the lift I checked to make sure the weight was correct which 500 pounds was . Record review of witness statement written by CNA#2 dated [DATE] revealed CNA#2 would like to state the day of the fall of CR#1 was very tragic. I was helping another aide to put CR#1 onto the shower bed, when we hooked CR#1 onto the Hoyer lift. We pulled him close to the shower bed but before we could put him on it, somehow the Hoyer lift tilted over . It was an accident but both of us did everything correct due to my knowledge of the lift and transferring . Record review of facility training after the incident dated ,[DATE]-[DATE] revealed proper lift and transfer and reporting any broken sling or lift. CNA#1 and #2 were the only attendants. Further review of training details provided revealed Both CNAs were in-serviced and watched video on lift transferring , they were also verbally in serviced on proper alignment of a resident prior to turning , repositioning or transferring . No other staff education or in-services were provided at that time. Two attempts to interview CNA#1 on [DATE] were unsuccessful. He was a part time staff of the facility, and calls made to his phone were not returned. Interview on [DATE] at 11:20 a.m., CNA#2 stated she was called to assist CNA#1 in transferring CR#1 from the bed to the shower bed. Both aides placed a shower bed outside of the resident ' s room entrance because there was not enough space for the long shower bed in the room. She said they put the resident on the Hoyer lift and pulled the lift backward out of the room to the hallway where the shower bed was. CNA #2 held the resident and the sling while CNA#1 controlled the Hoyer and the remote. As CNA#1 was about to turn the Hoyer lift to be in a parallel position with the shower bed, the Hoyer lift tilted over and the resident came down with his back to the ground. She said she was trained on how to use the Hoyer lift but stated they did everything right and did not know what happened. CNA#2 said she received no one on one demonstration after the incident but was asked to watch a video on how to use the Hoyer lift. Interview on [DATE] about 12:20 p.m., CNA#3 said the Hoyer lifts in the facility have acceptable weights allowed. She explained that some of Hoyer lifts will tilt over if the weight was not evenly distributed. She illustrated with a 400 pound maximum Hoyer lift would shake and could tilt over if used on residents of 314 LBS despite the manufactures instruction. She further stated staff had to know which one to use on certain residents to be safe. Interview on [DATE] at 3:40 p.m., the DON said the facility determined the aides did not properly use the Hoyer lift during the transfer of CR#1 which resulted in the Hoyer lift tilting over. She said she was of the opinion that the aides lowered the resident to the floor and the fall occurred while the resident was being transferred back to bed from the shower bed. The DON further said the aides should not use the Hoyer lift as a mode of transportation. She said it was determined the base of the Hoyer lift was closed instead of open which caused the lift to tilt over. The DON agreed there were lots of inconsistent documentation regarding the incident which the facility should have identified during their investigation. The DON said the two aides were re-educated and she would continue to educate staff on proper use of the lift. She explained the two aides were given verbal education and they watched a video on Hoyer lift use. The DON was asked why other facility staff were not trained and if a return demonstration was conducted with the staff using the facility Hoyer lifts, and she said no. Interview on [DATE] at 4:35 p.m., the facility Administrator agreed the incident could have been avoided if staff used the right technique during CR#1 ' s transfer. She further said the facility identified the staff needed additional training which was given. The Administrator agreed the facility did not ensure the safety of the residents dependent on Hoyer lift for transfer when they failed to train staff on the proper use of the Hoyer lifts in the facility instead of a video and also to ensure understanding of training with return demonstration. Record review of facility policy on abuse and neglect prohibition dated [DATE] revealed each resident has the right to free from mistreatment , neglect , abuse , involuntary seclusion, injuries of unknown origin and misappropriation of property . Facility census dated [DATE] listed 51 residents required the use of the Hoyer lift for transfers.
F 0505 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Quickly tell the resident's doctor the results of lab tests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promptly notify the physician of lab results of one of seven residents (CR#1) whose laboratory results were reviewed. CR # 1's urine culture sample collected 8/8/15 was never received by the facility and was not communicated to the CR#1 ' s physician. This failure affected one resident and placed 134 residents at risk for delay in treatment and worsening of a medical condition due to their labs not being promptly reviewed and addressed by their physicians. Intake # 1 and # 0 Findings include: Record review of CR# 1's face sheet revealed a [AGE] year old year male admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Record review of CR#1 ' s physician's orders [REDACTED]. Record review of CR#1 ' s clinical record revealed a urine analysis result dated 8/10/15 which indicated a preliminary report of Gram negative Rods greater than 100,000 cfu/ml. Hand written on the result was spoke with RN, awaiting result of sensitivity . Further review of CR#1 ' s record revealed no urine culture with sensitivity. Record review of CR#1 ' s nurses notes dated 8/10/15 at 9:50 p.m., revealed Urine analysis results Gram negative rods greater than 100,000 cfu/ml, please call MD with BMP (Basal metabolic panel) and sensitivity results when they are in . Record review of CR#1 ' s nurses notes dated 8/11/15 at 6:36 a.m., revealed final result for culture and sensitivity and BPM not in at this time, please AM nurses follow up . Record review of CR#1 ' s nurses notes dated 8/11/15 at 09:45 a.m.,revealed called the lab company for CR#1 ' s urine culture and sensitivity result, said it is still pending, will continue to follow up . There were no further documentations regarding the urine culture and sensitivity result. Interview on 9/15/15 at 1:36 p.m., RN#1 said she contacted the lab company on 8/11/15 but was informed the lab was still pending. She stated she asked other nurses to follow up but it was never received. RN#1 said she called the lab company and they were to fax over the results which were never received prior to exit. Interview on 9/15/15 at 3:40 p.m., the DON said the nurses should have followed up on the lab. The DON said she was not aware of this lab. She further said CR#1 had a lot going on.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455800	A. BUILDING ______ B. WING _____	**09/15/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHASE HEALTH AND REHABILITATION CENTER	**8820 TOWN PARK DR HOUSTON, TX 77036**

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 0505 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) Record review of the facility's policy on laboratory management dated February 2010 revealed residents requiring laboratory services will receive accurate and timely laboratory services so that the utilization of laboratory testing for [DIAGNOSES REDACTED]. The facility is responsible for quality and timely laboratory services whether or not they are provided by the facility or an outside agency. The attending physician will be promptly notified of laboratory finding so that prompt , appropriate actions may be taken if indicated for the resident care. After notification of MD, lab results should be filed in medical record . The facility's census dated 9/15/15 listed 134 residents.
F 0507 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Keep complete, dated lab records in the resident's file.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to file in the resident's clinical record, laboratory reports that were dated and contained the name and address of the testing laboratory for one of seven residents (CR#1) whose laboratory reports were reviewed: CR # 1's urine culture sampled collected 8/8/15 was never received by facility, and was not filed in his clinical record. This deficient practice affected one resident and placed 134 residents at risk of inadequate treatment due to unavailability of lab reports for the physician to review. Intake # 1 and # 0 Findings include: Record review of CR# 1's face sheet revealed a [AGE] year old year male admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Record review of CR#1 ' s physician's orders [REDACTED].>Record review of CR#1 ' s clinical record revealed urine analysis result dated 8/10/15 which indicated preliminary report of Gram negative Rods greater than 100,000 cfu/ml. Hand written on the result was spoke with RN, awaiting result of sensitivity . Further review of CR#1 ' s record revealed no urine culture with sensitivity report. Record review of CR#1 ' s nurses notes dated 8/10/15 at 9:50 p.m., revealed Urine analysis results Gram negative rods greater than 100,000 cfu/ml, please call MD with BMP (Basal metabolic panel) and sensitivity results when they are in . Record review of CR#1 ' s nurses notes dated 8/11/15 at 6:36 a.m., revealed final result for culture and sensitivity and BPM not in at this time, please AM nurses follow up . Record review of CR#1 ' s nurses notes dated 8/11/15 at 09:45 a.m., revealed called the lab company for CR#1 ' s urine culture and sensitivity result, said it is still pending, will continue to follow up . There were no further documentations regarding the urine culture and sensitivity result. Interview on 9/15/15 at 1:36 p.m., RN#1 said she contacted the lab company on 8/11/15 but was informed the was still pending, she asked other nurses to follow up but it was never received. RN#1 said she called the lab company and they were to fax over the result which was never received prior to exit. Interview on 9/15/15 at 3:40 p.m., the DON said the nurses should have followed up on the lab. The DON said she was not aware of this lab. The DON agreed the urine culture result should have been obtained from the Lab Company and should be part of CR#1 ' clinical records. Record review of the facility's policy on laboratory management dated February 2010 revealed residents requiring laboratory services will receive accurate and timely laboratory services so that the utilization of laboratory testing for [DIAGNOSES REDACTED]. The facility is responsible for quality and timely laboratory services whether or not they are provided by the facility or an outside agency. The attending physician will be promptly notified of laboratory finding so that prompt , appropriate actions may be taken if indicated for the resident care. After notification of MD, lab results should be filed in medical record . The facility's census dated 9/15/15 listed 134 residents.