STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455699	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON PLACE WHARTON	1405 VALHALLA DR WHARTON, TX 77488

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for 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** Based on interview and record review the facility failed to ensure adequate supervision and assistance devices to prevent accidents were provided to one resident of three residents (Resident #1) reviewed for accident prevention, in that; -CNA A and Nurse Aide used a broken Hoyer lift on Resident #1 which caused Resident #1 to be not transferred properly from his wheelchair to the bed. -CNA A and Nurse Aide failed to notify facility of a broken Hoyer lift. These failures affected one resident and placed him at risk of injury, pain and a diminished quality of life. Findings include: Record review of the face sheet for Resident #1 revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's Annual MDS dated [DATE] revealed a BI[CONDITION] score of 9 indicating he was moderately impaired. He was coded as totally dependent on two person for transfer and using a wheelchair for mobility. Record review of Resident #1's care plan dated 0[DATE] revealed the following care plan: problem: Resident is at risk for falls r/t to Hoyer lift .resident has osteopenia and is at high risk for fractures . Goal: Resident will be treated very gently by all staff during cares and transfers . Approach: assistive device as needed .notify charge nurse .as appropriate of a changes/issues . Record review of the facility's individual Inservice form dated 4/22/20 read in part, .Resident #1 came to RNC and stated that his leg had got hurt in the Hoyer lift while 2 staff were transferring .he stated it was not done on purpose .this was not reported to the charge nurse . Record review of the facility's maintenance log from February 2020- present (4/29/20) revealed no concerns listed about Hoyer lifts. Interview with Resident #1 on 4/24/20 at 4:05pm, on Monday (4/20) at night around 5:30pm 2 CNA's (CNA A and nurse aide) were in the process of transferring him from wheelchair to bed. He said one of them went and got this really old machine, I have never seen that machine here before. It was old, out dated and rusty. He said they tried to transfer him, but the machine was making sounds and the swing part wouldn't go above the bed and kept going down, they couldn't get the machine higher. He said the aides ended up having to hold the bottom of the sling and lowering him to bed. When asked, if he fell he said that he did not. He again said that the machine was broken and that he had never seen this machine before in the facility. Phone interview with CNA A on 4/29/20 at 9:50am, she said she was a full time CNA. When asked if she remembered working on 4/20/20, she said yes but could not recall which hall she worked. Surveyor asked if she recalled working with Resident #1 that day and she said yes. When asked if she transferred Resident #1 on 4/20/20, she said that she did. She said her and another aide (Nurse Aide) transferred Resident #1 from wheelchair to the bed on the Hoyer. When asked her about how the transfer went, she said, it was bad equipment. She said there was no sign or anything on the equipment to indicate that it was broken. When asked at what point did she realize the Hoyer was broken, she said it was after she had raised Resident #1 up above the bed and tried to get his head aligned with the head of the bed, the sling started to lower on it's own. At that point her and the other aide held the bottom of the sling and put him on the bed. She said Resident #1 did not fall and did not hurt himself anywhere from what she could tell. Phone interview with Nurse Aide on 4/29/20 at 10:11am, she said she was a full time aide at the facility. She said she does recall doing a transfer with CNA A on 4/20/20 with Resident #1. She said that CNA A was doing the transfer and then he started going down when she lifted him above bed so we both put him down on the bed. When asked where they got the Hoyer lift from, she said it was in the beauty salon because that's where all the Hoyer's were kept. She said on that day it was the only one that was there. There was no sign or anything on it to indicate it was broken. When asked if she told anyone about the Hoyer after the transfer with Resident #1, she said that she did not tell anyone. When asked why she did not tell anyone, she did not say anything. Interview with Maintenance Director on 4/29/20 at 10:25am, when asked how he was notified of broken items in the facility he said that there was a maintenance book that the staff write on and he checks it daily. When asked how many Hoyer's were in the facility, he said he believes there were 3. When asked if any of them were broken he said that he was not aware of any of them being broken. He said no one had mentioned anything to him and he had not seen it on his maintenance book. He said if they did tell him that there was a broken Hoyer, he would try to fix it himself and if he could not fix it, he would call the manufacture to come and fix it. He said all the Hoyer's were kept in the beauty salon. Phone Interview with LVN A on 4/29/20 at 6:50pm, he said he worked the 6pm-6am shift on 4/20/20 as the nurse for the 100 hall (where Resident #1 resided). He said Resident #1 was his patient that day. He said no one told him about a Hoyer being broken or not functioning properly that evening. He said had he known, he would have removed it from the floor. In another phone interview with CNA A on 4/30/20 at 9:40am, when asked what she did with the Hoyer after the transfer with Resident #1 on 4/20/20 she said that she just put it back in the beauty shop. She said that she did not tell anyone that it was broken. I mean I know that sounds bad but that's the truth because we used that Hoyer all the time and never had a problem with it. But I think it was the next day regional nurse asked me to point out which Hoyer it was, and I did and she removed it. Phone interview with Regional Nurse on 4/30/20 at 9:55am, she said she was the regional nurse for the facility. She said she had been coming into the facility pretty much daily since the DON left. When asked about the incident with Resident #1, she said that last Wednesday (4/22/20) Resident #1 wheeled himself to her office and told her that he hurt his leg on the Hoyer on 4/20/20. She said she asked him what happened and he told her that 2 CNA's were doing a transfer on him on the Hoyer lift and the Hoyer did not go high enough so his foot got caught in between the Hoyer. She said she immediately assessed his legs, there was no bruising, swelling, or redness or anything noted. She said she then got the 2 aides and asked them about the incident and what they said was consistent with what Resident #1 had said. She said she asked the CNA's to point out the Hoyer that they used and they did. She said she immediately removed that Hoyer from the floor and put it in the DON's office. When asked why the CNA's didn't report the Hoyer being broken to the facility, she said that she thinks that they were just scared but that they should have reported it. Interview with Administrator on 4/30/20 at 10:15am, she said on last Wednesday (4/22/20) the regional nurse brought Resident #1 into her office and said that he had a complaint. When she asked him what his concern was, he said that he hurt his leg on Monday (4/20/20) on the Hoyer. He told her that 2 CNA's were transferring him on an old Hoyer and it hurt his knee. She said the resident told her that he knew that the staff didn't do it on purpose. Administrator said that she spoke with the CNA's after and they told her that the Hoyer was hard to maneuver. She said her and the regional nurse immediately removed the Hoyer from the floor. She said the facility has other Hoyer's in the facility that's available for staff to use. She agreed that the aides should have notified the facility about the Hoyer not working properly. Record review of the facility's policy for safety and supervision of residents revised December 2007 read in part, . our facility strives to make the environment as free from accident hazards as possible .resident safety and supervision and assistance to prevent accidents are facility-wide priorities .employees shall be trained and in serviced on .accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents .
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep all essential equipment working safely.**

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.

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F 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all resident-care equipment was maintained in a safe and operating condition for 1 of 3 (Resident # 1), residents reviewed for safe operating equipment in that: The facility failed to ensure that a Hoyer lift used for Resident #1 was in safe functioning condition. This failure affected 1 resident and placed him at risk of falls injury or harm. Findings include: Record review of the face sheet for Resident #1 revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's Annual MDS dated [DATE] revealed a BI[CONDITION] score of 9 indicating he was moderately impaired. He was coded as totally dependent on two person for transfer and using a wheelchair for mobility. Record review of Resident #1's care plan dated 0[DATE] revealed the following care plan: problem: Resident is at risk for falls r/t to Hoyer lift .resident has osteopenia and is at high risk for fractures . Goal: Resident will be treated very gently by all staff during cares and transfers . Approach: assistive device as needed .notify charge nurse .as appropriate of a changes/issues . Record review of the facility's individual Inservice form dated 4/22/20 read in part, .Resident #1 came to RNC and stated that his leg had got hurt in the Hoyer lift while 2 staff were transferring .he stated it was not done on purpose .this was not reported to the charge nurse . Record review of the facility's maintenance log from February 2020- present (4/29/20) revealed no concerns listed about Hoyer lifts. Interview with Resident #1 on 4/24/20 at 4:05pm, on Monday (4/20) at night around 5:30pm 2 CNA's (CNA A and nurse aide) were in the process of transferring him from wheelchair to bed. He said one of them went and got this really old machine, I have never seen that machine here before. It was old, out dated and rusty. He said they tried to transfer him, but the machine was making sounds and the swing part wouldn't go above the bed and kept going down, they couldn't get the machine higher. He said the aides ended up having to hold the bottom of the sling and lowering him to bed. When asked, if he fell he said that he did not. He again said that the machine was broken and that he had never seen this machine before in the facility. Phone interview with CNA A on 4/29/20 at 9:50am, she said that she was a full time CNA. When asked if she remembered working on 4/20/20, she said yes but could not recall which hall she worked. Surveyor asked if she recalls working with Resident #1 that day and said yes. When asked if she transferred Resident #1 on 4/20/20, she said that she did. She said her and another aide (Nurse Aide) transferred Resident #1 from wheelchair to the bed on the Hoyer. When asked her about how the transfer went, she said, it was bad equipment. She said there was no sign or anything on the equipment to indicate that it was broken. When asked at point did she realize the Hoyer was broken, she said it was after she had raised Resident #1 up above the bed and tried to get his head aligned with the head of the bed, the sling started to lower on it's own. At that point her and the other aide held the bottom of the sling and put him on the bed. She said Resident #1 did not fall and did not hurt himself anywhere from what she could tell. Phone interview with Nurse Aide on 4/29/20 at 10:11am, she said she was a full time aide at the facility. She said she does recall doing a transfer with CNA A on 4/20/20 with Resident #1. She said that CNA A was doing the transfer and then he started going down when she lifted him above bed so we both put him down on the bed. When asked where they got the Hoyer lift from, she said it was in the beauty salon because that's where all the Hoyer's were kept. She said on that day it was the only one that was there. There was no sign or anything on it to indicate it was broken. When asked if she told anyone about the Hoyer after the transfer with Resident #1, she said that she did not tell anyone. When asked why she did not tell anyone, she did not say anything. Interview with Maintenance Director on 4/29/20 at 10:25am, when asked how he was notified of broken items in the facility he said that there was a maintenance book that the staff write on and he checks it daily. When asked how many Hoyer's were in the facility, he said he believes there were 3. When asked if any of them were broken he said that he was not aware of any of them being broken. He said no one has mentioned anything to him and he has not seen it on his maintenance book. He said if they did tell him that there was a broken Hoyer, he would try to fix it himself and if he could not fix it, he would call the manufacture to come and fix it. He said all the Hoyer's were kept in the beauty salon. Phone interview with Regional Nurse on 4/30/20 at 9:55am, she said she was the regional nurse for the facility. She said she had been coming into the facility pretty much daily since the DON left. When asked about the incident with Resident #1, she said that last Wednesday (4/22/20) Resident #1 wheeled himself to her office and told her that he hurt his leg on the Hoyer on 4/20/20. She said she asked him what happened and he told her that 2 CNA's were doing transfer on him on the Hoyer lift and the Hoyer did not go high enough so his foot got caught in between the Hoyer. She said she asked the CNA's to point out the Hoyer that they used and they did. She said she immediately removed that Hoyer from the floor and put it in the DON's office. When asked why the CNA's didn't report the Hoyer being broken to the facility, she said that she thinks that they were just scared but that they should have reported it. Interview with Administrator on 4/30/20 at 10:15am, she said on last Wednesday (4/22/20) the regional nurse brought Resident #1 into her office and said that he had a complaint. When she asked him what his concern was, he said that he hurt his leg on Monday (4/20/20) on the Hoyer. He told her that 2 CNA's were transferring him on an old Hoyer and it hurt his knee. She said the resident told her that he knew that the staff didn't do it on purpose. Administrator said that she spoke with the CNA's after and they told her that the Hoyer was hard to maneuver. She said her and the regional nurse immediately removed the Hoyer from the floor. She said the facility has other Hoyer's in the facility that's available for staff to use. She agreed that the aides should have notified the facility about the Hoyer not working properly. When asked how often the Hoyer lifts should be checked, she said she was not sure and would have to look into it. She said that the Maintenance Director was responsible for maintaining the Hoyer lifts and for checking it to ensure it was safe to use. Observation of the Hoyer lift in the DON's office that's been identified as the broken Hoyer on 04/30/20 at 11:00am, revealed a sticker on the side that read that it was last checked on 10/2/19 and it was due 10/31/20. Interview with the Maintenance Director at this time of observation, he said that he had not checked this Hoyer lift yet to see if there was anything wrong with it. He said normally, he checks it first to see if there was anything wrong with it and if he could not fix it, he would call the manufacturing company to come fix it. He said he can't recall when he checked this machine last, he said this was one of the old Hoyer's. When asked how often he checks the Hoyer's he said that the manufacturer comes out once a year to check. He said he checks the Hoyer if staff tell him if there were any issues with it. A policy for safe operating equipment was requested from the Administrator on 4/30/20 at 10:50am, she provided surveyor with policy for bed safety and said this was what they used. Record review of the facility's policy for Bed safety revised December 2007 read in part, .to try to prevent deaths/injuries from the beds and related equipment .the facility shall promote the following approaches .inspection by maintenance staff .to identify risks and problems including potential entrapment risks .identify additional safety measures for residents . Record review of the facility's policy for safety and supervision of residents revised December 2007 read in part, . our facility strives to make the environment as free from accident hazards as possible .resident safety and supervision and assistance to prevent accidents are facility-wide priorities .