STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675058	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOMEPLACE MANOR	425 SW AVE F HAMLIN, TX 79520

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 -** 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 observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 3 reviewed for accidents and supervision. CNA A and CNA B transferred Resident #1 from her wheelchair to her bed by a two-person underarm lift instead of a Hoyer lift or using a gait belt. She sustained a displaced fracture in the right mid humerus shaft of her arm. This was determined to be past-noncompliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the inspection. This failure placed residents at risk of injury. Findings: Record review of Resident #1's most recent admission Minimum Data Set ((MDS) dated [DATE] revealed an [AGE] year-old female admitted from an acute hospital on [DATE] with the following Diagnosis: [REDACTED]. Resident #1 scored a 14 out of 15 on the Brief Interview for Mental Status (BI[CONDITION]) which indicates an intact cognition. Resident #1 Function Status revealed extensive assistance with two people was needed for bed mobility, dressing, toileting, and personal hygiene. Total dependence with two people needed for transfers. Section G also revealed a functional limitation in range of motion impairment on one side to an upper extremity and that Resident #1 utilizes a wheelchair for mobility. Record review of Resident #1's care plan dated 2/25/20 revealed it did not address her [DIAGNOSES REDACTED]. Record Review of Resident #1 electronic health record accessed on [DATE] revealed she arrived at the facility on [DATE] after a transfer from her wheelchair to the bed by a two person under arm transfer Resident #1 reported to the DON her arm was broken. Resident #1 had limitation in her right upper extremity and was complaining of pain at an 8 out of 10 to her right shoulder upon movement that was aching, and she had not experienced this pain before.The DON notified the Physician at 3:33pm and x-rays were obtained at 6:11 pm confirming an oblique or comminuted, displaced fracture in the right mid humerus shaft. Resident #1 was seen by Physician at 7:52 pm and was sent to area hospital to be evaluated and treated. On [DATE] at 3:09 am Resident #1 arrived back to the facility with confirmation of broken arm, her arm in a sling, and recommendation to follow up with an area Orthopedic doctor. In an interview on [DATE] at 11:08 am CNA A stated on 2/25/20 she took the facility van to go get Resident #1 from the hospital. Upon arrival to the hospital CNA A observed hospital staff use a Hoyer lift to get Resident #1 out of bed and placed into a wheelchair. CNA A stated the hospital staff said they cannot leave their sling under Resident #1 as they need their sling. CNA A stated the drive to the facility took about 30 minutes. CNA a stated when they arrived at the facility they kept Resident #1 in her wheelchair to obtain a weight and once that was complete at Resident's #1 request they went to lay her down. CNA A and CNA B debated putting a sling under Resident #1, but the slings in their facility are long slings, not cross over slings and it would be very difficult to get it under her. CNA A stated after her and CNA B discussed the options they decided to do a two person under arm lift without the use of a gait belt, CNA a added they did not have a gait belt available in her room. CNA A stated she groaned during the transfer but never yelled in pain. CNA A stated once they had her bottom on the bed the Director of Nursing (DON) entered the room and helped them to get her on the bed. CNA a stated before she left the facility she was informed that Resident #1 may not be able to stand. CNA A stated she did not inform the Administrator or DON they were about to lay Resident #1 down, and even though she observed the hospital use a Hoyer lift to transfer the resident, they still chose to use a two person under arm lift. In an interview on [DATE] at 11:44 am CNA B stated when Resident #1 arrived to the facility she assisted CNA A get her off the van and Resident #1 was telling them to hurry she wanted to lay down. CNA B stated she was not aware Resident #1 required a lift and there was no sling under her to indicate the need for one, but since Resident #1 kept pushing them to lay her down they decided to do an under-arm lift. CNA B stated that Resident #1 complained during the transfer and was moaning, but once transfer was complete she was talking with the DON, and they left the room. In an observation and interview on [DATE] at 2:00pm Resident #1 stated she arrived at the facility in a wheelchair. Resident #1 states they came to get her to put her to bed, and she told them they needed a Hoyer lift to get her from her chair to her bed. Resident #1 stated the aides talked back and fourth then decided to lift her under her arms. Resident #1 stated she felt her arm break and she told them they broke her arm. Resident #1 was in bed with her right arm in a blue sling. In an interview on [DATE] at 3:35 pm the DON revealed she feels the injury occurred because the aides failed to use the Hoyer lift to transfer her. The DON stated CNA A was informed Resident #1 was a Hoyer lift before leaving the facility to pick her up from an area hospital. The DON stated it is not an acceptable practice to lift residents in the manor they lifted Resident #1, and if the aides were uncertain how she needed to be transferred they should ask the charge nurse. The DON stated the two CNAs were suspended; a facility investigation was started; staff were given demonstration training by Habilitation Therapies with check offs for competency in transfers with a using draw sheets, gaitbelt, and Hoyer lift; in servicing on Abuse and Neglect; care plan was updated; and weekly observation of resident transfers will be conducted. In an interview on [DATE] at 4:25 pm the Administrator stated she feels the failure occurred because the CNAs knew better, but still used a two person under arm lift with Resident #1. The Administrator stated she suspended both CNAs; insured training on Abuse and Neglect; and transfers. Record review of facility policy dated 2001 with a revision date of July 2017 revealed a policy for Safe Lifting and Movement of Residents . In order to protect the safety and well-being of staff and resident, and to promote quality care, this facility uses appropriate techniques and devices to lift and move resident . 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible.
F 0726 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one resident (Resident #1) of three reviewed for safe transfers and two of four nurse aides (CNA A and CNA B) observed for transfers. CNA A and CNA B transferred Resident #1 from her wheelchair to her bed by a two-person underarm lift instead of a Hoyer lift or using a gait belt. She sustained a displaced fracture in the right mid humerus shaft of her arm. This was determined to be past-noncompliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the inspection. This failure placed residents at risk of injury. Findings: Record review of Resident #1's most recent admission Minimum Data Set ((MDS) dated [DATE] revealed an [AGE] year-old female admitted from an acute hospital on

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 0726 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) [DATE] with the following Diagnosis: [REDACTED]. Resident #1 scored a 14 out of 15 on the Brief Interview for Mental Status (BI[CONDITION]) which indicates an intact cognition. Resident #1 Function Status revealed extensive assistance with two people was needed for bed mobility, dressing, toileting, and personal hygiene. Total dependence with two people needed for transfers. Section G also revealed a functional limitation in range of motion impairment on one side to an upper extremity and that Resident #1 utilizes a wheelchair for mobility. Record review of Resident #1's care plan dated 2/25/20 revealed it did not address her [DIAGNOSES REDACTED]. Record Review of Resident #1 electronic health record accessed on [DATE] revealed she arrived at the facility on [DATE] after a transfer from her wheelchair to the bed by a two person under arm transfer Resident #1 reported to the DON her arm was broken. Resident #1 had limitation in her right upper extremity and was complaining of pain at an 8 out of 10 to her right shoulder upon movement that was aching, and she had not experienced this pain before.The DON notified the Physician at 3:33pm and x-rays were obtained at 6:11 pm confirming an oblique or comminuted, displaced fracture in the right mid humerus shaft. Resident #1 was seen by Physician at 7:52 pm and was sent to area hospital to be evaluated and treated. On [DATE] at 3:09 am Resident #1 arrived back to the facility with confirmation of broken arm, her arm in a sling, and recommendation to follow up with an area Orthopedic doctor. In an interview on [DATE] at 11:08 am CNA A stated on 2/25/20 she took the facility van to go get Resident #1 from the hospital. Upon arrival to the hospital CNA A observed hospital staff use a Hoyer lift to get Resident #1 out of bed and placed into a wheelchair. CNA A stated the hospital staff said they cannot leave their sling under Resident #1 as they need their sling. CNA A stated the drive to the facility took about 30 minutes. CNA a stated when they arrived at the facility they kept Resident #1 in her wheelchair to obtain a weight and once that was complete at Resident's #1 request they went to lay her down. CNA A and CNA B debated putting a sling under Resident #1, but the slings in their facility are long slings, not cross over slings and it would be very difficult to get it under her. CNA A stated after her and CNA B discussed the options they decided to do a two person under arm lift without the use of a gait belt, CNA a added they did not have a gait belt available in her room. CNA A stated she groaned during the transfer but never yelled in pain. CNA A stated once they had her bottom on the bed the Director of Nursing (DON) entered the room and helped them to get her on the bed. CNA a stated before she left the facility she was informed that Resident #1 may not be able to stand. CNA A stated she did not inform the Administrator or DON they were about to lay Resident #1 down, and even though she observed the hospital use a Hoyer lift to transfer the resident, they still chose to use a two person under arm lift. In an interview on [DATE] at 11:44 am CNA B stated when Resident #1 arrived to the facility she assisted CNA A get her off the van and Resident #1 was telling them to hurry she wanted to lay down. CNA B stated she was not aware Resident #1 required a lift and there was no sling under her to indicate the need for one, but since Resident #1 kept pushing them to lay her down they decided to do an under-arm lift. CNA B stated that Resident #1 complained during the transfer and was moaning, but once transfer was complete she was talking with the DON, and they left the room. In an observation and interview on [DATE] at 2:00pm Resident #1 stated she arrived at the facility in a wheelchair. Resident #1 states they came to get her to put her to bed, and she told them they needed a Hoyer lift to get her from her chair to her bed. Resident #1 stated the aides talked back and fourth then decided to lift her under her arms. Resident #1 stated she felt her arm break and she told them they broke her arm. Resident #1 was in bed with her right arm in a blue sling. In an interview on [DATE] at 3:35 pm the DON revealed she feels the injury occurred because the aides failed to use the Hoyer lift to transfer her. The DON stated CNA A was informed Resident #1 was a Hoyer lift before leaving the facility to pick her up from an area hospital. The DON stated it is not an acceptable practice to lift residents in the manor they lifted Resident #1, and if the aides were uncertain how she needed to be transferred they should ask the charge nurse. The DON stated the two CNAs were suspended; a facility investigation was started; staff were given demonstration training by Habilitation Therapies with check offs for competency in transfers with a using draw sheets, gaitbelt, and Hoyer lift; in servicing on Abuse and Neglect; care plan was updated; and weekly observation of resident transfers will be conducted. In an interview on [DATE] at 4:25 pm the Administrator stated she feels the failure occurred because the CNAs knew better, but still used a two person under arm lift with Resident #1. The Administrator stated she suspended both CNAs; insured training on Abuse and Neglect; and transfers. Record review of facility policy dated 2001 with a revision date of July 2017 revealed a policy for Safe Lifting and Movement of Residents . In order to protect the safety and well-being of staff and resident, and to promote quality care, this facility uses appropriate techniques and devices to lift and move resident . 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible.