STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675220	A. Building B. Wing	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Place Kirbyville	700 N Herndon Kirbyville, TX 75956

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** 14645 Based on observation, interview, and record review, the facility failed to ensure adequate supervision and assistance devices to prevent accidents was provided for 1 of 4 Residents (Resident #1) reviewed for accidents. Resident #1 was transferred to and from the wheelchair without using a Hoyer lift resulting in a fractured right leg. This failure could place residents at risk for improper care, injury, pain, and decreased quality of life. Findings included: Record review of Resident #1's face sheet dated 4/6/22, indicated Resident #1 was [AGE] years old and admitted on [DATE]. Resident #1's diagnoses included: unspecified fracture of right femur (thigh bone), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), and multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves). Record review of Resident #1's MDS dated [DATE] indicated Resident #1 was cognitively intact. No transfers occurred in the assessment period. Record review of Resident #1's care plan dated 4/16/21 and reviewed 12/30/21 indicated Resident #1 required a Hoyer lift (a mobility tool used to help residents with mobility challenges get out of bed) for all transfers due to poor trunk/limb control secondary to multiple sclerosis. Record review of a progress noted dated 3/2/22 at 10:54 p.m., completed by LVN A, indicated Resident #1 complained of right knee pain. Resident #1 told her she felt her knee pop while CNAs were repositioning her in bed. There was no bruising or swelling noted at the time. The Resident's leg was elevated on a pillow and the resident was given pain medication. Record review of an incident report dated 3/3/22, completed by LVN H, indicated Resident #1 reported she was lifted by two CNAs when one of the CNAs stumbled trying to lift her out of her electric wheelchair without a lift pad. The resident indicated she landed in bed and the CNAs fell over on her leg causing pain. LVN H documented Resident #1 had a bruise and swelling to the right knee. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of an x-ray report dated 3/3/22 indicated Resident #1 had mild arthritic changes of the knee with acute distal femur fracture. During an observation and interview on 04/06/22 at 12:02 p.m., Resident #1 was in her bed with her right leg elevated and she was eating her lunch. She said she did not want to get out of bed. She said CNA F transferred her from her bed to her wheelchair and did not know why she did not use the Hoyer lift to transfer her. She said she told CNA F to put her down, but CNA F wrapped her arms around her (Resident #1) and transferred her to the wheelchair. She said when she was put back in bed that evening, the staff did not use a Hoyer lift. She said her knee popped when she was transferred to the bed. She said she had some pain and received pain medication. She said the staff always used the Hoyer lift when she was being transferred. She said she did not know why the staff transferred her without the Hoyer lift that day. During observation rounds on 4/6/22 from 12:02 p.m. to 2:30 p.m. Resident #2 and #3 were up in their wheelchairs and had lift pads underneath them. There were no opportunities for observations of Hoyer lift transfer during the investigation. During an interview on 04/06/22 at 12:24 p.m., LVN A said staff were not supposed to transfer or lift residents who required a Hoyer lift without using the Hoyer lift. She said she was called to Resident #1's room by CNA G on 3/2/22 around 8:30 p.m. She saw there was no lift pad under Resident #1. She went to get one and took it back to the room. She said Resident #1 repeatedly kept saying she wanted to get to bed. She said rather than trying to put the Hoyer lift pad underneath Resident #1, CNA G and CNA I each got opposite sides of Resident #1 and transferred her to bed. She said Resident #1 fell on to her side. She said when CNA G and CNA I laid Resident #1 on her back, Resident #1 said her knee had popped. She said Resident #1 did not complain of pain initially and she thought it was because she had administered a pain pill at 6:00 p.m. She said staff received training on Hoyer lifts and transfers prior to the incident and immediately after the incident. She said she checked on Resident #1 throughout the night and she did not complain of any pain. Record review of an Employee Counseling Form dated 3/4/22 indicated CNA F told the DON she could not get to a Hoyer lift on Hall 2 because it was lunch time, and the other Hoyer lift's wheel was stuck. Resident #1 was demanding to get up before lunch time. CNA F indicated the CNA on Hall 1 was not available to help her, so she transferred Resident #1 without difficulty and did not put a Hoyer pad underneath her. Attempted to call CNA F on 4/6/22 at 12:50 p.m. regarding the incident involving Resident #1's incident. A message was left for her to call. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/6/22 at 1:59 p.m., CNA G said she was teaching another CNA how to use the Hoyer lift. She said Resident #1 was supposed to have a Hoyer lift for all transfers. CNA G said Resident #1 did not have a lift pad under her. Resident #1 told her the aide in the morning gave her a bear hug and transferred her. CNA G said she went to get the nurse because Resident #1 did not have the pad under her for the Hoyer lift. CNA G said she and CNA I did a 2-person transfer to put Resident #1 in bed. She said Resident #1 kept telling them to just get her back in bed. She said when they transferred her the Resident wound up face down and they had to reposition her. She said when they repositioned her, they heard a pop. CNA G said she does not know who said someone fell on Resident #1. She said nobody fell on the resident. CNA G said she did not feel comfortable transferring Resident #1 without the Hoyer lift. She said looking back they probably should have put the lift pad under her while she was in her wheelchair. During an interview on 4/6/22 at 2:31 p.m., LVN H said Resident #1 told her about her knee hurting and then told her she had been transferred without the Hoyer lift. She said she was not working the night of the incident. During an interview on 4/11/22 at 3:39 p.m., CNA I said she was asked to help transfer Resident #1 back to bed because she did not have the lift pad under her. She said Resident #1 was supposed to be transferred with the Hoyer lift. CNA I said she grabbed the upper part of her body and CNA G grabbed her lower body. When they got her in bed, she had to be repositioned because she had rolled onto her face. She said she thought she heard a pop when they repositioned her in bed. During an interview on 4/6/22 at 9:21 a.m., the DON said on the morning of 3/2/22 CNA F body lifted Resident #1 from her bed to her wheelchair. CNA F told the DON it was around lunch time and the lunch carts were on the hall so she could not get to the Hoyer lift and could not find any co-workers to assist her with a transfer so she made the decision to transfer Resident #1 because the Resident can pressure staff. The DON said that evening the staff were going to put Resident #1 back to bed and there was no lift pad underneath her. The CNAs got the nurse and they decided to do a 2-person transfer. When they got her in bed and were repositioning her, they heard a pop. She said Resident #1 opted not to have surgery for the fracture. She said Resident #1 should have been transferred with the Hoyer lift and the evening aides should have put the pad under her for the transfer. Record review of the facility's Safe Lifting and Movement of Residents policy revised October 2009 indicated In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility use appropriate techniques and devices to lift and move residents . 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 resident shall be eliminated when feasible .5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. During the exit conference on 4/06/22 at 4:20 p.m., the Administrator and the DON were asked for any additional information related to care plans. No additional information was provided. 25115