

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676290	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/27/2024
NAME OF PROVIDER OR SUPPLIER  Spjst Rest Home 1		STREET ADDRESS, CITY, STATE, ZIP CODE  1810 Old Granger Road Taylor, TX 76574	
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 - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</b></p> <p>Based on observation, interviews, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for three (Resident #1, and Resident #2) of five residents reviewed for accidents and hazards.</p> <p>Hospitality Aide A and CNA C observed the sling prior to entering Resident #1 room and determined at this time the sling was not safe to use. Hospitality Aide A and CNA C did not report this to anyone and used the unsafe sling on the Mechanical lift during transfer of Resident #1. Hospitality Aide A and CNA C observed the loops on the sling to be frayed. There were four green loops on the sling and three of the four green loops broke during the transfer. The bottom four blue loops were already torn and unable to use prior to hooking the sling to Mechanical lift. There were three of four purple loops frayed and was beginning to tear and these loops were used on the Mechanical lift during transfer of Resident #1.</p> <p>An Immediate Jeopardy (IJ) situation was identified on [DATE] at 6:27 PM. While the IJ was removed on [DATE] at 7:50 PM, the facility remained out of compliance at a severity of no actual harm that is not immediate and a scope of isolated.</p> <p>This failure could result in residents experience accidents, injuries, unrelieved pain, and diminished quality of life.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's face sheet, dated [DATE], reflected Resident #1 was a [AGE] year-old-female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses of: nontraumatic intracerebral hemorrhage in cerebellum (primary, admission - a devastating condition whereby a hematoma ( swelling or clotted blood) is formed within the brain parenchyma ( functional part of an organ) with or without blood extension into the ventricles (cavities in the brain)- this is a new diagnosis after return from hospital on [DATE], the following are diagnosis prior to being admitted to hospital on [DATE]: hemiplegia and hemiparesis following cerebral infarction left non-dominant side ( paralysis or partial or total body function on one side of the body, whereas hemiparesis is characterized by one-sided weakness, but without complete paralysis), lack of coordination (not able to move different parts of the body together easily), muscle wasting and atrophy ( thinning of the muscle mass), and type 2 diabetes mellitus with diabetic neuropathy, unspecified ( nerve damage caused by high blood sugars levels over time, leading to various complications in different parts of the body).</p> <p>Record review of Resident #1's Annual MDS Assessment, dated [DATE], reflected Resident #1 had a BIMS score of 15 indicated her cognition was intact. Resident #1 was assessed to have limited range of motion with upper and lower extremity on one side (left side). She required assistance with ADLs such as eating, all hygiene, upper and lower dressing including assist with footwear, toileting, all transfers, and repositioning in bed.</p> <p>Record review of Residents #1 Comprehensive Care Plan revised on [DATE], reflected Resident #1 had impaired physical mobility related to decreased in muscle strength and recent clavicle fracture (broken collar bone). Resident #1 required two person Mechanical lift transfer assistance. Intervention dated [DATE]: staff to provide a safe environment during transfers and will use a Mechanical lift with two-person assistance. Resident #1 had impaired physical mobility related to hemiplegia and hemiparesis following cerebral infarction affecting left-dominant side. Intervention: Assess need for an provide as indicated adaptive devices, furniture, and clothing. She was assessed to be at risk for unstable blood glucose level related to Type 2 diabetes mellitus with diabetic neuropathy. Intervention: Assess blood glucose levels as ordered. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Resident #1 was assessed to be at risk for falls related to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Intervention dated [DATE]: Encourage to keep bed in low position. Keep call light in reach. Keep personal belongings in reach. Increased staff supervision with intensity based on resident need. Resident # 1 had ADL self-care performance deficit. Interventions: She was total dependent on staff for bathing/showering, toileting, transfers and required extensive assistance with personal hygiene and oral care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Nurses Note dated [DATE] at 9:10 AM reflected DON was called to the room at 0901 (9:01 AM), upon arrival to the room, resident was laying in supine position, stating 'help me'. Noted blood and skin tear to LUE and LLE. OTA with resident on the floor. CNA's present in the room. Statements received from 3 CNA's. ADON present and at resident's head holding steady and asking resident not to move. DON conducted partial assessment for visible injuries without moving resident. Resident complaining of neck pain. Resident alert and oriented to self only. Baseline is A&amp;O X 4. Pupils reactive to light. Right cheek bone noted to be swollen along with orbital swelling around right eye. Petechiae( a small red or purple spot caused by bleeding into the skin) noted to right cheek bone and right bicep area. Top of right shoulder with abrasion and blue bruising noted. Blue discoloration and bruising noted to top right middle knuckle. Resident breathing WNL. Vitals obtained (did not see vital entered in documentation). ADON states she will kept resident calm and talking until EMS comes and has the situation under control. DON left room with ADON and 2 aides present in room. Floor RN was on phone with 911attempting to get EMS on the way. Signed by Director of Nurses.</p> <p>Record review of Resident #1's Nurses Note dated [DATE] at 9:49 AM reflected, called to room by CNA- upon entering room client in prone position with face and lower extremities laying across Mechanical legs non responsive during course of log roll to supine client started groaning started neuro checks pupils non responsive client groaning and grunting- sent CNA to get DON left OTA and two other CNAs in room started process to send out to hospital-unable to reach ( she named two persons names question of these people are at the time of reading the nurses note when in the facility determined after reviewing face sheet she was referring to two family members) One family member called back as EMS was entering room-report given to them along with transfer paperwork - spoke to family member concerning the incident: client being transferred by Mechanical, Mechanical sling broke client fell to floor informed of clients condition, other family member called also given same information and updated him on where they would be taking her. Signed by RN E.</p> <p>Record review of Hospital Records, dated [DATE], reflected Resident #1 had new diagnosis after her CT scans. New diagnosis: back pain, brain bleed (bleeding between the brain tissue and the skull or inside the brain tissue), cerebellar hemorrhage (where the bleeding is located in a small space in the skull, found near the brainstem and cerebellum. The cerebellum is the part of the brain responsible for balance and coordinated movements. The brainstem is responsible for controlling vital body functions, such as breathing), closed head injury (rotational forces when the head twists or turns side to side or from the brain moving forward or backward inside of the skull), facial contusion (a bruise appears on your face after an injury), fall (to drop or descend under the force of gravity, as to a lower place through loss or lack of support), intraventricular hemorrhage (bleeding inside or around the ventricles-spaces in the brain that contain the cerebral spinal fluid. Bleeding in the brain can put pressure on the nerve cells and damage them. If the nerve cells are severely damaged, it can result in irreversible brain injury), right clavicle fracture (broken collar bone), right hip pain (injuries to your hip), subarachnoid hemorrhage (bleeding in the space between your brain and the membrane that covers it), traumatic intraventricular hemorrhage (an uncommon but important condition that may be a marker of severe injury in patients with blunt head trauma), traumatic subarachnoid hemorrhage (there is bleeding in the space that surrounds the brain), and traumatic subdural hemorrhage ( type of brain hemorrhage happens when blood is leaking out of a torn blood vessel and below the space of the brain and skull. This prevents the brain from getting enough oxygen).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's facility investigation dated ,[DATE], reflected skin tear to left forearm and left upper thigh, bruising noted to right middle knuckle, right side of face on cheek bone with petechiae (round spots that form on the skin), along with petechiae on right upper extremity. Resident #1 complaining of neck pain. Resident #1 kept still on ground by ADON for prevention of further injury since complaining of neck pain. The sling to Mechanical lift ripped and caused the resident to fall to the ground. The investigation findings were confirmed. Signed by DON.</p> <p>Record review of written statement by CNA C, dated [DATE] reflected I was working halls 500 and 600, Hospitality Aide A and I went into Resident #1's room to get her up for a shower, to get her ready to go and see religious service., we put the sling underneath it, we noticed the blue hook was already ripped so we put it on the green hook, we got her ready her arms were on her chest like she always did. CNA D walked into the room because she needed the Mechanical lift for another resident. Hospitality Aide A was on one side of the bed and I was on the other side of the bed, as Hospitality Aide A began to move the Mechanical, I began my way by the shower chair because I was going to grab Resident #1, from behind to make sure that she was sitting properly in the shower chair, and as I got by the shower chair, that was when I saw her fall, the sling broke from under her. CNA D did not sign her statement.</p> <p>Record review of written statement by Hospitality Aide A , dated [DATE], reflected I went into Resident #1's room to give her a shower. We (does not specify who assisted Hospitality Aide A) prepared the water to the shower, her clean clothes on the chair, I went to her bed. CNA C and I put the sling under her (Resident #1). We went to hook the sling to the Mechanical. The blue hooks were ripped. We used the green hooks. At this point, I did not report the ripped blue hooks. I would have reported the sling to RN E. The green hooks looked good. We did look for other slings but were unable to locate one. I was using the remote for the sling. On the way up, everything looked and went well. When I went to move Resident #1 to the shower chair, I heard the sling rip. It was really fast. Both hooks ripped. Resident #1 was holding her left arm, she flipped and landed face down on the Mechanical legs. CNA D went to call for help. I was trying to get Resident #1 to respond to me, but she was not responding at all. RN D came into the room with the therapy guy, and they took over care for Resident #1. Signed by Hospitality Aide A</p> <p>Record review of written statement by CNA D, not dated, reflected I walked into Resident #1's room [ROOM NUMBER] around 9:00 AM on [DATE] (no year documented). When I walked in Resident #1's room I saw Hospitality Aide A had the Mechanical controller in her hand and Resident #1 was on the bed. CNA C was at the foot of the bed with the shower chair in front of her. I came in and shut the door. Hospitality Aide A moved it (did not specify in her statement) out to put in front of the shower chair. The back strap broke which cuz (do not know the meaning of cuz) Resident #1 to fall and hit the floor. She hit her eye/cheek on the leg of the Mechanical. She was on her stomach. I ran out in the hallway looking for RN E. There was not a signature of CNA D or a date when she wrote the statement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of written statement by DON, dated [DATE], reflected the same information from nurses note dated [DATE] by they DON was documented on the top paragraph of the statement. The second paragraph reflected DON spoke with 3 CNAs to gather information on how incident occurred. 3 CNAs were standing near restroom with Mechanical lift in resident's room. DON asked each CNA to explain what occurred in exact details. Group statement received was that CNA C was standing on the window side of the bed, Hospitality Aide A was on the opposite side of the bed with the Mechanical lift and controls. CNA C was walking around the bed and as they began to move Resident #1 by a Mechanical lift to the shower chair, the sling ripped, resident fell to the ground landing with her face on the legs of the Mechanical lift. They (did not specify in statement of who she was referring to as they) then called for help. CNA D was standing in the resident's room observing the transfer and witnessed the incident. CNAs called for help and floor RN E came. CNA (don't know which CNA did not specify) called for DON, Medical Records Coordinator F and the Receptionist G came to the conference room and informed DON and ADON that we were needed on hall 500. The sling was located by the door in the Resident #1's room. Upon inspection, the 3 green hooks and 4 blue hooks were ripped and tore. Signed by the DON.</p> <p>Record review on [DATE] of Hospitality Aide personnel file reflected she was a Hospitality Aide. She did receive one-on- one in-service by the DON of hospitality aide job description on [DATE] and was given a copy of the job description. She signed the original Hospitality Aide job description on [DATE]. She did not have another job description or any indication she was a CNA in her personnel file. The hospitality aide job description reflected the following:</p> <ol style="list-style-type: none"> <li>1. Answer call lights in a timely manner; determine if request does not involve direct care and then carry out request.</li> <li>2. Examples of non-direct care: helping with television, telephone, getting a personal item for a resident, giving a blanket or a pillow.</li> <li>3. Be alert to resident's comfort and needs. Answer their requests promptly and report to nurse any need that exceeds your ability.</li> <li>4. Uses tactful, appropriate communications in sensitive and emotional situations.</li> <li>5. Observe all residents and report anything unusual or abnormal to Charge Nurse.</li> <li>6. Offer fluids and encourage residents to drink (check with nurse for a list of residents with fluid restrictions or on thickened liquids).</li> <li>7. Pass out meal trays and labeled snacks to residents</li> <li>8. Clean and pick up rooms.</li> <li>9. Stock gloves in rooms and notify housekeeping/maintenance if paper towels running low.</li> <li>10. Pass ice and pick up meal trays from resident's room.</li> <li>11. Empty bedside commodes.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 9:15 AM Hospitality Aide A stated she did not inspect the sling on the Mechanical lift, and she did not witness CNA B inspect the sling prior to using it on the Mechanical Lift. She stated her name tag was correct she was a Hospitality Aide and not a CNA. She stated she had taken written CNA test and past . Hospitality Aide A also stated she told everyone that she was nervous when she took the clinicals. Hospitality Aide A also stated she was not nervous she did not know how to do some of the clinicals, and she did not pass. She stated on most of the clinicals she guessed on how to the tasks including using Mechanical lift and transfers. She stated she does get confused on some of the slings especially which hooks to use to place on the Mechanical lift. She stated it depended on the resident which color to use and she does gets this confused sometimes. She also stated that she and CNA B obtained the sling from the closet they noticed the sling was ragged and did not look safe to use. Hospitality Aide A stated she had concern about using the sling, however, she did check the storage closet on 500 and 600 hall and did not see any more slings. She stated she did not report this to the nurse or to anyone. She stated on that particular day ([DATE]) with the incident with Resident #1 she asked CNA C and they discussed which color to use because the blue hooks were broken the purple hooks was tattered and a little torn. She stated the only option was the green hooks and she had never used the green hooks before until that day. She also stated she was not qualified to do any type of transfers including Mechanical lifts. She stated she needed to do something and asked if she could finish this interview later today.</p> <p>In an interview on [DATE] at 9:35AM CNA B stated she did not inspect the sling prior to using it on the Mechanical lift to transfer Resident #2. She stated she had been in-service to inspect the sling prior to placing under the resident. CNA B stated she was in serviced in July the day of incident with Resident #1. She stated She was not aware that Hospitality Aide A was not allowed to do Mechanical Lift transfers. She stated Hospitality Aide A has been doing Mechanical lift transfers over 5 months. She agreed she remembered the incident when she was observed assisting with Mechanical lift during an investigation with a surveyor U in [DATE] and she continued to do Mechanical lift transfers after the surveyor U left the facility. She stated Hospitality Aide passed her written test and did not pass her clinicals. CNA B stated the staff coordinator H was aware she was completing Mechanical lift transfers and did not say it was not ok for her to bed completing this task.</p> <p>In an interview on [DATE] at 9:50 AM Staff Coordinator H stated he was aware Hospitality Aide A was doing Mechanical Lift transfers and did not believe it was a problem. He stated she passed her written test but did not pass her clinicals. He stated he believed since she had passed her written test, she was a Certified CNA. He stated he was aware of the incident with this same Hospitality Aide using Mechanical Lifts during an investigation in [DATE]. He stated she did continue to use Mechanical lift after [DATE]. He stated she had been trained by CNAs and also went through training with him and the therapy department after the investigation in [DATE]. He stated he did have her on the schedule but did not put what her duties would be on the schedule. He stated only CNAs were required to use Mechanical lift and if she did not pass her clinicals she was not a Certified Nursing Assistant. He also stated prior to entering a resident room with a sling the staff was expected to check the sling and if it was torn or looked unsafe the staff was to report this to their charge nurse and the charge nurse would obtain a new sling for the staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 10:15 AM CNA C stated she was aware Hospitality Aide A was not a certified nursing assistant. She stated she was not aware Hospitality Aide A was not to assist with any type of transfers. CNA C stated she did not recall who informed her of this information. She stated the Hospitality Aide A has been doing CNA work over 4 months. She also stated she had continued to assist CNAs with Mechanical lifts and also had been performing care on residents such as: showers, peri care, assisting residents to the bathroom and everything a CNA would do without another CNA with her doing these tasks except for Mechanical Lift transfers. She stated she did not report this to anyone. CNA C also stated she thought everyone knew it especially the floor nurses. She stated the day of the incident on [DATE] Resident #1 was wanting a shower to go to a religious activity. She stated she was working with Hospitality Aide A on [DATE]. She stated she walked with Hospitality Aide to the linen closet to get obtain a sling. She stated both of them looked at the sling and saw where the blue hooks were torn. She stated they noticed the purple hooks was a little torn and tattered. She stated she did not recall if they looked at the green hooks. CNA C also stated they had concerns of the safety of the sling and went to other linen closets trying to find another sling to use due to the one they had did not look safe. She stated they did not find another sling and did not report it to the nurse on duty (RN E). She stated they were in a hurry and decided to use the sling they did not believe was safe to use. CNA C stated she entered Resident #1 room with the Hospitality Aide A. She stated she went by the window and the Hospitality Aide A was behind the Mechanical lift. She stated during the time of the transfer prior to Resident #1 being lifted off the bed CNA C entered the room to wait for the Mechanical lift to be used on another resident. She stated the blue hoops were torn and was unable to use them and the some of the purple hooks was tearing and was tattered and they discussed if the green hooks were the appropriate hooks to use. She stated they did not look closely at the green hooks and used the green ones to hook to the Mechanical lift. She stated they placed the sling under Resident #1 and Hospitality Aide began to lift her off the bed and this is when I moved from the window area to the shower chair. She stated when she placed herself by the shower chair to assist with the transfer, she heard a noise and saw Resident #1 fall to the floor hitting her face on the legs of the Mechanical lift. CNA C stated CNA D left the room to find the nurse. She also stated the RN E entered the room and began to assess the resident and within 3 minutes the DON, OTA and ADON entered the room. She stated that particular sling was not safe to use due to some of the hooks being torn and some tattered and was tearing. She also stated the sling overall was worn and beginning to tear. should have never been used on Resident #1. She stated it was not safe to use and they (Her and Hospitality Aide A) should have reported it to RN D or to the DON. She stated they knew for a fact the sling was not safe and because they did not see another one, they decided to use the unsafe sling. She stated Resident #1 was not responsive when she fell and hit her head on the legs of the Mechanical lift. CNA C stated they did have an in-service in March after the investigation by surveyor U of the hospitality aides job description. She stated in the in-service it was discussed the hospitality aide could only pass out ice, make beds, answer call lights, and never do hands on care with a resident including Mechanical lift and any type of care to a resident with a CNA or alone.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 10:45 AM Hospitality Aide A stated she was in serviced in March after surveyor U had left completing investigation where she was observed using a Mechanical lift. She stated she was in-serviced one on one and within a group. She stated her job description of being a hospitality aide was reviewed with her. She stated she was informed by the DON to only pass out water, answer call lights, make up beds, assist residents to the dining room in their wheelchairs and she stated it was a lot more but could not recall the rest of it at this time. She stated she was also informed during the in-service never do any type of hands-on care such as Mechanical lift, any type of care that was hands on with a resident by herself or with a CNA present. She stated she had been doing everything the CNAs does during ADL care with the residents since before [DATE] but was in-serviced in [DATE] about only doing her job description of being Hospitality Aide. She stated she continued to do Mechanical lifts and gave care to residents after being in-service in [DATE]. She stated she gave the following care without any other staff with her such as: peri-care, assisting resident to the shower and giving showers, transfer residents to the toilet, transfer residents from their bed to wheelchair and to the shower chair, feeding residents, assisted CNAs using Mechanical lifts. She stated she had been doing everything the CNAs does during ADL care with the residents since before [DATE] but was in-serviced in [DATE] about only doing her job description of being Hospitality Aide. She stated she knew she was not qualified on [DATE] and any other time she assisted to do Mechanical lifts. Hospitality Aide A stated she knew the sling was not safe and it was tearing and ripped. She stated she did not look at the green hooks prior to placing them on the Mechanical lift when transferring Resident #1. Hospitality Aide A stated she was not qualified to perform a lot of skills a CNA performed. She stated she realized this when she took her skills test and failed. Hospitality Aide A stated she told staff that she became nervous but that was not the truth. She stated she guessed at a lot of the skills tasks during the test and passed but it was not because she knew what she was doing it was just luck. She stated she did not feel she was qualified to do any of the CNA ADL care. Hospitality Aide A stated she did it because she felt she could learn if she continued to do care with the residents. She stated she did not consider the residents safety when she was giving ADL care. Hospitality Aide A stated a resident may had a serious injury due to her lack of ability and knowledge on how to operate a Mechanical lift. She also stated she should not had been the one to operate the Mechanical lift the day of [DATE] due to not knowing what to do about the sling. She stated she did not know how to use that particular sling and was confused with the hooks torn and she always used the purple hooks and was afraid to use them because they were tattered and beginning to tear. She stated she discussed it with CNA C and they decided to go with the green hooks but they did not look at the green loops to determine if they were in good condition. She stated she did not request to be removed from the Mechanical lift when they used it on Resident #1 she did not want others to know she did not know what she was doing because she was afraid that she may be asked to resign from her job until she became a CNA. Hospitality Aide A stated the Staff Coordinator was aware she had continued to assist with Mechanical Lifts over the past 4 or 5 months. She stated he had observed her go into residents' rooms and ask if she was going to assist the CNA with Mechanical lift transfer and did not say she could not do this task. She stated when she and CNA B obtained the sling from the closet, they noticed the sling was ragged and did not look safe to use. Hospitality Aide A stated she had concern about using the sling, however, she did check the storage closet on 500 and 600 hall and did not see any more slings. She stated she did not report this to the nurse or to anyone. She stated she walked with CNA B into Resident #1's room with the sling and the Mechanical lift was already in the room. Hospitality Aide A stated CNA B was by the window, and she was using the Mechanical lift. She also stated she had never used this type of sling before and one the blue hooks was broken, and they couldn't use them, and the purple hooks looked old and was frailed such as slightly tearing apart. She stated she discussed with CNA B of which hooks to use on the Mechanical lift. She also stated they had to use the purple that was frail and the green hooks. She stated she did not notice if the green hooks were tearing /frail looking like the purple hooks. Hospitality Aide A stated she placed the hooks on one side and CNA B placed hooks on the other side of Mechanical lift. She stated when she began to lift Resident #1 from the bed and was pulling the Mechanical lift away from the bed, she heard a snap and Resident #1 fell to the floor when she was in the air on the Mechanical lift. She stated the green hooks broke. Hospitality Aide A stated she was aware it was not in her job description to do Mechanical lift transfers and she had been doing them for 5 months. She stated she did not know if the</p>		

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER  Spjst Rest Home 1		STREET ADDRESS, CITY, STATE, ZIP CODE  1810 Old Granger Road Taylor, TX 76574	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p>Observation and interview on [DATE] at 11: 20 AM with Resident #1. She was lying in bed. Resident #1 had bruises on her face and her shoulder. Resident #1 had burrowed eyebrows and a frown on her face. She stated she was afraid to get on that lift again. She stated she never wanted to be dropped again. Resident #1 had difficulty finishing her sentences but was able to when given time. This was not abnormal to her per staff and her medical records. Resident #1 stated she was sadder and more depressed. Resident #1 did not feel like talking about the incident and wanted to go to sleep.</p> <p>In an interview on [DATE] at 12:04 PM CNA D stated she entered Resident #1's room (did not recall the time) and was waiting for Hospitality Aide A and CNA C to transfer Resident #1 because she needed to use the Mechanical lift on another resident. She stated when she entered Resident #1 room the resident lying on the bed and the Hospitality Aide A had the controller in her hand to maneuver Resident #1 in the air to transfer her to the shower chair. She stated CNA C was stand [TRUNCATED]</p>		

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F 0726  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</b></p> <p>Based on observation, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of three residents (Resident #1 and Resident #2 .reviewed for Mechanical lift transfers.</p> <p>The facility failed to ensure Resident #1 was transferred with qualified staff. Hospitality Aide A knew the sling was not safe to use by observing the bottom loops were broken and three of the four top purple loops was frayed and beginning to tear. Hospitality Aide A did not report the unsafe sling to nurse prior to using the sling. Hospitality Aides were allowed to assist with resident transfers outside of the scope of their job description.</p> <p>An Immediate Jeopardy (IJ) situation was identified on [DATE] at 6:27 PM. While the IJ was removed on [DATE] at 7:50 PM, the facility remained out of compliance at a severity of no actual harm that is not immediate and a scope of isolated.</p> <p>This failure could place residents at risk for serious injury, serious harm, serious impairment, or death.</p> <p>Findings included :</p> <p>Record review of Resident #1's face sheet, dated [DATE], reflected Resident #1 was a [AGE] year-old-female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses of: nontraumatic intracerebral hemorrhage in cerebellum (primary, admission - a devastating condition whereby a hematoma ( swelling or clotted blood) is formed within the brain parenchyma ( functional part of an organ) with or without blood extension into the ventricles (cavities in the brain)- this is a new diagnosis after return from hospital on [DATE], the following are diagnosis prior to being admitted to hospital on [DATE]: hemiplegia and hemiparesis following cerebral infarction left non-dominant side ( paralysis or partial or total body function on one side of the body, whereas hemiparesis is characterized by one-sided weakness, but without complete paralysis), lack of coordination (not able to move different parts of the body together easily), muscle wasting and atrophy ( thinning of the muscle mass), and type 2 diabetes mellitus with diabetic neuropathy, unspecified ( nerve damage caused by high blood sugars levels over time, leading to various complications in different parts of the body).</p> <p>Record review of Resident #1's Annual MDS Assessment, dated [DATE], reflected Resident #1 had a BIMS score of 15 indicated her cognition was intact. Resident #1 was assessed to have limited range of motion with upper and lower extremity on one side (left side). She required assistance with ADLs such as eating, all hygiene, upper and lower dressing including assist with footwear, toileting, all transfers, and repositioning in bed.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Residents #1 Comprehensive Care Plan revised on [DATE], reflected Resident #1 had impaired physical mobility related to decreased in muscle strength and recent clavicle fracture (broken collar bone). Resident #1 required two person Mechanical lift transfer assistance. Intervention dated [DATE]: staff to provide a safe environment during transfers and will use a Mechanical lift with two-person assistance. Resident #1 had impaired physical mobility related to hemiplegia and hemiparesis following cerebral infarction affecting left-dominant side. Intervention: Assess need for an provide as indicated adaptive devices, furniture, and clothing. She was assessed to be at risk for unstable blood glucose level related to Type 2 diabetes mellitus with diabetic neuropathy. Intervention: Assess blood glucose levels as ordered. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Resident #1 was assessed to be at risk for falls related to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Intervention dated [DATE]: Encourage to keep bed in low position. Keep call light in reach. Keep personal belongings in reach. Increased staff supervision with intensity based on resident need. Resident #1 had ADL self-care performance deficit. Interventions: She was total dependent on staff for bathing/showering, toileting, transfers and required extensive assistance with personal hygiene and oral care.</p> <p>Record review of Resident #1's Nurses Note dated [DATE] at 9:10 AM reflected DON was called to the room at 0901 (9:01 AM), upon arrival to the room, resident was laying in supine position, stating 'help me'. Noted blood and skin tear to LUE and LLE. OTA with resident on the floor. CNA's present in the room. Statements received from 3 CNA's. ADON present and at resident's head holding steady and asking resident not to move. DON conducted partial assessment for visible injuries without moving resident. Resident complaining of neck pain. Resident alert and oriented to self only. Baseline is A&amp;O X 4. Pupils reactive to light. Right cheek bone noted to be swollen along with orbital swelling around right eye. Petechiae( a small red or purple spot caused by bleeding into the skin) noted to right cheek bone and right bicep area. Top of right shoulder with abrasion and blue bruising noted. Blue discoloration and bruising noted to top right middle knuckle. Resident breathing WNL. Vitals obtained (did not see vital entered in documentation). ADON states she will kept resident calm and talking until EMS comes and has the situation under control. DON left room with ADON and 2 aides present in room. Floor RN was on phone with 911 attempting to get EMS on the way. Signed by Director of Nurses.</p> <p>Record review on [DATE] of Hospitality Aide personnel file reflected she was a Hospitality Aide. She did receive one-on- one in-service by the DON of hospitality aide job description on [DATE] and was given a copy of the job description. She signed the original Hospitality Aide job description on [DATE]. She did not have another job description or any indication she was a CNA in her personnel file. The hospitality aide job description reflected the following:</p> <ol style="list-style-type: none"> <li>1. Answer call lights in a timely manner; determine if request does not involve direct care and then carry out request.</li> <li>2. Examples of non-direct care: helping with television, telephone, getting a personal item for a resident, giving a blanket or a pillow.</li> <li>3. Be alert to resident's comfort and needs. Answer their requests promptly and report to nurse any need that exceeds your ability.</li> <li>4. Uses tactful, appropriate communications in sensitive and emotional situations.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation/Interview on [DATE] at 9:15 AM CNA B opened utility room door and reached for a Mechanical lift sling. Did not observe her inspecting the Mechanical lift sling. She began to walk down the hall with the staff coordinator was walking with her. Upon observation of his name tag noticed it stated staff coordinator. Asked the staffing coordinator to get two CNAs for observation of a Mechanical lift transfer. He stated he trained staff on how to transfer using Mechanical lift with the therapy department and he was qualified to do Mechanical lift transfers. It was explained to the staff coordinator preferred two CNAs to observe and not the training staff. The Staff Coordinator agreed and stated he would find another CNA. Observed someone walking down the hall and it was the same Hospitality Aide who was observed in [DATE] assisting with Mechanical lifts. Hospitality Aide A was walking toward CNA B. They entered Resident #2's room and Hospitality Aide A rolled Resident toward CNA B and placed the sling underneath Resident #2. CNA B rolled Resident #2 toward Hospitality Aide A and reached for the sling and pulled it under Resident #2. CNA B hooked the loops onto the sling and began to move resident. Hospitality Aide moved to Resident's wheelchair and assisted resident from behind as she was being lowered into the wheelchair. The legs of the Mechanical lift were widened, and the wheelchair was locked. The Hospitality Aide A and the CNA B did not inspect the sling prior to using it on the Mechanical lift.</p> <p>In an interview on [DATE] at 9:15 AM Hospitality Aide A stated she did not inspect the sling on the Mechanical lift and she did not witness CNA B inspect the sling prior to using it on the Mechanical Lift. She stated her name tag was correct she was a Hospitality Aide and not a CNA. She stated she had taken CNA written test and past . Hospitality Aide A also stated she told everyone that she was nervous when she took the clinicals. Hospitality Aide A also stated she was not nervous she did not know how to do some of the clinicals, and she did not pass. She stated on most of the clinicals she guessed on how to the tasks including using Mechanical lift and transfers. She stated she does get confused on some of the slings especially which hooks to use to place on the Mechanical lift. She stated it depended on the resident which color to use and she does gets this confused sometimes. She also stated that she and CNA B obtained the sling from the closet they noticed the sling was ragged and did not look safe to use. Hospitality Aide A stated she had concern about using the sling, however, she did check the storage closet on 500 and 600 hall and did not see any more slings. She stated she did not report this to the nurse or to anyone. She stated on that particular day ([DATE]) with the incident with Resident #1 she asked CNA C and they discussed which color to use because the blue hooks were broken the purple hooks was tattered and a little torn. She stated the only option was the green hooks and she had never used the green hooks before until that day. She also stated she was not qualified to do any type of transfers including Mechanical lifts. She stated she needed to do something and asked if she could finish this interview later today.</p> <p>In an interview on [DATE] at 9:35AM CNA B stated she did not inspect the sling prior to using it on the Mechanical lift to transfer Resident #2. She stated she had been in-service to inspect the sling prior to placing under the resident. CNA B stated she was in serviced in July the day of incident with Resident #1. She stated She was not aware that Hospitality Aide A was not allowed to do Mechanical Lift transfers. She stated Hospitality Aide A has been doing Mechanical lift transfers over 5 months. She agreed she remembered the incident when she was observed assisting with Mechanical lift during an investigation with a surveyor U in [DATE] and she continued to do Mechanical lift transfers after the surveyor U left the facility. She stated Hospitality Aide passed her written test and did not pass her clinicals. CNA B stated the staff coordinator H was aware she was completing Mechanical lift transfers and did not say it was not ok for her to bed completing this task.</p> <p>(continued on next page)</p>		

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F 0726  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p>In an interview on [DATE] at 9:50 AM Staff Coordinator H stated he was aware Hospitality Aide A was doing Mechanical Lift transfers and did not believe it was a problem. He stated she passed her written test but did not pass her clinicals. He stated he believed since she had passed her written test she was a Certified CNA. He stated he was aware of the incident with this same Hospitality Aide using Mechanical Lifts during an investigation in [DATE]. He stated she did continue to use Mechanical lift after [DATE]. He stated she had been trained by CNAs and also went through training with him and the therapy department after the investigation in [DATE]. He stated he did have her on the schedule but did not put what her duties would be on the schedule. He stated only CNAs were required to use Mechanical lift and if she did not pass her clinicals she was not a Certified Nursing Assistant. He also stated prior to entering a resident room with a sling the staff was expected to check the sling and if it was torn or looked unsafe the staff was to report this to their charge nurse and the charge nurse would obtain a new sling for the staff.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 10:15 AM CNA C stated she was aware Hospitality Aide A was not a certified nursing assistant. She stated she was not aware Hospitality Aide A was not to assist with any type of transfers. CNA C stated she did not recall who informed her of this information. She stated the Hospitality Aide A has been doing CNA work over 4 months. She also stated she had continued to assist CNAs with Mechanical lifts and also had been performing care on residents such as: showers, peri care, assisting residents to the bathroom and everything a CNA would do without another CNA with her doing these tasks except for Mechanical Lift transfers. She stated she did not report this to anyone. CNA C also stated she thought everyone knew it especially the floor nurses. She stated the day of the incident on [DATE] Resident #1 was wanting a shower to go to a religious activity. She stated she was working with Hospitality Aide A on [DATE]. She stated she walked with Hospitality Aide to the linen closet to get obtain a sling. She stated both of them looked at the sling and saw where the blue hooks were torn. She stated they noticed the purple hooks was a little torn and tattered. She stated she did not recall if they looked at the green hooks. CNA C also stated they had concerns of the safety of the sling and went to other linen closets trying to find another sling to use due to the one they had did not look safe. She stated they did not find another sling and did not report it to the nurse on duty RN E. She stated they were in a hurry and decided to use the sling they did not believe was safe to use. CNA C stated she entered Resident #1 room with the Hospitality Aide A. She stated she went by the window and the Hospitality Aide A was behind the Mechanical lift. She stated during the time of the transfer prior to Resident #1 being lifted off the bed CNA C entered the room to wait for the Mechanical lift to be used on another resident. She stated the blue hoops were torn and was unable to use them and the some of the purple hooks was tearing and was tattered and they discussed if the green hooks were the appropriate hooks to use. She stated they did not look closely at the green hooks and used the green ones to hook to the Mechanical lift. She stated they placed the sling under Resident #1 and Hospitality Aide began to lift her off the bed and this is when I moved from the window area to the shower chair. She stated when she placed herself by the shower chair to assist with the transfer she heard a noise and saw Resident #1 fall to the floor hitting her face on the legs of the Mechanical lift. CNA C stated CNA D left the room to find the nurse. She also stated the RN E entered the room and began to assess the resident and within 3 minutes the DON, OTA and ADON entered the room. She stated that particular sling was not safe to use due to some of the hooks being torn and some tattered and was tearing. She also stated the sling overall was worn and beginning to tear. should have never been used on Resident #1. She stated it was not safe to use and they (Her and Hospitality Aide A) should have reported it to RN D or to the DON. She stated they knew for a fact the sling was not safe and because they did not see another one they decided to use the unsafe sling. She stated Resident #1 was not responsive when she fell and hit her head on the legs of the Mechanical lift. CNA C stated they did have an in-service in March after the investigation by surveyor U of the hospitality aides job description. She stated in the in-service it was discussed the hospitality aide could only pass out ice, make beds, answer call lights, and never do hands on care with a resident including Mechanical lift and any type of care to a resident with a CNA or alone.</p> <p>(continued on next page)</p>		

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She stated she had been doing everything the CNAs does during ADL care with the residents since before [DATE] but was in-serviced in [DATE] about only doing her job description of being Hospitality Aide. She stated she continued to do Mechanical lifts and gave care to residents after being in-service in [DATE]. She stated she gave the following care without any other staff with her such as: peri-care, assisting resident to the shower and giving showers, transfer residents to the toilet, transfer residents from their bed to wheelchair and to the shower chair, feeding residents, assisted CNAs using Mechanical lifts. She stated she had been doing everything the CNAs does during ADL care with the residents since before [DATE] but was in-serviced in [DATE] about only doing her job description of being Hospitality Aide. She stated she knew she was not qualified on [DATE] and any other time she assisted to do Mechanical lifts. Hospitality Aide A stated she knew the sling was not safe and it was tearing and ripped. She stated she did not look at the green hooks prior to placing them on the Mechanical lift when transferring Resident #1. Hospitality Aide A stated she was not qualified to perform a lot of skills a CNA performed. She stated she realized this when she took her skills test and failed. Hospitality Aide A stated she told staff that she became nervous but that was not the truth. She stated she guessed at a lot of the skills tasks during the test and passed but it was not because she knew what she was doing it was just luck. She stated she did not feel she was qualified to do any of the CNA ADL care. Hospitality Aide A stated she did it because she felt she could learn if she continued to do care with the residents. She stated she did not consider the residents safety when she was giving ADL care. Hospitality Aide A stated a resident may had a serious injury due to her lack of ability and knowledge on how to operate a Mechanical lift. She also stated she should not had been the one to operate the Mechanical lift the day of [DATE] due to not knowing what to do about the sling. She stated she did not know how to use that particular sling and was confused with the hooks torn and she always used the purple hooks and was afraid to use them because they were tattered and beginning to tear. She stated she discussed it with CNA C and they decided to go with the green hooks but they did not look at the green loops to determine if they were in good condition. She stated she did not request to be removed from the Mechanical lift when they used it on Resident #1 she did not want others to know she did not know what she was doing because she was afraid that she may be asked to resign from her job until she became a CNA. Hospitality Aide A stated the Staff Coordinator was aware she had continued to assist with Mechanical Lifts over the past 4 or 5 months. She stated he had observed her go into residents' rooms and ask if she was going to assist the CNA with Mechanical lift transfer and did not say she could not do this task. She stated when she and CNA B obtained the sling from the closet they noticed the sling was ragged and did not look safe to use. Hospitality Aide A stated she had concern about using the sling, however, she did check the storage closet on 500 and 600 hall and did not see any more slings. She stated she did not report this to the nurse or to anyone. She stated she walked with CNA B into Resident #1's room with the sling and the Mechanical lift was already in the room. Hospitality Aide A stated CNA B was by the window and she was using the Mechanical lift. She also stated she had never used this type of sling before and one the blue hooks was broken and they couldn't use them and the purple hooks looked old and was frayed such as slightly tearing apart. She stated she discussed with CNA B of which hooks to use on the Mechanical lift. She also stated they had to use the purple that was frail and the green hooks. She stated she did not notice if the green hooks were tearing /frail looking like the purple hooks. Hospitality Aide A stated she placed the hooks on one side and CNA B placed hooks on the other side of Mechanical lift. She stated when she began to lift Resident #1 from the bed and was pulling the Mechanical lift away from the bed she heard a snap and Resident #1 fell to the floor when she was in the air on the Mechanical lift. She stated the green hooks broke. Hospitality Aide A stated she was aware it was not in her job description to do Mechanical lift transfers and she had been doing them for 5 months. She stated she did not know if the director of nurses knew she was</p>		

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NAME OF PROVIDER OR SUPPLIER  Spjst Rest Home 1		STREET ADDRESS, CITY, STATE, ZIP CODE  1810 Old Granger Road Taylor, TX 76574	
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)		
<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 12:04 PM CNA D stated she entered Resident #1's room (did not recall the time) and was waiting for Hospitality Aide A and CNA C to transfer Resident #1 because she needed to use the Mechanical lift on another resident. She stated when she entered Resident #1 room the resident lying on the bed and the Hospitality Aide A had the controller in her hand to maneuver Resident #1 in the air to transfer her to the shower chair. She stated CNA C was standing behind the shower chair. When Resident #1 was being assisted in the air and Hospitality Aide A was beginning to maneuver her away from the bed this is when Resident #1 fell to the floor and hit her head on the legs of the Mechanical lift. She stated she immediately left the room to find RN E or any nurse. She stated Hospitality Aide A has been using Mechanical lifts before [DATE]. She stated she was not aware of any in-service being given of the Hospitality Aide job description. CNA D stated someone told her but she did not recall who told her it was ok for Hospitality Aide A to do any type of ADL care including Mechanical lifts on residents since she passed her written test. She stated you do have to pass written and skills test to be a CNA. She stated she did know Hospitality Aide A did not pass her skills test. CNA D stated she was not to touch the residents and give any type of care including Mechanical lift if she did not have her CNA certification. She also stated she is not qualified to do Mechanical lifts or any ADL care but she had been doing this before [DATE]. CNA D stated she did not report any concerns about qualifications of Hospitality Aide A to anyone. She stated she knew of two nurse supervisors knowing Hospitality Aide A was assisting with Mechanical lift and doing ADL care. She did not give any names of the nurse supervisors and stated they were not working today ([DATE]).</p> <p>In an interview on [DATE] at 1:10 PM RN E stated Hospitality A and CNA C did not report to her about their concerns of the safety of the sling used on Resident #1. She stated if she had known the staff felt the sling was unsafe, she had new slings she could have given them. She stated she knew Hospitality Aide A was not to use a Mechanical lift. She stated she was not aware when she worked on the hall, she was assigned to that she was assisting with transfer via Mechanical lift or doing any CNA tasks without a CNA assisting her. RN E stated she has worked with Hospitality Aide A several times but did not recall how many times a week or a month. She stated Hospitality Aide A was not qualified to use Mechanical lift or to do any type of care on a resident. RN E stated on the day Resident #1 fell CNA D came out of the room and found me and immediately went to Resident #1's room. She stated Resident #1 was not responsive and within 3 minutes DON, ADON and OTA entered the room and took over while I went to make phone calls to 911, physician, and family. She stated it was her responsibility to monitor the nursing staff working under her on the floor she was assigned to. RN E also stated she knew Hospitality Aide A was working helping CNA C on [DATE] and she did not monitor Hospitality Aide A to ensure she was not doing hands on care. RN E stated Hospitality Aide A was only to pass out ice, answer call lights, assist residents to the dining room and make up beds and this was discussed in an in-service in [DATE]. She also stated she expected all staff to check the slings prior to entering the resident's room for safety of the sling. She stated if the sling was not safe the staff was to report to nurse supervisor and if the nurse supervisor was busy the staff was to go to the ADON or DON and report the sling was not safe to use.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 1:35 PM LVN I stated she was aware Hospitality Aide A was doing Mechanical lifts over 6 months. She stated she was also doing CNA care alone such as: peri care, showers, grooming, feeding residents, and transfer residents to the bathroom. LVN I stated Hospitality Aide A had been doing everything a CNA does and has been doing these tasks alone except for Mechanical lifts. She stated she was informed that the Hospitality Aide A could do anything that CNAs could do due to recently she passed her written test but failed her skilled test. She stated this does not make her a CNA if she did not pass the clinicals. LVN I stated she was the nurse supervisor and had been a supervisor when Hospitality Aide A worked on her hall. She stated she did not feel she was responsible for monitoring the staff as much as the ADON and DON. She also stated the correct proper chain of command with the CNAs was the nurse supervisor, the ADON and the DON. LVN I stated she did not report Hospitality Aide A was doing Mechanical lift transfers or any other hands-on care to the residents. She stated she assumed everyone knew since the Hospitality Aide had continued to do these tasks after the incident when surveyor U came in the facility around March. She stated the Hospitality Aide A never quit doing Mechanical lifts or any CNA care. She stated she realize after the incident with Resident #1 she should have reported it to upper management. LVN I also stated they had an in-service in [DATE] related to the Hospitality Aides job description. She stated the DON read the job description and explained that Hospitality Aides are only to pass out water, answer call lights, make up beds, can push residents in wheelchairs to activities and to the dining room. The Hospitality Aide was never to do hands on care with any resident. She also stated the staff was required to check the slings before entering the resident's room to ensure they were safe to use. She stated she received in-service on the checking the slings the day of the incident with Resident #1 on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 2:00 PM the DON stated there were three CNAs in Resident #1's room on [DATE] the day of the incident with Resident #1 was not correct . DON stated in her statement she put there were 3 CNAs in the room and this was not correct. There were 2 CNAs in the room and one Hospitality Aide. She stated there were two CNAs present (CNA C and CNA D). She also stated the other staff was present was Hospitality Aide A. She stated there were never 3 CNAs in Resident #1's room and she did interview the staff that was in the room at the time of Resident #1 falling from the Mechanical lift and she interviewed Hospitality Aide A, CNA C, and CNA D). She stated she in-service Hospitality Aide A after the state investigation in [DATE]. She stated she reviewed the Hospitality Aide job description and explained to Hospitality Aide A not to give any type of direct care including Mechanical lifts to any resident. Her job description was only to pass out ice, make beds, answer call lights, assist residents to the dining room in their wheelchairs, etc. She stated Hospitality Aide A signed the in-service. DON stated she was not aware Hospitality Aide was continuing to perform Mechanical lifts on residents or giving ADL care without another CNA assisting her. She stated no one had reported this to her. She stated the nurse supervisor was to monitor the staff on their halls. The DON also stated she did not follow up on monitoring or designate anyone to monitor Hospitality Aide A after the state investigation of Hospitality Aide A using Mechanical lift in [DATE] and this was part of the facilities plan of correction. She stated if someone had been monitoring Hospitality Aide A the incident with Resident #1 may not have occurred if there was another CNA using the Mechanical lift and reported to someone the sling was damaged. She also stated the sling should not have been used on Resident #1. The DON stated it was not a safe sling and should have been thrown away by staff. She stated that she and another administrator from sister facility completed a facility wide check on all slings. The staff had slings to use that was safe and the facility ordered more new slings on [DATE]. She stated in service began on [DATE] on how to inspect slings for any imperfections prior to every use. Who purchases new slings (DON or Medical supply), what to do if a sling is not in working condition-repot sling, the concerns of chain of command (floor nurse, DON, and then the Administrator), laundry to inspect slings each wash and all remaining slings in the facility was inspected by the DON. There were no further defected slings found in the facility. The DON [TRUNCATED]</p>		

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F 0908  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</b></p> <p>Based on observation, interview, and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in a safe operating condition for 1 of 6 residents (Resident #1) reviewed for safe requirements.</p> <p>The facility failed to provide a safe sling to be used for Resident #1 on [DATE]. On [DATE], Resident #1 was being transferred by Mechanical lift and the sling broke while Resident #1 was in the air, and she fell and hit her face on the legs of the Mechanical lift.</p> <p>The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for serious injury, serious impairment, or death.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated [DATE], reflected Resident #1 was a [AGE] year-old-female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses of nontraumatic intracerebral hemorrhage in cerebellum (primary, admission - a devastating condition whereby a hematoma ( swelling or clotted blood) is formed within the brain parenchyma ( functional part of an organ) with or without blood extension into the ventricles (cavities in the brain)- this is a new diagnosis after return from hospital on [DATE], the following are diagnosis prior to being admitted to hospital on [DATE]: hemiplegia and hemiparesis following cerebral infarction left non-dominant side ( paralysis or partial or total body function on one side of the body, whereas hemiparesis is characterized by one-sided weakness, but without complete paralysis), lack of coordination (not able to move different parts of the body together easily), muscle wasting and atrophy ( thinning of the muscle mass), and type 2 diabetes mellitus with diabetic neuropathy, unspecified ( nerve damage caused by high blood sugars levels over time, leading to various complications in different parts of the body).</p> <p>Record review of Resident #1's Annual MDS Assessment, dated [DATE], reflected Resident #1 had a BIMS score of 15 indicated her cognition was intact. Resident #1 was assessed to have limited range of motion with upper and lower extremity on one side (left side). She required assistance with ADLs such as eating, all hygiene, upper and lower dressing including assist with footwear, toileting, all transfers, and repositioning in bed.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Residents #1 Comprehensive Care Plan revised on [DATE], reflected Resident #1 had impaired physical mobility related to decreased in muscle strength and recent clavicle fracture (broken collar bone). Resident #1 required two person Mechanical lift transfer assistance. Intervention dated [DATE]: staff to provide a safe environment during transfers and will use a Mechanical lift with two assistance. Resident #1 had impaired physical mobility related to hemiplegia and hemiparesis following cerebral infarction affecting left-dominant side. Intervention: Assess need for an provide as indicated adaptive devices, furniture, and clothing. She was assessed to be at risk for unstable blood glucose level related to Type 2 diabetes mellitus with diabetic neuropathy. Intervention: Assess blood glucose levels as ordered. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Resident #1 was assessed to be at risk for falls related to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Intervention dated [DATE]: Encourage to keep bed in low position. Keep call light in reach. Keep personal belongings in reach. Increased staff supervision with intensity based on resident need. Resident # 1 had ADL self-care performance deficit. Interventions: She was total dependent on staff for bathing/showering, toileting, transfers and required extensive assistance with personal hygiene and oral care.</p> <p>Record review of Resident #1's Nurses Note dated [DATE] at 9:10 AM reflected DON was called to the room at 0901 (9:01 AM), upon arrival to the room, resident was laying in supine position, stating 'help me'. Noted blood and skin tear to LUE and LLE. OTA with resident on the floor. CNA's present in the room. Statements received from 3 CNA's. ADON present and at resident's head holding steady and asking resident not to move. DON conducted partial assessment for visible injuries without moving resident. Resident complaining of neck pain. Resident alert and oriented to self only. Baseline is A&amp;O X 4. Pupils reactive to light. Right cheek bone noted to be swollen along with orbital swelling around right eye. Petechiae ( small red or purple spot caused by bleeding into the skin) noted to right cheek bone and right bicep area. Top of right shoulder with abrasion and blue bruising noted. Blue discoloration and bruising noted to top right middle knuckle. Resident breathing WNL. Vitals obtained (did not see vital entered in documentation). ADON stated she would kept resident calm and talking until EMS comes and has the situation under control. DON left room with ADON and 2 aides present in room. Floor RN was on phone with 911 attempting to get EMS on the way. Signed by Director of Nurses.</p> <p>Record review of Resident #1's Nurses Note dated [DATE] at 9:49 AM reflected, called to room by CNA- upon entering room client in prone position with face and lower extremities laying across Mechanical legs non responsive during course of log roll to supine client started groaning started neuro checks pupils non responsive client groaning and grunting- sent CNA to get DON left OTA and two other CNAs in room started process to send out to hospital-unable to reach ( she named two persons names question of these people are at the time of reading the nurses note when in the facility determined after reviewing face sheet she was referring to two family members) One family member called back as EMS was entering room-report given to them along with transfer paperwork - spoke to family member concerning the incident: client being transferred by Mechanical, Mechanical sling broke client fell to floor informed of clients condition, other family member called also given same information and updated him on where they would be taking her. Signed by RN E.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Hospital Records, dated [DATE], reflected Resident #1 had new diagnosis after her Computed Tomography scans. New diagnosis: back pain, brain bleed (bleeding between the brain tissue and the skull or inside the brain tissue), cerebellar hemorrhage (where the bleeding is located in a small space in the skull, found near the brainstem and cerebellum. The cerebellum is the part of the brain responsible for balance and coordinated movements. The brainstem is responsible for controlling vital body functions, such as breathing), closed head injury (rotational forces when the head twists or turns side to side or from the brain moving forward or backward inside of the skull), facial contusion (a bruise appears on your face after an injury), fall (to drop or descend under the force of gravity, as to a lower place through loss or lack of support), intraventricular hemorrhage (bleeding inside or around the ventricles-spaces in the brain that contain the cerebral spinal fluid. Bleeding in the brain can put pressure on the nerve cells and damage them. If the nerve cells are severely damaged, it can result in irreversible brain injury), right clavicle fracture (broken collar bone), right hip pain (injuries to your hip), subarachnoid hemorrhage (bleeding in the space between your brain and the membrane that covers it), traumatic intraventricular hemorrhage (an uncommon but important condition that may be a marker of severe injury in patients with blunt head trauma), traumatic subarachnoid hemorrhage (there is bleeding in the space that surrounds the brain), and traumatic subdural hemorrhage ( type of brain hemorrhage happens when blood is leaking out of a torn blood vessel and below the space of the brain and skull. This prevents the brain from getting enough oxygen).</p> <p>Record review of Resident #1's facility investigation dated ,[DATE], reflected a skin tear to left forearm and left upper thigh, bruising noted to right middle knuckle, right side of face on cheek bone with petechiae (round spots that form on the skin), along with petechiae on right upper extremity. Resident #1 complaining of neck pain. Resident #1 kept still on ground by ADON for prevention of further injury since complaining of neck pain . The sling to Mechanical lift ripped and caused the resident to fall to the ground. The investigation findings were confirmed. Signed by DON.</p> <p>Record review of written statement by CNA C, dated [DATE] reflected I was working halls 500 and 600, Hospitality Aide A and I went into Resident #1's room to get her up for a shower, to get her ready to go and see religious service., we put the sling underneath it, we noticed the blue hook was already ripped so we put it on the green hook, we got her ready her arms were on her chest like she always did. CNA D walked into the room because she needed the Mechanical lift for another resident. Hospitality Aide A was on one side of the bed and I was on the other side of the bed, as Hospitality Aide A began to move the Mechanical, I began my way by the shower chair because I was going to grab Resident #1, from behind to make sure that she was sitting properly in the shower chair, and as I got by the shower chair, that is when I saw her fall, the sling broke from under her. CNA D did not sign her statement.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of written statement by Hospitality Aide A, dated [DATE], reflected I went into Resident #1's room to give her a shower. We (does not specify who assisted Hospitality Aide A) prepared the water to the shower, her clean clothes on the chair, I went to her bed. CNA C and I put the sling under her (Resident #1). We went to hook the sling to the Mechanical. The blue hooks were ripped. We used the green hooks. At this point, I did not report the ripped blue hooks. I would have reported the sling to RN E. The green hooks looked good. We did look for other slings but were unable to locate one. I was using the remote for the sling. On the way up, everything looked went well. When I went to move Resident #1 to the shower chair, I heard the sling rip. It was really fast. Both hooks ripped. Resident #1 was holding her left arm, she flipped and landed face down on the Mechanical legs. CNA D went to call for help. I was trying to get Resident #1 to respond to me, but she was not responding at all. RN D came into the room with the therapy guy and they took over care for Resident #1. Signed by Hospitality Aide A</p> <p>Record review of written statement by CNA D, not dated, reflected I walked into Resident #1's around 9:00 AM on [DATE] (no year documented). When I walked in Resident #1's room I saw Hospitality Aide A had the Mechanical controller in her hand and Resident #1 was on the bed. CNA C was at the foot of the bed with the shower chair in front of her. I came in and shut the door. Hospitality Aide A moved it (did not specify in her statement) out to put in front of the shower chair. The back strap broke which cuz (do not know the meaning of cuz) Resident #1 to fall and hit the floor. She hit her eye/cheek on the leg of the Mechanical. She was on her stomach. I ran out in the hallway looking for RN E. There was not a signature of CNA D or a date when she wrote the statement.</p> <p>Record review of written statement by DON, dated [DATE], reflected the same information from nurses note dated [DATE] by the DON was documented on the top paragraph of the statement. The second paragraph reflected DON spoke with 3 CNAs to gather information on how incident occurred. 3 CNAs were standing near restroom with Mechanical lift in resident's room. DON asked each CNA to explain what occurred and exact details. Group statement received was that CNA C was standing on the window side of the bed, Hospitality Aide A was on the opposite side of the bed with the Mechanical lift and controls. CNA C was walking around the bed and as they began to move Resident #1 via Mechanical lift to the shower chair, the sling ripped, resident fell to the ground landing with her face on the legs of the Mechanical lift. They (did not specify in statement of who she was referring to as they) then called for help. CNA D was standing in the resident's room observing the transfer and witnessed the incident. CNAs called for help and floor RN E came. CNA (don't know which CNA did not specify) called for DON, Medical Records Coordinator F and the Receptionist G came to the conference room and informed DON and ADON that we were needed on hall 500. The sling was located by the door in Resident #1's room. Upon inspection, the 3 green hooks and 4 blue hooks were ripped and tore. Signed by the DON.</p> <p>Record review of maintenance of slings from the Mechanical lift manual reflected to check sling for wear; discard if worn. and to Ensure sling hardware is in good condition before each use.</p> <p>Observation on [DATE] at 3:30 PM of the sling used to transfer Resident #1 on [DATE] revealed there were four green loops, and three of the four green loops broke during the transfer. The bottom loops had already broken prior to using the sling. There were three out of four top purple loops frayed and was beginning to tear when the sling was used for Resident #1 transfer.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 10:45 AM Hospitality Aide A stated she knew the sling used on Resident #1 was not safe and it was tearing and ripped. She stated she did not look at the green hooks prior to placing them on the Mechanical lift when transferring Resident #1. Hospitality Aide A stated she was not qualified to perform a lot of skills a CNA performed. She stated she realized this when she took her skills test and failed. Hospitality Aide A stated she told staff that she became nervous but that was not the truth. She stated she guessed at a lot of the skills tasks during the test and passed but it was not because she knew what she was doing it was just luck. She stated she did not feel she was qualified to do any of the CNA ADL care. Hospitality Aide A stated she did it because she felt she could learn if she continued to do care with the residents. She stated she did not consider the residents safety when she was giving ADL care. Hospitality Aide A stated a resident may had a serious injury due to her lack of ability and knowledge on how to operate a Mechanical lift. She also stated she should not had been the one to operate the Mechanical lift the day of [DATE] due to not knowing what to do about the sling. She stated she did not know how to use that particular sling and was confused with the hooks torn and she always used the purple hooks and was afraid to use them because they were tattered and beginning to tear. She stated she discussed it with CNA C and they decided to go with the green hooks but they did not look at the green loops to determine if they were in good condition. She stated she did not request to be removed from the Mechanical lift. She stated when she and CNA B obtained the sling from the closet they noticed the sling was ragged and did not look safe to use. Hospitality Aide A stated she had concern about using the sling, however, she did check the storage closet on 500 and 600 hall and did not see any more slings. She stated she did not report this to the nurse or to anyone. She stated she walked with CNA B into Resident #1's room with the sling and the Mechanical lift was already in the room. Hospitality Aide A stated CNA B was by the window and she was using the Mechanical lift. She also stated she had never used this type of sling before and one the blue hooks was broken and they couldn't use them and the purple hooks looked old and was frayed such as slightly tearing apart. She stated she discussed with CNA B of which hooks to use on the Mechanical lift. She also stated they had to use the purple that was frail and the green hooks. She stated she did not notice if the green hooks were tearing /frail looking like the purple hooks. Hospitality Aide A stated she placed the hooks on one side and CNA B placed hooks on the other side of Mechanical lift. She stated when she began to lift Resident #1 from the bed and was pulling the Mechanical lift away from the bed she heard a snap and Resident #1 fell to the floor when she was in the air on the Mechanical lift. She stated the green hooks broke. Hospitality Aide A stated she was aware it was not in her job description to do Mechanical lift transfers and she had been doing them for 5 months. She stated she did not know if the director of nurses knew she was doing the Mechanical lift transfers. She stated she had been in serviced on her job description when the facility got into trouble about her using Mechanical lift in March. She stated she did CNA care thinking she was helping the staff. She stated now she realizes without being qualified she caused a resident serious injury from not knowing how to properly use a Mechanical lift with a defected sling and she had never used that type of sling before until [DATE]. She stated a resident fell and had serious injuries as a result of her not being a CNA and not being qualified to use a Mechanical lift. She stated Resident #1 could have died or any resident could have been seriously injured or died with me not being qualified to give any type of hands-on care to the residents. She stated she should have followed the Hospitality Aide job description and never completed any type of CNA care to a resident. Hospitality Aide A stated she was placing all residents she assisted in danger of being harmed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Spjst Rest Home 1		STREET ADDRESS, CITY, STATE, ZIP CODE  1810 Old Granger Road Taylor, TX 76574	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0908</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 12:04 PM CNA D stated she entered Resident #1's room (did not recall the time) and was waiting for Hospitality Aide A and CNA C to transfer Resident #1 because she needed to use the Mechanical lift on another resident. She stated when she entered Resident #1 room the resident lying on the bed and the Hospitality Aide A had the controller in her hand to maneuver Resident #1 in the air with the Mechanical lift to transfer her to the shower chair. She stated CNA C was standing behind the shower chair. When Resident #1 was being assisted in the air and Hospitality Aide A was beginning to maneuver her away from the bed this is when Resident #1 fell to the floor and hit her head on the legs of the Mechanical lift. She stated she immediately left the room to find RN E or any nurse. She stated Hospitality Aide A has been using Mechanical lifts before [DATE]. She stated she was not aware of any in-service being given of the Hospitality Aide job description. CNA D stated someone told her, but she did not recall who told her it was ok for Hospitality Aide A to do any type of ADL care including Mechanical lifts on residents since she passed her written test. She stated you do have to pass written and skills test to be a CNA. She stated she did know Hospitality Aide A did not pass her skills test. CNA D stated she was not to touch the residents and give any type of care including Mechanical lift if she did not have her CNA certification. She also stated she is not qualified to do Mechanical lifts or any ADL care, but she had been doing this before [DATE]. CNA D stated she did not report any concerns about qualifications of Hospitality Aide A to anyone. She stated she knew of two nurse supervisors knowing Hospitality Aide A was assisting with Mechanical lift and doing ADL care. She did not give any names of the nurse supervisors and stated they were not working today ([DATE]).</p> <p>In an interview on [DATE] at 1:10 PM RN E stated Hospitality A and CNA C did not report to her about their concerns of the safety of the sling used on Resident #1. She stated if she had known the staff felt the sling was unsafe, she had new slings she could have given them. She stated she knew Hospitality Aide A was not to use a Mechanical lift. She stated she was not aware when she worked on the hall, she was assigned to that she was assisting with transfer via Mechanical lift or doing any CNA tasks without a CNA assisting her. RN E stated she has worked with Hospitality Aide A several times but did not recall how many times a week or a month. She stated Hospitality Aide A was not qualified to use Mechanical lift or to do any type of care on a resident. RN E stated on the day Resident #1 fell CNA D came out of the room and found me and immediately went to Resident #1's room. RN E stated Resident #1 was not responsive and within 3 minutes DON, ADON and OTA entered the room and took over while I went to make phone calls to 911, physician, and family. She stated it was her responsibility to monitor the nursing staff working under her on the floor she was assigned to. RN E also stated she knew Hospitality Aide A was working helping CNA C on [DATE] and she did not monitor Hospitality Aide A to ensure she was not doing hands on care. RN E stated Hospitality Aide A was only to pass out ice, answer call lights, assist residents to the dining room and make up beds and this was discussed in an in-service in [DATE]. She also stated she expected all staff to check the slings prior to entering the resident's room for safety of the sling. She stated if the sling was not safe the staff was to report to nurse supervisor and if the nurse supervisor was busy the staff was to go to the ADON or DON and report the sling was not safe to use.</p> <p>In an interview on [DATE] at 1:35 PM LVN I stated no one reported to her of sling not being safe to use on [DATE] when Hospitality Aide A and CNA C transferred Resident #1 via Mechanical lift and the sling broke, and Resident #1 fell to the floor hitting her face on the legs of the Mechanical lift. She stated if the Hospitality Aide A or the CNA C reported their concern safety of the sling, she could have given them a new sling.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Spjst Rest Home 1		STREET ADDRESS, CITY, STATE, ZIP CODE  1810 Old Granger Road Taylor, TX 76574	
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<p>F 0908</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 2:00 PM the DON stated there were three CNAs in Resident #1's room on [DATE] the day of the incident with Resident #1 was not correct . She stated there were two CNAs present (CNA C and CAN D). She also stated the other staff was present was Hospitality Aide A. She stated there were never 3 CNAs in Resident #1's room and she did interview the staff that was in the room at the time of Resident #1 falling from the Mechanical lift and she interviewed Hospitality Aide A, CNA C, and CNA D). She also stated after she inspected the sling the Hospitality Aide A and CNA C used on Resident #1 date of [DATE] she did confirm the sling was unsafe to use for the transfer of Resident #1. She stated the sling was tattered and the purple hooks was beginning to tear. She stated the sling was not in safe condition to use on any resident. The DON stated no one was inspecting the Mechanical lift slings used for mechanical transfer of residents and did not have a way of ensuring worn out slings were not in use. She also stated the maintenance supervisor did check the Mechanical lifts weekly, but no one was assigned to inspect the slings. She stated she in-service Hospitality Aide A after the state investigation in [DATE]. She stated she reviewed the Hospitality Aide job description and explained to Hospitality Aide A not to give any type of direct care including Mechanical lifts to any resident. Her job description was only to pass out ice, make beds, answer call lights, assist residents to the dining room in their wheelchairs, etc. She stated Hospitality Aide A signed the in-service. DON stated she was not aware Hospitality Aide was continuing to perform Mechanical lifts on residents or giving ADL care without another CNA assisting her. She stated no one had reported this to her. She stated the nurse supervisor was to monitor the staff on their halls. The DON also stated she did not follow up on monitoring or designate anyone to monitor Hospitality Aide A after the state investigation of Hospitality Aide A using Mechanical lift in [DATE] and this was part of the facilities plan of correction. She stated if someone had been monitoring Hospitality Aide A the incident with Resident #1 may not have occurred if there was another CNA using the Mechanical lift and reported to someone the sling was damaged. She also stated the sling should not have been used on Resident #1. The DON stated it was not a safe sling and should have been thrown away by staff. She stated that she and another administrator from sister facility completed a facility wide check on all slings. The staff had slings to use that was safe and the facility ordered more new slings on [DATE]. She stated in service began on [DATE] on how to inspect slings for any imperfections prior to every use. Who purchases new slings (DON or Medical supply), what to do if a sling is not in working condition-repot sling, the concerns of chain of command (floor nurse, DON, and then the Administrator), laundry to inspect slings each wash and all remaining slings in the facility was inspected by the DON. There were no further defected slings found in the facility. The DON stated it was not in the facility policy or protocol for Hospitality Aide to give direct care to any residents. She stated the investigation was confirmed that Hospitality Aide A was not qualified to do any Mechanical lift transfers. She also stated the staff coordinator did not report to her the Hospitality Aide A was using Mechanical lifts with another CNA or completing any type of ADL care without a CNA assistance.</p> <p>Record review of Sling inspection protocol, not dated, reflected inspect slings prior to each use. Report sling concerns to chain of command (floor nurse, DON, and then Administrator).</p> <p>Action:</p> <p>Record review on [DATE] of documentation of the investigation reflected on [DATE], the sling that was used on failed transfer was immediately removed from employee access by the DON at the time of the incident. The hall was delivered a new sling to begin using from this point forward.</p> <p>(continued on next page)</p>		

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F 0908  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p>Record review on [DATE] of inspecting sling in-service dated [DATE] reflected the DON was in-serviced by sister facility DON and Administrator via zoom conference call regarding manufacturer recommendations on signs of deterioration for slings such as: sling faded, illegible tags, extreme curling or permanent wrinkles or creases, strap brittleness, stiffness, surface, and edge abrasions, decomposition of edge binding, surface abrasion and color loss.</p> <p>Record review on [DATE] of in-service regarding inspecting slings dated on [DATE] reflected the employees were educated one-on-one by the DON or designee, this in-service included a guideline for identifying signs of deterioration which include a guideline for identifying signs of deterioration which include completely faded, missing, illegible tags, extreme curling or permanent wrinkles or creases, strap brittleness, stiffness, surface, and edge abrasions, decomposition of edge binding, surface abrasion and color loss. She stated the staff was in serviced on chain of command the floor nurse was first in command, then DON and then the Administrator and how to report faulty equipment to appropriate supervisor. All resident care staff was informed new slings were readily available in the facility for replacement of unsafe or compromised equipment.</p> <p>The noncompliance was identified as PNC. The IJ began on [DATE] and ended [DATE]. The facility had corrected the noncompliance before the survey began.</p>		