STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195203	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45877 Based on record review and interview, the facility failed to ensure an injury of unknown origin was reported to the state survey agency no later than 2 hours after it was discovered for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: Review of the facility's incident documentation dated 04/11/2024 at 3:01 p.m., revealed, in part, sustained a fracture of unknown origin. Further review revealed, the type of incident was bruising/swelling. Review of Resident #2's MDS(Minimum Data Sheet) with an ARD (Assessment Reference Date) of 04/03/2024, revealed in part, Resident #2 had a BIMS (brief interview mental status) score of 03 indicating she had severe cognitive impairment. Review of Resident #2's care plan revealed Resident #2 had a history of falls and was identified as being at high risk for falls related to poor safety awareness Review of the facility's report to the state agency revealed, in part, Resident #2 had a major injury of unknown origin that was discovered on 04/11/2024 at 3:00 p.m. Further review revealed the incident was not reported to the state until 04/13/2024 at 10:02 a.m. In an interview on 04/15/2024 at 12:02 p.m., S1Administrator indicated she did not report Resident #2's fracture to the state within two hours of discovery.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877 Based on interview and record review, the facility failed to administer pain medication when a nonverbal resident showed signs and symptoms of pain for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. This deficient practice resulted in actual harm for Resident #2 beginning on 04/09/2024 when S4Occupational Therapist (OT) reported to S3Licensed Practical Nurse (LPN) Resident #2 had facial grimacing with movement of the right lower extremity with no intervention to manage Resident #2's pain. Findings: Review of the facility's policy titled, Pain Management dated January 2024 revealed, in part, identifying pain in a non-verbal resident was observing for facial grimacing and being resistive to movement and care. Further review revealed pain can be managed by pharmacological interventions such as prescribed medication. Further review revealed interventions for pain would need to be reassessed and if it has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Review of Resident #2's record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses, in part, of aphasia (a condition in which a person is unable to express themselves verbally) and a history of Polio (a virus that may cause muscle pain, joint pain, loss of bone density, and osteoporosis related fractures). Review of Resident #2's Polio care plan initiated on 12/06/2023 revealed, in part, an intervention for staff to observe Resident #2 for muscle, bone or joint pain and medicate as ordered. Review of Resident #2's April 2024 Physician's orders revealed, in part, an order with a start date of 11/18/2019 for Acetaminophen (a medication given for pain) 325 milligrams (mg) tablet give 2 tablets every 6 hours as needed for pain. Review of Resident #2's Occupational Therapist note dated 04/09/2024 revealed Resident #2 had appeared uncomfortable and was grimacing with right lower extremity movement. Review or Resident #2's nurse's notes dated 04/10/2024 at 3:23 p.m., revealed S3Licensed Practical Nurse (LPN) documented Resident #2 was complaining of pain to the right lower leg. Review of Resident #2's April 2024 Electronic Medication Administration Record (EMAR) revealed no documented evidence and the facility was unable to provide any documented evidence Resident #2 received pain medication. Review of Resident #2's x-ray results dated 04/11/2024 revealed, in part, a subacute fracture of the left distal femur (bone in upper leg) which required surgery. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/16/2024 at 2:16 p.m., S4OT indicated she worked with Resident #2 on 04/09/2024. S4OT further indicated when she went to take Resident #2's legs off of the leg rest and Resident #2 grimaced in pain. S4OT stated she notified S3LPN of Resident #2's pain. In an interview on 04/16/2024 at 2:54 p.m., S5Certfiied Nursing Assistant (CNA) indicated on 04/10/2024, Resident #2 pushed her a way when S5CNA would touch or try to reposition Resident #2. S5CNA further indicated Resident #2 displayed facial grimacing. In an interview on 04/17/2024 at 1:00 p.m., S5CNA indicated on 04/11/2024, Resident #2 did not want to be touched, and she reported Resident #2's pain to S7CNA Supervisor. S5CNA further indicated S7CNA Supervisor instructed her to report Resident #2's pain to the Director of Nursing (DON). In an interview on 04/17/2024 at 1:10 p.m., S2DON indicated she went to assess Resident #2 after S5CNA reported Resident #2 did not want to be touched, and S2DON noticed bruising and swelling to Resident #2's left lower leg. S2DON further indicated she notified Resident #2's doctor after her assessment, and the doctor ordered an x-ray, which revealed a fracture. In an interview on 04/17/2024 at 3:20 p.m., S3LPN indicated a nonverbal sign of pain was facial grimacing. S3LPN confirmed she did not give Resident #2 any pain medication on 04/09/2024 or 04/10/2024 following staff's reports of Resident #2's pain. S3LPN further indicated she should have given Resident #2 pain medication. In an interview on 04/17/2024 at 4:27 p.m., S2Director of Nursing indicated the nurse should have administered pain medication to Resident #2.