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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195258	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Nursing Home	1181 Hwy 19 Slaughter, LA 70777

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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 42681 Based on observations and interviews, the facility failed to post the names, addresses, and telephone numbers of all pertinent state agencies and advocacy groups, such as the State Survey Agency and a statement as to how a resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation. This deficient practice had the potential to affect any of the 123 residents residing in the facility. Findings: On 09/03/2024 at 2:00 p.m., a brief tour of the facility revealed no postings of the names, addresses and telephone numbers of all pertinent state agencies and advocacy groups, and/or no postings regarding the process as to how a resident may file a complaint with the State Survey Agency. On 09/04/2024 at 11:36 a.m., a brief tour of the facility was conducted with S8SS. S8SS confirmed there were no postings of the names, addresses and telephone numbers of all pertinent state agencies and advocacy groups, and/or no postings regarding the process as to how a resident may file a complaint with the State Survey Agency. On 09/04/2024 at 11:43 a.m., an interview was conducted with S1ADM. S1ADM confirmed there were no postings of the names, addresses and telephone numbers of all pertinent state agencies and advocacy groups, and/or no postings regarding the process as to how a resident may file a complaint with the State Survey Agency.

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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NAME OF PROVIDER OR SUPPLIER: Grace Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1181 Hwy 19 Slaughter, LA 70777	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on interviews and record reviews, the facility failed to protect a resident's right to be free from neglect for 1 (#1) of 4 (#1, #2, #3, and #4) residents reviewed for neglect. The facility failed to ensure an effective system was in place for staff to identify whether a resident was out of the facility on pass or missing, which resulted in Resident #1 being left outside overnight without required care. This deficient practice resulted in an Immediate Jeopardy (IJ) situation on 08/26/2024 at 5:44 p.m., when Resident #1, a severely cognitively impaired resident who required extensive assistance, self-propelled outside the facility without staff knowledge. From 5:44 p.m. until the next morning at 8:15 a.m., staff assumed the resident was out of the facility on pass with family. When Resident #1 was found, she was lethargic, wet with urine, and her vital signs were pulse 119, blood pressure 155/54, and blood glucose of 287. Resident #1 was transferred to the hospital and admitted for Hypertensive Urgency, Hyponatremia, Dehydration and Mild AKI (Acute Kidney Injury). S1ADM was notified of the Immediate Jeopardy situation on 08/30/2024 at 5:39 p.m. The Immediate Jeopardy situation was removed on 08/30/2024 at 8:37 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The deficient practice continued at the potential for more than minimal harm for the remaining 123 residents residing in the facility. Findings: Review of the facility policy titled Identifying Neglect, with a revision date of 09/2022, revealed the following, in part: 5. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of or should have been aware of, goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference to or disregard for resident care, comfort or safety results in (or could have resulted in) physical harm, pain, mental anguish, or emotional distress. Review of Resident #1's Clinical Record revealed Resident #1 was admitted to the facility on [DATE] and had diagnoses which included Type 2 Diabetes Mellitus, Essential (Primary) Hypertension, Paroxysmal Atrial Fibrillation, Need For Assistance With Personal Care, and Acquired Absence of Left Leg Below Knee. Further review revealed Resident #1 was transferred to a local hospital on 08/27/2024 and had not returned to the facility. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #1's MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 07/09/2024, revealed Resident #1 had a BIMS (Brief Interview for Mental Status) of 07, which indicated severe cognitive impairment. Further review revealed Resident #1 was always incontinent of bladder and bowel, and required extensive two person assistance with bed mobility, transfers, and toilet use. Review of Resident #1's Care Plan revealed the following, in part: Focus: Alteration in elimination related to incontinent of bowel and bladder Interventions/Tasks: Assist with personal hygiene and perineal care as needed; Check every 2 hours for dryness. Focus: Diagnoses Diabetes Mellitus: Potential for hypoglycemia/hyperglycemia Interventions: Insulin as ordered; Medication as ordered. Focus: Diagnoses Atrial Fibrillation: At risk for decreased cardiac output. Interventions: Medications as ordered. Focus: Diagnosis Hypertension: at risk for fluctuations in blood pressure. Interventions: Medications as ordered. Focus: Potential for skin breakdown related to decreased mobility, incontinence. Interventions: Check for incontinent episode every 2 hours; Encourage frequent position changes. Review of Resident #1's August 2024 Medication Administration record revealed Resident #1 was not administered Atorvastatin Calcium Oral 40 mg, Insulin Glargine 15 units, Apixaban Oral Tablet 2.5 mg, and Metoprolol Tartrate Oral Tablet 50 mg as ordered on 08/26/2024 at 8:00 p.m. Further review revealed Resident #1 was not administered Diltiazem HCI ER Beads Capsule Extended Release 24 Hour 300 mg, Lisinopril Oral Tablet 5 mg, Synthroid Oral Tablet 25 mcg, Apixaban Oral Tablet 2.5 mg, and Metoprolol Tartrate Oral Tablet 50 mg as ordered on 08/27/2024 at 7:00 a.m. Review of Resident #1's Incident Report dated 08/27/2024 at 9:00 a.m. revealed Resident #1 was found outside by staff around 8:30 a.m. and sent to the hospital to be evaluated. The incident investigation revealed the LPN and CNA thought Resident #1 was out of the facility on pass with family. Review of Resident #1's Nursing Progress Notes revealed the following, in part: 08/27/2024 at 6:30 a.m., Upon S6LPN making rounds, she observed Resident #1's bed was empty and continued to make rounds. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	08/27/2024 7:50 a.m., S6LPN attempted to locate Resident #1 for morning medications. CNAs nor other staff were aware of Resident #1's location. S6LPN along with other facility staff members began to look for Resident #1. Resident #1 was located outside sitting in the wheelchair along the enclosed fence line. S6LPN observed Resident #1 was easily aroused per staff. Staff members rolled the resident into the facility to her room. Resident #1's clothes were wet with urine. The treatment nurse stated her bottom is red, but I don't see anything else. S6LPN questioned how did she get outside? Along with how long had she been outside? The resident stated I don't know. Assessment performed per S6LPN vital signs as follows: B/P 155/54; P=119, R=22, Oral Temp =97.8, Blood Glucose=287. Fluids offered and encouraged, resident drinking without difficulty. Resident stated I am tired and sleepy. Review of the facility's document titled Resident Sign-Out Roster revealed Resident #1 was not signed out of the facility by family on 08/26/2024. On 08/30/2024 at 2:43 p.m., video footage of Resident #1's incident was reviewed and confirmed with S1ADM, which revealed following: On 08/26/2024 at 5:44 p.m., another resident opened the door and Resident #1 self-wheeled herself out on the patio. At 6:24 p.m., Resident #1 was observed wheeling her chair down the sidewalk, turned right where the sidewalk intersected, and got her left wheelchair leg stuck in the grass between the fence and side walk. Resident #1 was observed attempting to get her wheelchair unstuck. At around 8:30 p.m., Resident #1 was no longer visible due to darkness. On 08/27/2024 at 6:12 a.m., Resident #1 was observed asleep in her wheelchair and slightly leaned forward. At 8:12 a.m., S9AA came into the footage and at 8:15 a.m., facility staff were attending to Resident #1. Review of the Prehospital Care Record from a local ambulance company dated 08/27/2024 revealed the following, in part: On Scene: 9:37 a.m. Vitals: 9:47 a.m. Blood Pressure 157/46, Pulse: 49, Respirations 18, Blood Sugar 326. HPI (History of Present Illness) Some time yesterday Resident #1 was left outside and not found until this morning between 8-9 a.m. Resident #1 is very lethargic but arouses easily. Review of the local hospital records for Resident #1's dated 08/27/2024 revealed the following, in part: Vitals: 08/27/2024 10:24 a.m., Blood Pressure: 176/74; Pulse: 59 Chief Complaint: Hyponatremia, Acute Kidney Injury (AKI) History of Present Illness: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #1 is a [AGE] year old female with a past medical history of Hypertension, Hyperlipidemia, Dementia, BKA (Below Knee Amputation), Diabetes Mellitus, Atrial Fibrillation, and Rheumatoid Arthritis, who presents to this hospital from a local nursing home after being found outside sitting in her wheelchair unattended by a fence. Here in the Emergency Department, labs reveled patient has an AKI with Creatinine of 1.18, Hyponatremia with Sodium 131. She has an elevated blood glucose of 319. Blood pressure was 186/62. Hospital Medicine was called to admit for Hypertensive Urgency, Hyponatremia, Dehydration and Mild AKI. On 08/30/2024 at 12:30 p.m., an interview was conducted with S12CNA. S12CNA confirmed she worked on 08/26/2024 from 6:00 a.m. to 6:00 p.m. S12CNA stated the last time she saw Resident #1 was around 6:00 p. m. when she was leaving the facility and Resident #1 was visiting with her family. On 08/30/2024 at 12:06 p.m., an interview was conducted with S5CNA. S5CNA stated staff should check on the residents every 2 hours. S5CNA stated if a resident was not in their room, she would ask the previous shift where the resident was or ask their roommate. S5CNA confirmed she worked the night shift from 6:00 p. m. to 6:00 a.m. on 08/26/2024, and she did not see Resident #1 during her shift. S5CNA stated she started her rounds at 6:00 p.m. and rounded on Resident #1's room around 7:20 p.m. S5CNA stated at that time the resident was not in her room and she asked Resident #1's roommate where Resident #1 was. The roommate told her Resident #1 left the facility with her family. S5CNA stated she reported Resident #1 was with her family to S7LPN. S5CNA stated she thought Resident #1's family had taken her out of the facility for a day when Resident #1 was not in bed the next morning. S5CNA stated she did not know there was a binder for the residents to sign out on pass, and to check if the resident had been signed out. S5CNA confirmed Resident #1 required incontinence care, assistance with dressing, and bed transfers, and confirmed she had not provided care for Resident #1 at any time during her 08/26/2024 shift. On 08/30/2024 at 11:45 a.m., an interview was conducted S4LPN. S4LPN confirmed she worked on 08/26/2024 from 6:00 a.m. to 10:00 p.m. S4LPN stated on 08/26/2024 she went to Resident #1's room to administer medications around 8:00 p.m. and Resident #1 was not in her room. S4LPN stated she asked S5CNA where Resident #1 was and S5CNA stated Resident #1 was out on pass with her daughter. S4LPN stated Resident #1's daughters were at the facility between lunch and dinner on 08/26/2024. S4LPN stated there was a log book for signing residents out, and she did not check the book to see if Resident #1 had been signed out. S4LPN stated she reviewed the notes in the computer from the previous shift and did not see where Resident #1 had been signed out. S4LPN stated most families will notify staff if the residents will be out all night. S4LPN stated she assumed Resident #1 would return. On 08/30/2024 at 10:53 a.m., an interview was conducted with S6LPN. S6LPN stated Resident #1 used a wheelchair and could propel it with her arms and upper body. S6LPN stated Resident #1 was forgetful at times, but knew who she was and could tell time with a watch. She stated she worked the morning of 08/27/2024. S6LPN stated Resident #1 was not in her room at 7:00 a.m. and she thought the resident could be in the whirlpool or the dining room. S6LPN confirmed at 7:50 a.m., she realized Resident #1 was missing and staff found Resident #1 outside by the fence in her wheelchair. S6LPN stated Resident #1 she was lethargic, sleepy, and wet with urine. S6LPN stated she did not know how long Resident #1 was outside. S6LPN confirmed she did not administer Resident #1's morning medications on 08/27/2024 at 7:00 a.m. prior to the resident being transferred to the hospital. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/30/2024 at 11:08 a.m., an interview was conducted S9AA. S9AA stated on 08/27/2024 she saw Resident #1 asleep, outside in her wheelchair by the fence. S9AA stated Resident #1's wheelchair wheel had dropped off the sidewalk into a rut between the sidewalk and the grass. S9AA stated Resident #1's pants were soaked with urine from her knees up. On 08/30/2024 at 12:34 p.m., an interview was conducted with S13WC. S13WC confirmed she worked on 08/27/2024. S13WC stated after the resident was found outside, she and S6LPN brought Resident #1 to her room and conducted a body audit. S13WC stated Resident #1's amputation stump and right leg were swollen, she had redness to her sacrum, and her pants were wet with urine. S13WC stated Resident #1 stated she was tired and could not remember how she got outside or how long she had been out there. On 08/30/2024 at 2:11 p.m., an interview was conducted with S2DON. S2DON stated on the night of 08/26/2024, S5CNA asked Resident #1's roommate where the resident was. The roommate said Resident #1 was out of the facility on pass with family. S2DON reported S5CNA then reported this to S4LPN. S2DON confirmed neither staff verified if the resident was actually out on pass by checking the sign out log or calling the family. S2DON said he was not sure how long Resident #1 was outside for before being found. On 08/30/2024 at 2:11 p.m., an interview was conducted with S3ADON. S3ADON stated Resident #1's family had visited the resident on 08/26/2024. S3ADON explained the evening staff presumed the resident was out of the building with family on the evening of 08/26/2024. S3ADON stated staff should have investigated and verified if Resident #1 was actually out on pass. S3ADON stated the situation could have been avoided had staff verified the resident was out of the facility on pass. S3ADON stated the nurse should have checked the sign out log book and/or called the family to verify the resident's location when they could not find a resident. S3ADON stated he did not know how long Resident #1 was outside. S3ADON stated there was a system breakdown when the staff did not verify if Resident #1 was out of the facility which resulted in the resident not receiving the required ADL (Activities of Daily Living) care or medications. On 08/30/2024 at 2:50 p.m., and interview was conducted with S1ADM. S1ADM stated he became aware Resident #1 had been outside all night around 8:30 a.m. on 08/27/2024. S1ADM stated the CNA reported information to the nurse which was relayed by Resident #1's roommate. He explained the roommate said Resident #1 was out of the facility on pass with family. S1ADM stated the nurse should have checked the sign out binder, called the family, looked for the resident, and notified S3ADON, S2DON and S1ADM. S1ADM confirmed Resident #1 did not receive medications or incontinence care while she was outside. On 09/03/2024 at 3:15 p.m., an interview was conducted with S7LPN. S7LPN confirmed she came in to work at 10:00 p.m. on 08/26/2024. S7LPN stated when she arrived she was notified by S4LPN and S5CNA that Resident #1 was out of the facility on pass with her family. S7LPN confirmed she did not check the log book to see if Resident #1 was signed out on pass. On 09/04/2024 at 9:59 a.m., an interview was conducted with S2DON. S2DON reviewed Resident #1's medication administration record and confirmed Resident #1 had not received her 8:00 p.m. medications on 08/26/2024 or her 7:00 a.m. medications on 08/27/2024. S2DON stated the hospital reported the resident to be dehydrated and hypertensive with a low sodium level upon admission. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 09/03/2024 9:38 a.m., an interview was conducted with S1ADM. S1ADM confirmed Resident #1 was neglected by nursing staff for over 14 hours when the resident was outside.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39121 Based on observation of video surveillance, interviews and record review, the facility failed to ensure alleged violations involving neglect were reported to the state survey agency within twenty four hours after the allegations were made for 1 (#1) of 4 (#1, #2, #3, and #4) residents reviewed for neglect. Findings: Review of the facility policy titled Identifying Neglect, with a revision date of 09/2022, revealed the following, in part: 5. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of or should have been aware of, goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference to or disregard for resident care, comfort or safety results in (or could have resulted in) physical harm, pain, mental anguish, or emotional distress. Review of the facility policy titled Abuse Investigation and Reporting with a revision date of 06/2022, revealed the following, in part: All reports of resident neglect shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Reporting 1. All alleged violations involving neglect will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; 2. An alleged violation of neglect will be reported immediately, but no later than: b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Review of Resident #1's Incident Report dated 08/27/2024 at 9:00 a.m. revealed Resident #1 was found outside by staff around 8:30 a.m. and sent to the hospital to be evaluated. The incident investigation revealed the LPN and CNA thought Resident #1 was out of the facility on pass with family. Review of Resident #1's Nursing Progress Notes revealed the following, in part: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	08/27/2024 at 6:30 a.m., Upon S6LPN making rounds, she observed Resident #1's bed was empty and continued to make rounds. 08/27/2024 7:50 a.m., S6LPN attempted to locate Resident #1 for morning medications. CNAs nor other staff were aware of Resident #1's location. S6LPN along with other facility staff members began to look for Resident #1. Resident #1 was located outside sitting in the wheelchair along the enclosed fence line. S6LPN observed Resident #1 was easily aroused per staff. Staff members rolled the resident into the facility to her room. Resident #1's clothes were wet with urine. The treatment nurse stated her bottom is red, but I don't see anything else. S6LPN questioned how did she get outside? Along with how long had she been outside? The resident stated I don't know. Assessment performed per S6LPN vital signs as follows: B/P 155/54; P=119, R=22, Oral Temp =97.8, Blood Glucose=287. Fluids offered and encouraged, resident drinking without difficulty. Resident stated I am tired and sleepy. On 08/30/2024 at 9:47 a.m., an interview was conducted with S1ADM. S1ADM stated there have been no incidents reported to the state agency since last year. On 08/30/2024 at 2:43 p.m., video footage of Resident #1's incident was reviewed and confirmed with S1ADM, which revealed following: On 08/26/2024 at 5:44 p.m., another resident opened the door and Resident #1 self-wheeled herself out on the patio. At 6:24 p.m., Resident #1 was observed wheeling her chair down the sidewalk, turned right where the sidewalk intersected, and got her left wheelchair leg stuck in the grass between the fence and side walk. Resident #1 was observed attempting to get her wheelchair unstuck. At around 8:30 p.m., Resident #1 was no longer visible due to darkness. On 08/27/2024 at 6:12 a.m., Resident #1 was observed asleep in her wheelchair and slightly leaned forward. At 8:12 a.m., S9AA came into the footage and at 8:15 a.m., facility staff were attending to Resident #1. On 08/30/2024 at 2:50 p.m., and interview was conducted S1ADM. S1ADM stated he became aware of the situation with Resident #1 around 8:30 a.m. on 08/27/2024. S1ADM stated staff reported Resident #1 was found outside. On 09/03/2024 9:38 a.m., an interview was conducted with S1ADM. S1ADM confirmed Resident #1 was neglected by nursing staff for over 14 hours when the resident was outside. S1ADM confirmed he did not report the incident to the state agency. S1ADM confirmed the incident with Resident #1 should have been reported to the state agency.