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	06/12/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	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** Based on observation, interviews and record reviews, the facility failed to ensure each resident had the right to be free from neglect for 1 (#1) of 3 (#1, #2 and #3) sampled residents reviewed for neglect. S3CNA and S4CNA neglected Resident #1 when they failed to verify Resident #1's transfer status prior to transferring Resident #1, who required mechanical lift for transfer. This deficient practice resulted in actual physical harm on 05/13/2025 at approximately 12:30 p.m., when S3CNA and S4CNA transferred Resident #1, who required a mechanical lift, by using a draw sheet without verifying what type of transfer assistance Resident #1 required. Following the transfer, Resident #1 yelled out in pain and an x-ray of the left shoulder was ordered. Resident #1 was diagnosed with a Closed Displaced Fracture of Proximal End of Left Humerus and was sent to the local emergency room for evaluation and treatment. After returning to the facility, Resident #1 continued to have pain and required her left arm to remain in a sling. Findings: Review of the facility's policy titled Identifying Neglect with a revision date of 09/2022, revealed the following in part: Policy Interpretation and Implementation: 4. 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, mental anguish or emotional distress. 7. Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as: d. staff lack of knowledge of the needs of the resident. 9. Examples of failures to provide care and services to the resident that result in neglect include: f. Failure of staff to implement resident interventions, even when residents are assessed and interventions are identified in the care plan. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE], with diagnoses which included but were not limited to Parkinson's Disease, Unspecified Osteoarthritis, History of Falling, Presence of Left Artificial Knee Joint and Acquired Absence of Right Leg Below the Knee. Review of Resident #1's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/16/2025, revealed a BIMS (Brief Interview for Mental Status) of 3, which indicated the resident was severely cognitively impaired and her cognitive skills for daily decision making were severely impaired. Further review revealed in Section GG that the resident was dependent on staff for chair/bed transfers. Review of Resident #1's current care plan revealed a focus problem of self-care deficit related to needs assistance with ADLs, decreased mobility, diagnosis of Parkinsons, and right BKA (below knee amputation). Interventions included the following in part, requires Hoyer lift with 2 staff assistance for transfers. Review of the nurse's notes dated 05/13/2025 revealed the following in part: 05/13/2025 at 1:46 p.m.: Resident #1 screaming in pain regarding left shoulder. Resident unable to move shoulder without significant pain. Notified Nurse Practitioner, x-ray ordered. Tylenol given. Resident states nothing happened to shoulder, that it just hurts. Resident did get up into chair today and sat up for a few hours. No falls noted. Signed by S5LPN. 05/13/2025 at 4:51 p.m.: See x-ray results. Nurse practitioner notified. Ordered to be sent to emergency room for evaluation and pain management. Signed by S5LPN. Review of the facility's investigation report revealed in part the following: 05/13/2025 Resident #1 was brought to her room by S3CNA and S4CNA around 12:30 p.m. At this time, she was being transferred to the bed by S3CNA and S4CNA. She began to yell after the transfer. The CNAs reported to nurse the resident was yelling after she was put in bed. The nurse then assessed her and gave her some Tylenol. She notified the Nurse Practitioner who ordered an x-ray. X-ray showed fracture to left humerus. She was sent out acute to emergency room and later returned that night. 05/14/2025 DON and Administrator interviewed S3CNA and S4CNA. It was determined by administration after interviewing both CNAs the fracture happened after lunch when being put to bed. After interviewing both employees, it was determined that they did not transfer her using the Hoyer lift. Review of the hospital after visit summary dated 05/13/2025, revealed the resident was seen in the emergency department for left arm pain where she was diagnosed with a closed displaced fracture of proximal end of left humerus. Further review revealed she received the following treatment x-ray left Humerus and x-ray of left shoulder. Prescribed Hydrocodone-acetaminophen for pain. She was seen by orthopedic surgery who recommended a sling and follow-up outpatient. Resident is to wear sling until able to follow-up with orthopedic surgery. (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 - Actual harm Residents Affected - Few	On 06/11/2025 at 1:00 p.m., a telephone interview was conducted with S5LPN. She stated she was the nurse assigned to Resident #1 on 05/13/2025 and confirmed Resident #1 had obtained a fracture to her left arm that day after being transferred. She stated she had taken care of the resident since then and Resident #1 complained of pain to her arm periodically. S5LPN said when the resident complained of pain, she administered PRN pain medication as ordered. On 06/11/2025 at 3:10 p.m., an observation and interview was conducted with Resident #1. The resident was observed lying in bed with a sling to her left arm. Resident #1 stated she hurt her arm but, did not know how. The resident said her arm hurt sometimes, but not right now. When asked if she received any pain medication when her arm hurt she answered yes. Resident #1 was unable to provide any more information due to being cognitively impaired. On 06/11/2025 at 2:00 p.m., a telephone interview was conducted with S4CNA. She confirmed she assisted S3CNA with transferring Resident #1 on 05/13/2025. She stated that morning she and S3CNA went into Resident #1's room and transferred her from her bed to her wheelchair using a draw sheet. She stated she did not often work with Resident #1 and was not familiar with the type of assistance she required for transfers. She stated normally, when she was unsure of what type of assistance a resident required with transferring, she would ask the nurse, another CNA, or look it up on the kiosk on the wall under tasks or Kardex. She stated after lunch she and S3CNA bought Resident #1 back into her room and used the same draw sheet to transfer her back to the bed. She stated when they moved her back into bed, the resident yelled out in pain. She stated at that time the nurse practitioner was walking down the hall, heard the resident yell, went in the room to assess the resident, and came out saying that the resident complained of left arm pain. S4CNA stated she told Resident #1's nurse about the resident complaining her arm was in pain. She confirmed she had not looked in the system to verify the level of assistance Resident #1 required for transfer prior to transferring her from the bed to her wheelchair and from her wheelchair back to bed with the draw sheet, and should have. On 06/12/2025 at 9:15 a.m., an interview was conducted with S3CNA. She stated on 05/13/2025 she was pulled to work on Resident #1's hall due to a call in. She stated she had not cared for Resident #1 often and had never gotten her up prior to that day. She stated she and S4CNA transferred Resident #1 using the bed draw sheet from the bed to her wheelchair and she remained in her wheelchair until after lunch. She stated after lunch she and S4CNA brought Resident #1 back to her room and transferred her back into bed from her wheelchair using the draw sheet. She stated when they transferred Resident #1 back to bed, she yelled out in pain. S3CNA stated she reported it to the nurse practitioner, who was in the hallway, and S5LPN. She stated the resident had not complained of pain prior to being transferred back to bed after lunch. She stated if she needed to determine the type of level of assistance a resident required for transfer she would look in the kiosk to verify. She confirmed she did not look at the kiosk to verify Resident #1's transfer status prior to transferring her with the draw sheet and should have. She stated she was not aware Resident #1 required a Hoyer lift for transfer prior to transferring her that day. On 06/11/2025 at 3:33 p.m., an interview was conducted with S6LPN. She stated she was responsible for completing resident care plans. She reviewed Resident #1's care plan and confirmed the resident required a hoyer lift with 2 staff assistance for transfers. She stated if a resident was care planned for Hoyer lift transfers then she expected staff to transfer the resident using a Hoyer lift with 2 staff assistance. (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 - Actual harm Residents Affected - Few	On 06/12/2025 at 10:48 a.m., an interview was conducted with S2DON. He stated on 05/13/2025 S3CNA and S4CNA told him they had transferred Resident #1 from her wheelchair back into her bed and when they did, she yelled out and stated she was in pain. He stated once the results of the x-ray showed Resident #1's left arm was fractured he began to further investigate the situation. He stated after speaking with both S3CNA and S4CNA, it was determined Resident #1's fracture occurred after lunch when S3CNA and S4CNA transferred Resident #1 from her wheelchair back to bed using a draw sheet. He confirmed Resident #1 required Hoyer lift with 2 staff assist for transfers and staff had not transferred her according to her plan of care and should have. He stated if a resident was care planned for Hoyer lift transfers then he expected staff to transfer the resident using a Hoyer lift with 2 staff assist. He stated if staff did not know what type of assistance a resident required he expected staff to look in the kiosk and verify what type of assistance is required and provide care according to the resident's plan of care. He stated he had not considered what occurred with Resident #1 to be neglect. He stated only S3CNA and S4CNA received in-service training on the proper way to use a hoyer lift and ensuring to look in the kiosk to verify transfer assistance required for residents prior to transfer. He confirmed no monitoring of staff was done after the in-service training was completed. On 06/12/2025 at 1:50 p.m., an interview was conducted with S1ADM. He stated he did not consider staff failing to transfer Resident #1 according to her care plan and sustaining an injury during improper transfer as neglect. He stated he considered it to be a mistake and stated S3CNA and S4CNA were in-serviced afterwards. He confirmed no monitoring of staff was done after in-service training was completed.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure an allegation involving neglect was reported to the State Survey Agency in the required timeframe for 1 (#1) of 3 (#1, #2 and #3) sampled residents reviewed for neglect. Findings: Review of the facility's policy titled Abuse Investigation and Reporting with a revision date of 06/2022, revealed the following in part: 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 not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. Review of the facility's policy titled Identifying Neglect with a revision date of 09/2022, revealed the following in part: Policy Interpretation and Implementation: 4. 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, mental anguish or emotional distress. 7. Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as: d. staff lack of knowledge of the needs of the resident. 9. Examples of failures to provide care and services to the resident that result in neglect include: f. Failure of staff to implement resident interventions, even when residents are assessed and interventions are identified in the care plan. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE], with diagnoses which included but were not limited to Parkinson's Disease, Unspecified Osteoarthritis, History of Falling, Presence of Left Artificial Knee Joint and Acquired Absence of Right Leg Below the Knee. Review of Resident #1's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/16/2025, revealed a BIMS (Brief Interview for Mental Status) of 3, which indicated the resident was severely cognitively impaired. Further review revealed in Section GG that the resident was dependent on staff for chair/bed transfers. Review of the facility's investigation report revealed in part the following: 05/13/2025 Resident #1 was brought to her room by S3CNA and S4CNA around 12:30 p.m. At this time, she was being transferred to the bed by S3CNA and S4CNA. She began to yell after the transfer. The CNAs reported to nurse the resident was yelling after she was put in bed. The nurse then assessed her and gave her some Tylenol. She notified the Nurse Practitioner who ordered an x-ray. X-ray showed fracture to left humerus. She was sent out acute to emergency room and later returned that night. 05/14/2025 DON and Administrator interviewed S3CNA and S4CNA. It was determined by administration after interviewing both CNAs the fracture happened after lunch when being put to bed. After interviewing both employees, it was determined that they did not transfer her using the Hoyer lift. Review of the facility's self-reported incidents to the state agency revealed no entries related to Resident #1's incident on 05/13/2025. Review of the hospital after visit summary dated 05/13/2025, revealed the resident was seen in the emergency department for left arm pain where she was diagnosed with a closed displaced fracture of proximal end of left humerus. On 06/11/2025 at 2:00 p.m., a telephone interview was conducted with S4CNA. She confirmed she assisted S3CNA with transferring Resident #1 on 05/13/2025. She stated she did not often work with Resident #1 and was not familiar with the type of assistance she required for ADLs or transfers. She stated normally, when she was unsure of what type of assistance a resident required with transferring, she would ask the nurse, another CNA or look it up on the kiosk on the wall under tasks or Kardex. She stated after lunch she and S3CNA brought Resident #1 back into her room and used a draw sheet to transfer her back to the bed. She stated when they moved her back into bed, she yelled out in pain. She confirmed she had not looked in the system to verify the level of assistance Resident #1 required for transfer prior to transferring her and should have. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2025 at 9:15 a.m., an interview was conducted with S3CNA. She stated on 05/13/2025 she was pulled to work on Resident #1's hall due to a call in. She stated she had not cared for Resident #1 often and had never gotten her up prior to that day. She stated she and S4CNA transferred Resident #1 using the bed draw sheet after lunch. She stated when they transferred Resident #1 back to bed, she yelled out in pain. She stated if she needed to determine the type of level of assistance a resident required for transfer she would look in the kiosk to verify. She confirmed she did not look at the kiosk to verify Resident #1's transfer status prior to transferring her with the draw sheet and should have. She stated she was not aware Resident #1 required a Hoyer lift for transfer prior to transferring her that day. She confirmed failing to look up the correct way to transfer the Resident and the resident sustaining an injury at transfer was considered neglect. On 06/12/2025 at 10:48 a.m., an interview was conducted with S2DON. He stated on 05/13/2025 S3CNA and S4CNA told him they had transferred Resident #1 from her wheelchair back into her bed and when they did, she yelled out and stated she was in pain. He stated once the results of the x-ray showed Resident #1's left arm was fractured he began to further investigate the situation and had notified S1ADM. He stated after speaking with both S3CNA and S4CNA, it was determined Resident #1's fracture occurred after lunch when S3CNA and S4CNA transferred Resident #1 from her wheelchair back to bed using a draw sheet. He confirmed Resident #1 required Hoyer lift with 2 staff assist for transfers and staff had not transferred her according to her plan of care and should have. He stated he had not considered what occurred with Resident #1 to be neglect. He stated the Administrator was responsible for reporting incidents of alleged neglect to the state survey agency. On 06/12/2025 at 1:50 p.m., an interview was conducted with S1ADM. He stated he was responsible for reporting any allegations of neglect, to the State Survey Agency within 2 hours. He stated S2DON had notified him of the incident that occurred on 05/13/2025 the day it occurred. He stated he did not consider staff failing to transfer Resident #1 properly according to her care plan and sustaining an injury during improper transfer as neglect. He stated he considered it to be a mistake. He confirmed he had not reported the incident that occurred with Resident #1 to the State Survey Agency.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement a comprehensive person-centered care plan for 1 (#1) of 3 (#1, #2 and #3) residents reviewed in the sample. The facility failed to ensure Resident #1 was transferred properly using the mechanical lift with two person assistance. Findings: Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE], with diagnoses which included but were not limited to Parkinson's Disease, Unspecified Osteoarthritis, History of Falling, Presence of Left Artificial Knee Joint and Acquired Absence of Right Leg Below the Knee. Review of Resident #1's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/16/2025, revealed a BIMS (Brief Interview for Mental Status) of 3, which indicated the resident was severely cognitively impaired and her cognitive skills for daily decision making were severely impaired. Further review revealed in Section GG that the resident was dependent in chair/bed transfers. Review of Resident #1's current care plan revealed a focus problem of self-care deficit related to needs assistance with ADLs, decreased mobility, diagnosis of Parkinsons, and right BKA (below knee amputation). Interventions included the following in part, requires Hoyer lift with 2 staff assistance for transfers. On 06/11/2025 at 2:00 p.m., a telephone interview was conducted with S4CNA. She confirmed she assisted S3CNA with transferring Resident #1 on 05/13/2025. She stated that morning she and S3CNA went into Resident #1's room and transferred her from her bed to her wheelchair using a draw sheet. She stated she did not often work with Resident #1 and was not familiar with the type of assistance she required for ADLs or transfers. She stated normally, when she was unsure of what type of assistance a resident require with transferring, she would ask the nurse, another CNA or she would look it up on the kiosk on the wall under tasks or Kardex. She stated after lunch she and S3CNA bought Resident #1 back into her room and used the same draw sheet to transfer her back to the bed. She confirmed she had not looked in the system to verify the level of assistance Resident #1 required for transfer prior to transferring her from the bed to her wheelchair and from her wheelchair back to bed with the draw sheet, and should have. On 06/12/2025 at 9:15 a.m., an interview was conducted with S3CNA. She stated on 05/13/2025 she was pulled to work on Resident #1's hall due to a call in. She stated she had not cared for Resident #1 often and had never gotten her up prior to that day. She stated she and S4CNA transferred Resident #1 using the bed draw sheet from the bed to her wheelchair and she remained in her wheelchair until after lunch. She stated after lunch she and S4CNA brought Resident #1 back to her room and transferred her back into bed from her wheelchair using the draw sheet. She stated if she needed to determine the type of level of assistance a resident required for transfer she would look in the kiosk to verify. She confirmed she did not look at the kiosk to verify Resident #1's transfer status prior to transferring her with the draw sheet and should have. She stated she was not aware Resident #1 required a Hoyer lift for transfer prior to transferring her that day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2025 at 10:48 a.m., an interview was conducted with S2DON. He stated on 05/13/2025 S3CNA and S4CNA told him they had transferred Resident #1 from her wheelchair back into her bed using a draw sheet. He confirmed Resident #1 required Hoyer lift with 2 staff assist for transfers and staff had not transferred her according to her plan of care and should have. He stated if a resident was care planned for Hoyer lift transfers then he expected staff to transfer the resident using a Hoyer lift with 2 staff assist. He stated if staff did not know what type of assistance a resident required he expected staff to look in the kiosk and verify what type of assistance is required and provide care according to the resident's plan of care.