

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Natchitoches Nursing and Rehabilitation Center,llc		STREET ADDRESS, CITY, STATE, ZIP CODE 750 Keyser Avenue Natchitoches, LA 71457	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45213</p> <p>Based on interview and record review, the facility failed to ensure Resident #1, who had been assessed to be at risk for elopement, received adequate supervision to prevent him from exiting the facility without staff knowledge, for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation for Resident #1 on 05/13/2024 at 11:30 a. m., when Resident #1, (a moderately cognitively impaired resident who was identified as an elopement risk), asked S5 Agency Nurse to unlock the facility's front door so he could go see his wife, while holding a clear trash bag containing clothing items. S5 Agency nurse did not notify any other staff of Resident #1's exit seeking behavior. Resident #1, who was last seen at the nurses' station by S3 LPN Unit Manager at 12:45 p. m., was found at 1:00 p.m., 0.4 miles away from the facility, down a busy four-lane roadway, by staff from Resident #1's IOP (Intensive Outpatient Program). The IOP staff notified S4 LPN SDC and S2 DON of Resident #1's whereabouts. S4 LPN SDC drove to Resident #1's location to assist the IOP staff with returning Resident #1 back to the facility.</p> <p>S1 Administrator was notified of the Immediate Jeopardy situation on 05/23/2024 at 5:25 p.m.</p> <p>The Immediate Jeopardy was removed on 05/24/2024 at 5:13 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility had implemented an acceptable Plan of Removal (POR) prior to the survey exit.</p> <p>The likelihood of elopement exists for all newly admitted residents with a history of wandering/elopement due to failure to retrain all facility staff.</p> <p>Findings:</p> <p>Review of a facility policy titled Missing Resident/Eloperments, and dated 05/2022, revealed in part .</p> <p>Policy: The Unit Charge Nurse is responsible for knowing the location of their residents. When residents are participating in various programs, such as physical therapy, recreational activities, dining, etc., the staff in these programs will be responsible for the location of their participants.</p> <p>Procedure:</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>I. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical.</p> <p>Review of Resident #1's medical records from a local hospital revealed in part . admitted : 03/27/2024</p> <p>Has been admitted to behavioral unit for worsening confusion. Apparently, he and his spouse live out in woods and he wandered off and had to be located by police. She brought him to primary care clinic where he was evaluated and sent here for further treatment.</p> <p>Reason for Admission: Neurocognitive Disorder with behavioral disturbances</p> <p>Review of Resident #1's clinical record revealed an admitted [DATE], with diagnoses that included: Major Depressive Disorder, Neurocognitive Disorder due to known physiological condition with Behavioral Disturbance, Unspecified Dementia, and Alzheimer's Disease.</p> <p>Review of Resident #1's Risk of Elopement Evaluation dated 04/15/2024, revealed he exhibited wandering behavior in the last 60 days, wandered aimlessly, ambulated independently, and was at risk for elopement with an intervention of door alarms.</p> <p>Review of Resident #1's Admission MDS with an ARD of 04/24/2024 revealed a BIMS score of 9, indicating moderate cognitive impairment.</p> <p>Review of Resident #1's care plan revealed a problem of at risk for elopement related to diagnoses of Dementia and Alzheimer's disease, and a history of wandering, with an onset date of 04/15/2024. Interventions included in part . alert staff to resident wandering/elopement behavior, provide reality orientation during routine care daily, monitor resident's whereabouts every 1 hour, and redirect when exhibit behaviors of elopement/wandering, such as going to doors, following staff to exit doors.</p> <p>Review of Resident #1's Admission/Readmission Evaluation dated 04/15/2024, revealed Resident #1 had a history of wandering, ambulated independently, and was at risk for elopement, with a care plan intervention of location monitoring.</p> <p>Review of Resident #1's Physician Progress note dated 04/29/2024 revealed in part .</p> <p>Seen today for admission visit . Recently hospitalized at a local Behavioral Hospital from 03/27/2024 through 04/15/2024. According to hospital paperwork, patient admitted due to worsening confusion. Patient was sent from walk-in clinic under PEC .He also wanders off at night and recently got lost in woods, law enforcement had to locate the patient .Attending IOP.</p> <p>Review of Resident #1's 05/2024 Flow Sheet revealed in part .</p> <p>-Start Date 04/18/2024 - Monitor resident location every hour.</p> <p>-05/13/2024 - S5 Agency Nurse initialed that Resident #1's location was monitored at 12:00 p.m. and 1:00 p. m.</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>Interview on 05/21/2024 at 3:26 p.m. with S3 LPN Unit Manager, revealed she last saw Resident #1 on 05/13/2024 at 12:45 p.m. at the nurses' station. S3 LPN Unit Manager reported another resident was being discharged from the facility at that time, and the other resident's family was back and forth, and in and out the facility's front door moving her things out. S3 LPN Unit Manager reported the other resident's family might have thought Resident #1 was a visitor because he was very ambulatory.</p> <p>Interview on 05/21/2024 at 3:42 p.m. with S4 LPN SDC, revealed on 05/13/2024, an employee (did not remember the name of the employee) from Resident #1's IOP program called the facility around 1:00 p.m. to report that one of their drivers saw Resident #1 walking down a busy four-lane roadway. S4 LPN SDC stated she found Resident #1 on the busy four-lane roadway approximately 0.4 miles away, sitting on the side of a business with 3 employees (could not remember their names) from the IOP Program. S4 LPN SDC stated when she asked Resident #1 why he left the facility, Resident #1 told her he wanted to go home. S4 LPN SDC stated Resident #1 got on the IOP Program van to go back to the facility, and she followed them. S4 LPN/SDC stated they arrived at the facility together around 1:05 p.m.</p> <p>Interview on 05/22/2024 at 12:19 p.m. with S2 DON revealed she received a telephone call at approximately 1:00 p.m., from an IOP Program employee, informing her Resident #1 was at a business down the busy four-lane roadway.</p> <p>Interview on 05/22/2024 at 3:19 p.m. with S6 Transportation, revealed she last saw Resident #1 walking towards his room around 12:00 p.m. on 05/13/2024. S6 Transportation stated she told Resident #1 it was time for lunch, and to go up front. S6 Transportation reported Resident #1 had been confused lately, and she told S5 Agency Nurse to keep an eye on him because he could not leave the facility. S6 Transportation reported around 12:00 p.m., Resident #1 was observed walking around the front near the nurses' station, and S5 Agency Nurse redirected him towards the dining room.</p> <p>Interview on 05/22/2024 at 3:58 p.m. with S1 ADM revealed a resident's family was moving belongings out of the facility on 05/13/2024, around the time that Resident #1 eloped from the facility. S1 ADM reported she assumed staff opened the door to let family members in and out. S1 ADM stated staff were at the nurses' station and corridor, and the staff must have left the open door unattended in order for Resident #1 to have been able to leave the facility without being seen by staff. S1 ADM stated it would have only taken a split second, and with a lot going on in a little space, no one noticed Resident #1 leave.</p> <p>Interview on 05/23/2024 at 11:21 a.m. with S3 LPN Unit Manager, revealed she did not think to monitor Resident #1 when another resident's family was moving belongings and holding the door open, because she did not think Resident #1 was at risk for elopement at that time. S3 LPN Unit Manager stated he was not at risk for elopement until he came back.</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>Telephone interview on 05/23/2024 at 11:52 a.m. with two IOP Program LPNs revealed they received a telephone call from their PRN van driver around 12:30 p.m., to report he had observed Resident #1 walking alone on a busy four-lane roadway. One LPN stated the van driver came to the office and she, along with a Senior Care Therapist, got into the van with the driver to go check on Resident #1, while the second LPN reported she called the facility to notify them. The first LPN stated it took them approximately 5 minutes from the van driver's telephone call to get to Resident #1, who was found standing by a business located on the busy four-lane roadway. The LPN stated Resident #1 was irritated, and said he did not want to go back to the nursing home because he wanted to go see his wife. The LPN stated Resident #1 was wearing a cowboy hat, jeans, and boots, and he was carrying an office sized trash bag with a few pieces of clothing in it. She stated S4 LPN SDC arrived about 5 minutes later and tried to get him to go with her in her vehicle; however, he refused. She stated Resident #1 finally agreed to go back, and got in their van and went back to the facility.</p> <p>Telephone interview on 05/23/2024 at 2:11 p.m. with S5 Agency Nurse revealed she was Resident #1's nurse on 05/13/2024 when he eloped from the facility. S5 Agency Nurse stated Resident #1 came to her at the nurses' station at around 11:30 a.m. asking her to unlock the front door so he could leave to see wife. S5 Agency Nurse stated Resident #1 was carrying a clear trash bag with clothes. S5 Agency Nurse reported S6 Transportation told her Resident #1 did that frequently, so she redirected him to the dining room. S5 Agency Nurse reported Resident #1 sat down at the table and when she asked if she could put his clothes up, he got agitated and said no to leave them with him. S5 Agency Nurse stated she left the bag with him and went back to the nurses' station. S5 Agency Nurse reported she was asked to go the dining room at 12:15 p.m. to go monitor a resident at risk for choking. S5 Agency Nurse stated she could not recall if Resident #1 was in the dining room at that time. S5 Agency Nurse reported that was the second shift she had worked at the facility, and she did not receive an official orientation to the facility. S5 Agency Nurse stated she was only oriented on where and what to chart. S5 Agency Nurse stated she was not told who was risk for elopement, and she was not aware Resident #1 was at risk for elopement, and he did not have a wander guard on. S5 Agency Nurse stated people are in and out of the front door and residents have the code. S5 Agency Nurse reported she was unsure of the last time she saw Resident #1 before he eloped from the facility. S5 Agency Nurse stated she did not feel Resident #1 needed increased supervision when he asked to leave while carrying a bag of clothes. She reported she did not notify the S3 Unit Manager, S2 DON or S1 ADM of Resident #1's behavior. S5 Agency Nurse reported she signed off on Resident #1's every hour location monitoring at 12:00 p.m. and 1:00 p.m., because she saw him at 11:30 a.m. and after 1:00 p.m.</p> <p>Interview on 05/23/2024 at 2:31 p.m. with S1 ADM confirmed supervision should have been increased at 11:30 a.m. on 05/13/2024, when Resident #1 asked S5 Agency Nurse to unlock the front door to leave to go see his wife. S1 ADM reported staff know what residents are at risk for elopement by an elopement binder that is maintained at the nurses' station. S1 ADM confirmed Resident #1 was at risk for elopement at the time of the incident on 05/13/2024, but he was not placed in the elopement binder until after he eloped from the facility. S1 SDM stated the off going nurse should in-service oncoming agency nurses on who is at risk for elopement.</p> <p>Interview on 05/23/2024 at 4:48 p.m. with S1 ADM revealed the facility did not have a policy on training all staff including agency staff on risk for elopement.</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>Telephone interview on 05/24/2024 at 1:32 p.m. with another resident's grandson, revealed he and his fiancée went to the facility around lunchtime on 05/13/2024, to help his grandmother move out. He stated when they first arrived, a couple that looked like visitors entered the code to the front door, to let them into the facility, and they gave him the code. He reported when he went to go out, the code did not work, so he got staff to let him out. He stated when he was coming back in the front door of the facility from moving his truck, he saw a man wearing a cowboy hat, a button up shirt, a vest, jeans, and boots, go out the door as he was coming in. He reported there were no staff by the front door at that time. He stated he could not recall who opened the door for him to come in after moving his truck. He reported when they were wheeling his grandmother out of the facility, the man was back inside. He stated he did not know the timeframe between the man leaving the facility, and seeing him back inside.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>45213</p> <p>Based on interview on record review, the facility failed to administer its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. The Administration failed to have an effective system in place to ensure Resident #1, who was assessed as being at risk for elopement, was adequately supervised to prevent him from exiting the front door of the facility unattended.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation for Resident #1 on 05/13/2024 at 11:30 a. m., when Resident #1, (a moderately cognitively impaired resident who was identified as an elopement risk), asked S5 Agency Nurse to unlock the facility's front door so he could go see his wife, while holding a clear trash bag containing clothing items. S5 Agency Nurse did not notify any other staff of Resident #1's exit seeking behavior. Resident #1, who was last seen at the nurses' station by S3 LPN Unit Manager at 12:45 p. m., and was found at 1:00 p.m., 0.4 miles away, down a busy four-lane roadway, by staff from Resident #1's IOP (Intensive Outpatient Program). The IOP staff notified S4 LPN SDC and S2 DON of Resident #1's whereabouts, and S4 LPN SDC drove to Resident #1's location to assist the IOP staff with returning Resident #1 back to the facility.</p> <p>S1 Administrator was notified of the Immediate Jeopardy situation on 05/23/2024 at 5:25 p.m.</p> <p>The Immediate Jeopardy was removed on 05/24/2024 at 5:13 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.</p> <p>The likelihood of elopement exists for all newly admitted residents with a history of wandering/elopement due to failure to retrain all facility staff.</p> <p>Findings:</p> <p>Cross Refer to F689</p> <p>Review of a facility policy titled Missing Resident/Eloperments, and dated 05/2022, revealed in part .</p> <p>Policy: The Unit Charge Nurse is responsible for knowing the location of their residents. When residents are participating in various programs, such as physical therapy, recreational activities, dining, etc., the staff in these programs will be responsible for the location of their participants.</p> <p>Procedure:</p> <p>I. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical.</p> <p>(continued on next page)</p>		

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