

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 06/20/2025
NAME OF PROVIDER OR SUPPLIER Natchitoches Nursing and Rehabilitation Center, LL		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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, record review and interview the facility failed to provide care and services that met professional standards of quality by failing to ensure x-ray results were followed up on in a timely manner for 1 (#1) of 3 (#1, #2, #3) sampled residents.</p> <p>Findings:</p> <p>Review of Resident #1's clinical record revealed an admit date of 09/08/2020, with diagnoses which included Alzheimer's Disease with Late Onset; Vitamin Deficiency, Pain in Left Hip; Unspecified Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Unspecified Abnormalities of Gait and Mobility; Lack of Coordination, Muscle Weakness, Fracture of Unspecified Part of Neck of Left Femur, Presence of Left Artificial Hip Joint, and Dementia.</p> <p>Review of Resident #1's Care Plan dated 01/12/2025 revealed in part At risk for falls/injuries. 2/28/24; 3/16/24; 5/30/25: Unwitnessed fall with interventions to include . Contact MD with abnormal findings.</p> <p>Review of Resident #1's Progress notes revealed in part . Nursing note dated 05/30/2025 at 5:18 p.m. by S2 LPN: around 3:45pm Aid notified this nurse that Resident #1 was in pain during brief change, aid states that resident was holding L hip and screaming during change, when this nurse went to assess resident, resident appeared to be in pain, resident was asked where did she hurt, resident began to hold left thigh, NP was notified around 4:00 pm and she ordered STAT X-ray of the L hip This nurse called . to order STAT X-ray of L hip, this nurse reported everything to the oncoming nurse.</p> <p>Nursing note dated 05/30/2025 at 8:30 p.m. by S3 LPN: Late Entry: Resident C/O left hip pain. Nurse administered PRN medications and was effective. Bed in low position. Will continue to monitor.</p> <p>Nursing note dated 05/31/2025 at 10:45 a.m. by S2 LPN: NP was notified of X-ray results NP ordered for resident to be sent out to ER for CT scan . Resident #1 left facility by ambulance around 10:30 am.</p> <p>Review of Client #1's x-ray results revealed . Date of Service: 05/30/2025. Findings: There is a nondisplaced intertrochanteric fracture noted; Electronically Signed: 05/30/2025 at 7:20 p.m. received on 05/31/2025 at 9:20 a.m.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with S2 LPN on 06/18/2025 at 2:19 p.m. revealed on 05/30/2025 around 4:00 p.m., she put in a STAT order for Resident #1's x-ray to her left hip and the x-ray tech came between 6:00 p.m. and 6:30 p.m. S2 LPN stated that STAT x-ray results normally came back within a few hours. S2 LPN revealed that she reported Resident #1's x-ray results were pending to S3 LPN during shift change.</p> <p>Interview with S3 LPN on 06/18/2025 at 4:25 p.m. revealed on 05/30/2025 at 6:00 p.m., she received report from S2 LPN and was made aware that Resident #1 was awaiting x-ray results. S3 LPN stated that she observed the x-ray technician and S2 LPN assisting Client #1 during the x-ray. S3 LPN revealed that she expected the x-ray results in 2-3hrs max and that she would normally call if results were taking a long time. S3 LPN revealed that the x-ray results still had not come in by 05/31/2025 at 6:00 a.m. S3 LPN confirmed that she did not call to check on the x-ray results and she should have. S3 LPN stated that had she known the results were a fracture, she would have sent Resident #1 out that night to the Emergency Room.</p> <p>Interview with S1 DNS on 06/18/2025 at 3:00 p.m. revealed that STAT orders are normally received within 1-2 hours and if the nurse was aware of a pending x-ray result, she should know to look for the results. S1 DNS revealed that nursing staff would normally call the Imaging Center if the results were not sent within 2 hours. S1 DNS confirmed Resident #1's x-ray results should have been followed up on by the nurse assigned to care for Resident #1 that night and had not been.</p>		