STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195310	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Many Healthcare and Rehabilitation Center	120 Natchitoches Hwy 6 East Many, LA 71449

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 - Minimal harm or potential for 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** 46773 Based on interview and record review the facility failed to ensure a resident's rights to be free from physical abuse for 1 (#6) of 8 (#1, #2, #3, #4, #5, #6, #7 and #8) residents reviewed for abuse. The facility failed to protect Resident #6 from physical abuse by Resident #8. The facility implemented corrective actions which were completed prior to the State Agency's Investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the facility policy on 09/17/2024, with a revision date of 05/17/2024 titled Abuse Prohibition Policy, read in part . Each resident has the right to be free from abuse, mistreatment neglect, corporal punishment, involuntary seclusion and financial abuse. Resident #6 Review of Resident #6's medical records revealed an admitted [DATE], with diagnoses that included: Heart Failure, Major Depressive Disorder, Osteoarthritis, Congestive Heart Failure, Hypertension, and Atrial Fibrillation. Review of Resident #6's Quarterly MDS with an ARD of 07/09/2024 revealed a BIMS score of 07, indicating severe cognition impairment. Resident #8 Review of Resident #8's medical record revealed an admitted [DATE], with diagnoses that included: Delusional Disorder, Generalized Anxiety Disorder, Schizoaffective Disorder, Bipolar type; Unspecified Dementia, Unspecified Severity with Agitation, Psychotic Disorder with Delusions due to known Physiological Condition, and Major Depressive Disorder, recurrent, severe with psychotic symptoms. Review of Resident #8's MDS with an ARD of 05/17/2024 revealed a BIMS of 3, indicating severe cognitive impairment. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's Comprehensive Person Centered Care Plan with a target date of 06/07/2024, read in part Resident #8 has a behavior problem: throwing items, restless, agitation. Resident #8 has the potential to be physically aggressive towards staff and residents. Review of a facility Incident Report dated 06/11/2024, revealed Resident #6, Resident #8 and other fell ow residents, were sitting in Hall X common area on 06/11/2024 at 6:00 p.m. Resident #8 began speaking to Resident #6 but she did not respond. Resident #8 rolled his wheelchair to Resident #6, and grabbed the back of her hair and left ear. Staff then entered Hall X's common area, took Resident #8 to his room, and began 1:1 monitoring. S1 Administrator, S2 DON, and responsible party were notified. Resident #8 remained on 1:1 monitoring until he was admitted to an inpatient psychiatric hospital on 06/12/2024. Interview on 09/10/2024 at 12:25 p.m. with Resident R1, revealed she was on Hall X 's common area visiting with other residents, when she heard Resident #8 making a fuss. Resident R1 stated she heard Resident #6 ask Resident #8 to stop screaming. Resident R1 stated Resident #8 then went to Resident #6 and grabbed her by her hair and ear. Resident R1 stated she then began yelling for help and a staff member showed up and removed Resident #8 from the Hall X common area. Interview on 09/16/2024 at 2:22 p.m. with S5 CNA, revealed she heard hollering from Hall X's common area, walked up, observed Resident #8 holding onto Resident #6's wheelchair, and would not let go. S5 CNA stated Resident R1 notified her that Resident #8 had pulled Resident #6's hair and ear. S5 CNA stated she separated Resident #6 and Resident #8, and redirected Resident #8 to his room and began 1:1 supervision. Interview on 09/16/2024 at 2:30 p.m. with S6 CNA, revealed she was on Hall X making rounds, and heard yelling from Hall X's common area. S6 CNA stated she ran to Hall X's common area, and observed S5 CNA separating Resident #6 and Resident #8. S6 CNA stated after the incident, Resident #6 complained of ear pain, and she observed a red mark to Resident #6's left ear. S6 CNA stated Resident #8 became 1:1 supervision until he was sent out to Psychiatric Hospital. The facility has implemented the following actions to correct the deficient practice: 1. Resident #6 and Resident #8 were separated and Resident #8 was placed on 1:1 monitoring immediately. 2. Resident #6 had a bruise observed to left ear after the incident, and has had no further injuries. 3. Each resident's physician and responsible party were notified regarding the incident. 4. New orders from Resident #8's physician for a psychiatric evaluation. Resident #8 continued 1:1 supervision until he was admitted to an inpatient psychiatric hospital on 06/12/2024 at 12:15 p.m. 5. Life satisfaction rounds were made on all cognitive residents who utilized Hall X's common area, with no issues noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. On 06/11/2024, S2 DON initiated an In-services/training reviewing the facility's abuse policy, and educated staff in aggressive behaviors in residents. All in services/training completed for facility staff as of 06/12/2024. 7. QA committed met on 06/11/2024 to discuss the resident to resident altercation that occurred between Resident #6 and Resident #8. Abuse QA is ongoing at this time. Facility correction date of 06/12/2024.

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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. 44315 Based on interview and record review the facility failed to ensure an allegation of resident to resident sexual abuse was reported to the State Survey Agency immediately but not later than 2 hours after the resident to resident sexual abuse was discovered for 2 (Resident #5 and Resident #7) of 8 residents reviewed for abuse. Findings: Review of the facility's policy titled, Abuse Prohibition Policy read in part . 1. Any employee who becomes aware of an allegation of abuse, neglect or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination. 2. The facility will report all allegations and substantiated occurrences of abuse, neglect or misappropriation of resident property to the state agency and to all other agencies as required by law and will take all necessary corrective actions depending on the results of the investigation. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within 2 hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation. Review of the SIMS (Statewide Incident Management System) report dated 07/15/2024 revealed the allegation of sexual abuse for Resident #5 and Resident #7. Documentation on the SIMS report reflected the date of sexual abuse for Resident #5 and Resident #7 occurred on 07/12/2024 and 07/13/2024 but unable to validate/verify. The SIMS entry time was noted as 07/15/2024 at 9:05 a.m. Interview on 09/16/2024 at 4:50 p.m. with S3 LPN revealed she had witnessed resident involved in 2 incidents over the weekend on Friday, 7/12/2024 and Saturday, 7/13/2024 but was not aware on needing to write an incident report immediately. S3 LPN reported she should have written the incident reports written within 2 hours after each incident but was not done. Interview on 09/17/2024 at 9:00 a.m. with S2 DON revealed it wasn't until the daily morning meeting on Monday, 07/15/2024 when she and the administrator were informed of the incidents over the weekend when she initiated the Sims report immediately after made aware. S2 DON verified that S3 LPN should have initiated the incident report immediately and did not. Interview on 09/17/2024 at 11:00 a.m. with S1 ADM confirmed the allegation of resident to resident sexual abuse was substantiated by the facility but was not notified and aware of the incident until Monday morning of 07/15/2024. S1 ADM confirmed a SIMS report was not entered immediately or within 2 hours after discovery of incident abuse and should have been.

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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** 46773 Based on observation, record review, and interview the facility failed to implement the resident's comprehensive plan of care for 1 (#4) of 8 (#1, #2, #3, #4, #5, #6 ,#7 and #8) sampled residents. The facility failed to place a fall mat at the bedside for resident #4. Findings: Review of Resident #4's clinical record revealed an admitted [DATE], with diagnoses which included repeated falls; other spondylosis, cervical region; spondylolisthesis, lumbar region; other abnormalities of gait and mobility; displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing; schizoaffective disorder, bipolar type; anxiety disorder, unspecified; and Alzheimer's disease, unspecified. Review of Resident #4's Quarterly MDS with an ARD/ Target date of 04/19/2024, revealed a BIMS score of 11; Moderate Impairment. Resident #4 requires supervision and one person physical assist with bed mobility; and requires Supervision and set up help only with transfers, eating and toilet use. Review of Resident #4's clinical record revealed a Morse Fall Scale Evaluation with a Post Fall score of 50 (High Risk for Falling) dated 06/26/2024. Review of Resident #4's physician's order with a start date of 07/08/2024, read in part .fall mat at bedside. Review of Resident #4's Care Plan revealed in part The resident is at risk for falls. Falls 2024: 06/26/2024 - fell in room beside bed, therapy screen, c/o right pain, x-ray performed and sent to ER. Interventions included: Fall mat at bedside as ordered, non-slip footwear when ambulating, re-educate on call light, move closer to nurse's station for close observation and aiding with assist post-op. Observation of Resident #4 on 09/09/2024 at 10:56 a.m., revealed Resident #4 propelling himself in his wheelchair. No fall mat at bedside, or in room. Interview with Resident #4 on 09/09/2024 at 10:57 a.m., revealed that he broke his right hip over a month ago, when he was getting ready to put his pajamas on (unable to recall the exact date). Resident #4 stated that he turned around too quick, and fell on his hip. Resident #4 stated that he was sent to a local hospital via Helicopter, and had surgery on his hip. He stated that he transfers himself from bed to chair, and chair to bed, and does not need help, so he does not call for help. Interview and observation on 09/09/24 at 1:02 p.m. with S2 DON, confirmed that there was no fall mat at Resident #4's bedside, or in room at all, and there should have been.