STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195312	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierremont Healthcare Center	725 Mitchell Lane Shreveport, LA 71106

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 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** 40957 Based on record review, interview, and video review the facility failed to provide services according to the written plan of care for 1(#4) of 4 (#1, #2, #3, #4) residents reviewed for plan of care. The facility failed to ensure fall mats were in place as ordered by a physician. Findings: Review of Resident #4's clinical record revealed the resident had the following diagnoses, in part, hemiplegia and hemiparesis following CVA (Cerebral Vascular Accident) affecting non-dominant side, cerebral infarction, seizures, and muscle weakness. Review of Resident #4's physician orders for March 2024 revealed an order dated 06/15/2021 for fall mats times two to every shift. Review of Resident #4's minimum data set assessment dated [DATE] revealed the resident had a BIMS (Brief Interview of Mental Status) of 2, which would indicate the resident was severely impaired. Review of the time stamped and dated video footage with audio from the camera located at the head of Resident #4's bed, provided by Resident #4's RP (Responsible Party), revealed a fall mat was not in place on the right side of Resident #4's bed when the resident fell on to floor on 03/19/2024 at 8:11 p.m. During an interview on 04/02/2024 at 4:00 p.m., Resident #4's RP indicated she saw the video footage of S2 CNA cleaning Resident #4 on 03/19/2024 and when S2 CNA (Certified Nurse Assistant) was trying to get something from drawer, Resident #4 fell out of the bed to the floor. The RP verified Resident #4 suffered a right patella fracture. During an interview on 04/03/2024 at 1:15 p.m., S2 CNA confirmed fall mats were not in place when Resident #4 fell out of the bed on 03/19/2024 and she was not aware that the fall mats were ordered. During an interview on 04/04/2024 at 10:00 a.m. S1 Corporate Nurse verified she had watched the video of Resident #4's fall and confirmed a fall mat was not placed to the right side of Resident #4's bed when he fell out of bed on 03/19/2024.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40957 Based on record review, interviews, and video evidence review the facility failed to ensure 1 (#4) of 1 (#4) residents reviewed for accidents received the necessary supervision and assistive devices to each resident to prevent avoidable accidents including a fall. The deficient practice resulted in actual harm for Resident #4 on 03/19/2024 at 8:11 p.m. when Resident #4 suffered a major injury when he fell out of the bed to the floor when incontinence care was being administered. S2 CNA (Certified Nursing Assistant) was providing incontinence care to Resident #4 and when S2 CNA turned to get an item out of a bedside table drawer, Resident #4 rolled off the bed and to the floor. Resident #4 was sent to a local hospital ER (emergency room) on 03/19/2024 and the hospital records showed Resident #4 suffered a closed non-displaced fracture of the right patella (kneecap). Resident #4 returned to the facility on [DATE]. 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 Resident #4's clinical record revealed the resident had the following diagnoses, in part, hemiplegia and hemiparesis following CVA (Cerebral Vascular Accident) affecting non-dominant side, cerebral infarction, seizures, and muscle weakness. Review of Resident #4's physician orders for March 2024 revealed the following, in part: 11/20/2020 order for assist bars times two to assist with bed mobility/transfer. 06/15/2021 order for fall mat times two every shift. Review of Resident #4's minimum data set assessment dated [DATE] revealed the resident had a BIMS (Brief Interview of Mental Status) of 2, which would indicate the resident was severely impaired. Review of Resident #4's MDS (Minimum Data Set) revealed Resident #4 required total dependence for bed mobility with one person assist. Resident #4 was always incontinent of bowel and bladder. Review of the facility's incident report on 03/20/2024 (entered date) for Resident #4's accident/fall on 03/19/2024 revealed the following, in part: Incident description- Allegation of neglect reported by RP (Responsible Party) of resident. S2 CNA was giving incontinent care to resident and he slipped off the bed. S2 CNA tried to grab him, but couldn't hold him and fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	S2 CNA stated that she went in the room to clean Resident #4 and she cleaned his front first, then as she was cleaning his back, the air-loss mattress aired up and Resident #4 started slipping. S2 CNA tried to grab him, but couldn't hold him up and he fell . S2 CNA stated she went and got her nurse. RP has video of incident from electronic monitoring surveillance. At 2:38 PM today, RP told CCS (unknown abbreviation), that she felt like the accused could have prevented victim's fall and reported incident to Abuse division of LDH (Louisiana Department of Health). Review of Resident #4's progress notes revealed the following, in part: Note on 03/19/2024 at 8:16 p.m. - S2 CNA called writer to room. Resident was lying on the floor on his left side between his bed and roommates' bed. Small amount of blood noted to forehead. Resident complained of bilateral knee pain. Ambulance called to transport resident to ER for evaluation. Pillows applied for resident's comfort during wait. S2 CNA states this happened during incontinence care, she wrote a statement. Writer stayed with resident until ambulance arrived . Complained of hip pain to EMTs (Emergency Medical Technicians). Resident #4 to go to local ER. Note on 03/20/2024 at 1:45 p.m. - Resident #4 returned to the facility from local hospital ER via stretcher per ambulance with two attendants. New orders were noted. Diagnosis: Right Patella Fracture. Review of Resident #4's hospital record dated 03/19/2024 revealed reason for visit was fall. Diagnosis was closed non-displaced fracture of right patella, unspecified fracture morphology, initial encounter. Another diagnosis was pain. Review of the time stamped and dated video footage with audio from the camera located at the head of Resident #4's bed, provided by Resident #4's RP, revealed the following, in part: On 03/19/2024 at 8:09 p.m., S2 CNA at bedside providing incontinence care. On 03/19/2024 at 8:10 p.m., S2 CNA rolled Resident #4 on his right side with Resident #4 on the edge of the mattress and both knees were bent and hanging over the edge of the mattress. S2 CNA was noted cleaning the backside of Resident #4. On 03/19/2024 at 8:11 p.m., S2 CNA, with one hand holding Resident #4 in place, placed a new pad and brief on the bed and rolled Resident #4 on to his back. S2 CNA removed her hand from holding Resident #4's left hip and turned to get supplies from the bedside table drawer. Resident #4 proceeded to roll forward to his right side and fell off the bed and onto the floor. Resident #4 could be heard yelling his knee hurt. During review of the video it was noted that the left assist rail was positioned at the left top corner of Resident #4's mattress and a fall mat was not noted on the floor of the right side of Resident #4's bed. During an interview on 04/02/2024 at 4:00 p.m., Resident #4's RP indicated she saw the video footage of S2 CNA cleaning Resident #4 and when S2 CNA was trying to get something from drawer, Resident #4 fell out of the bed to the floor. The RP verified Resident #4 suffered a right patella fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/03/2024 9:15 a.m., S1 Corporate Nurse reported Resident #4 should have been a two person assist due to his behaviors and mobility issues. She further acknowledged he was too close to the edge of the bed and the assist bars were not in the correct position when the incident occurred. During an interview on 04/03/2024 at 10:50 a.m., S2 CNA reported she gathered all supplies to clean and change Resident #4 on 03/19/2024. S2 CNA further reported after she cleaned Resident #4 she shifted him towards his back and reached for supplies from the bedside drawer. Resident #4 fell out of the bed and to the floor. During an interview on 04/03/2024 at 1:15 p.m., S2 CNA confirmed fall mats were not in place when Resident #4 fell out of the bed on 03/19/2024 and she was not aware that the fall mats were ordered. During an interview on 04/04/2024 at 10:00 a.m. S1 Corporate Nurse verified the problems that led to Resident #4's fall on 03/19/2024 were assist rails were at the top of the bed and not in the correct position, Resident #4 was too close to the edge of the bed while S2 CNA was cleaning him, and supplies were not safely within reach. During the survey, in-service records and QA (Quality Assurance) monitoring records were reviewed, and it was determined that the facility had implemented the following actions to correct the deficient practice. The facility implemented the following actions to correct the deficient practice with a completion date of 03/23/2024: 1. Resident #4 was sent to a local hospitalER on [DATE] for evaluation. 2. S2 CNA was suspended pending investigation. 3. Nursing staff was in-serviced on 03/21/2024 on positioning residents in bed. 4. S2 CNA was in-serviced on 03/23/2024 on positioning residents in bed. 5. S1 Corporate Nurse monitored fall mat placement weekly throughout the facility since the accident/fall on 03/19/2024. 6. S1 Corporate Nurse verified all total care residents had been changed to two person assist for bed mobility. 7. The 02/23/2024 QAPI (Quality Assurance/Performance Improvement) plan for falls with fracture or injury was revised on 03/21/2024 to include Resident #4. The plan put into place for Resident #4 included making the resident a two person assist, the assist bed rails were moved where the resident can reach them, and fall mats were placed on both sides of residents' bed.