STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195313	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Agnes Healthcare and Rehab Center	606 Latiolais Road Breaux Bridge, LA 70517

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 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** 47540 Based on record review and interview, the facility failed to ensure that all alleged violations of abuse were reported immediately to the administrative staff for 2 (#1 and #2) out of 3 (#1, #2, and #3) sampled residents. Findings: Review of the facility's Abuse and Neglect policy and procedure that was updated 01/2024 per S2AsstAdm (Assistant Administrator) read in part: Policy: It is the policy of this facility to provide an environment for our residents that is free of abuse, neglect, extortion, self-neglect or misappropriation of funds . 4. Identification-Any staff person receiving a complaint of abuse, neglect, or an injury of unknown origin whether it is from the resident, a family member or staff, should listen to the complaint, writing down the date, and time complaint was received, time, and any details given .The charge nurse then notifies the administrator or his designee immediately even if this is a weekend or at midnight . 1. Resident #1. Review of the resident's clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Muscle Spasm, Age-Related Osteoporosis, and Other Specified Disorders of Bone Density. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating her cognition was severely impaired. Review of the facility's incident report that was entered on 03/31/2024 at 8:28 p.m. revealed that on 03/30/2024 S7CNA (Certified Nursing Assistant) explains to Resident #1's RP (Responsible Party) that Resident #1 told her that she hurt her hands when helping her stand up . Review of the facility's incident report investigation revealed, On 04/05/2024 at 10:45 a.m., S2AsstAdm (Assistant Administrator) wrote: Resident #1 03/31/2024 S7CNA approached Resident #1's RP son of Resident #1) telling him that she was assisting Resident #1 the day before (03/30/2024) to stand and Resident #1 said she hurt her hands and bruised them . Interview with S8LPN, S7CNA never reported any incident on 03/30/2024 regarding Resident #1 to the nurse in charge or the supervisor. She reported to S8LPN at 5:45 p.m. on 03/31/2024 the conversation she had with Resident #1's RP was the first notification of this incident . (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of S8LPN's handwritten statement that was not dated revealed, 03/31/2024 at 5:45 p.m. On the above date and approximately time S7CNA called facility and stated that Resident #1 had informed her son that she had been abusive towards her. S7CNA stated that Resident #1's RP questioned her about this and she told him that she was helping the Resident #1 stand up with her hands clasping Resident #1 hard. Resident #1 alleged that she was hurt in the process . Three attempts were made to contact S7CNA via phone on 05/01/2024 at 2:00 p.m., at 2:20 p.m., and at 2:40 p.m. S7CNA failed to return any phone calls and was unable to be interviewed. On 05/01/2024 at 2:50 p.m., a telephone interview was conducted with S8LPN. S8LPN stated she was the nurse and S7CNA was the CNA for Resident #1 on 03/30/2024 and 03/31/2024. S8LPN stated that she received a telephone call on 03/31/2024 at around 5:45 p.m. from S7CNA who stated on 03/30/2024 that Resident #1 complained that S7CNA clasped her hands too tight while transferring her and hurt her hands. S8LPN confirmed that all alleged cases of any type of abuse has to be reported immediately to the charge nurse or supervisor and S7CNA did not report the case of alleged abuse to S8LPN until the next day. On 05/02/2024 at 8:51 a.m., a joint interview was conducted with S4Adm (Administrator) and S2AsstAdm. S2AsstAdm stated she initiated the facility incident report and completed the investigation regarding Resident #1's complaint. S4Adm and S2AsstAdm stated that they were notified of the allegation of abuse from S8LPN on 03/31/2024 in the evening around 6:30 p.m. They were told by S8LPN that S7CNA called the facility and told S8LPN that Resident #1 told her on 03/30/2024 that S7CNA clasped her hands to tight while transferring her and her hands were hurt and bruised. S4Adm and S2AsstAdm confirmed that S7CNA did not report the alleged abuse until the next day on 03/31/2024 and S7CNA should have immediately reported the alleged abuse to the charge nurse or administration staff. 17364 2. Resident #2. Review of the resident's clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance, Anxiety Disorder, and Dysphagia. Review of the resident's significant change MDS (Minimum Data Set) dated 03/27/2024 revealed the resident was assessed as being severely impaired for cognition. Review of the facility's incident report that was entered on 03/11/2024 at 4:41 p.m. revealed that on 03/11/2024 at 4:15 p.m. the resident's daughter entered the administration office. The resident's daughter stated that she was at the facility on Friday evening after supper and an aide came to take her mother, Resident #2, to bed. The resident's daughter stated that the CNA handled her mother really rough and did not want that CNA to provide care to her mother again. An investigation was assigned and started by the S2AsstAdm. Review of the facility's incident report investigation revealed, Incident Investigation: On 03/12/2024 at 4:23 p. m., S2AsstAdm wrote: 03/08/2024 S4CNA stated that S5CNA was assigned to care for Resident #2. After supper, the resident's daughter asked to have Resident #2 put to bed. S5CNA approached the resident and grabbed her hands and pulled her to stand, then S4CNA intervened and said she needs to go slow when helping her as she can't stand well. The resident's daughter then said that she doesn't want that aide taking care of her mother . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of S4CNA's handwritten statement that was not dated revealed, I S4CNA worked 03/08/2024 . with another agency CNA (S5CNA). After supper, the resident's daughter wanted her to be put in bed for the night. The CNA that had assigned to her went to yank on her in process of getting her up out chair to stand. I, myself, and the daughter got up and told the CNA she can't do that and she has to go slow with her in order to get her to stand and catch her balance . the daughter called me to the room and told me the other aide was very ruff (rough) handling her mother for me to get the nurse. I went to nurse S3LPN. She went talk with the daughter and I was told to care for resident. After that, the daughter didn't want the other aide in her mother's room or touching her . On 05/01/2024 at 3:50 p.m., a telephone interview was conducted with S4CNA. The CNA stated that she was working with S5CNA when the CNA attempted to get the resident out of the chair. S4CNA stated after supper one evening, the resident's daughter requested that the resident be put back to bed. S4CNA stated that S5CNA was observed handling the resident very rough. Surveyor asked, what do you mean the CNA was rough? S4CNA stated that S5CNA was pulling and yanking the resident's hands hard and fast to pull her up out of the chair. S4CNA stated that she and the resident's daughter told S5CNA no, you can't do that and that you have to go slow with her in order to get her up and out of the chair to stand up. S4CNA stated that the resident's daughter told her that she did not want S5CNA to take care of her mother because she did not like the way she was handling her mother. S4CNA stated that S3LPN was there and was informed about the incident. On 05/01/2024 at 4:01 p.m., an interview was conducted with S3LPN. She stated that Resident #2's daughter reported to her that she did not like the way the assigned CNA (S5CNA) was handling her mother during a transfer. S3LPN stated that she asked the resident's daughter if the CNA hurt her mother and the daughter replied that she did not want the CNA caring for her mother. The surveyor asked S3LPN if she reported the incident to the administrative staff. S3LPN stated that she did not report the incident to the administrative staff. On 05/01/2024 at 4:34 p.m., an interview was conducted with S2AsstAdm. She stated that she initiated the facility incident report concerning the resident's daughter's complaint that S5CNA was rough with her mother. S2AsstAdm stated that staff did not report the incident to her on 03/08/2024. S2AsstAdm stated that the resident's daughter reported the incident to her on 03/11/2024, which was 3 days after the incident occurred. On 05/02/2024 at 7:40 a.m., an interview was conducted with S1DON (Director of Nursing). S1DON stated S2AsstAdm was responsible for completing the facility incident reports and investigations. S1DON stated that she was not involved with the facility incident report or investigation concerning the incident involving the CNA handling the resident in a rough manner. S1DON stated that she would have expected S4CNA, S5CNA or S3LPN to report the incident to the administrative staff when the incident occurred on 03/08/2024. S1DON confirmed that the resident's daughter and not the staff members reported the incident to the S2Asst Adm on 03/11/2024, which was 3 days after the incident occurred.