

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/25/2024
NAME OF PROVIDER OR SUPPLIER  Heritage Manor of Opelousas		STREET ADDRESS, CITY, STATE, ZIP CODE  7941 I-49 South Service Road Opelousas, LA 70570	

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 - Minimal harm or potential for actual harm</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17364</p> <p>Based on observation, record review and interview, the facility failed to ensure the staff followed the policy and procedures to prevent accidents for 1 (#1) out of 3 (#1, #2, #3) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's policy titled Toileting Residents with the latest review date of 01/24 read in part . Purpose: Residents are toileted safely on a routine basis in a timely manner according to their individualized plan of care . Procedure: 5 . If the resident is high risk for falls, the nursing assistant/designee is to remain in the bathroom for resident safety.</p> <p>Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Atherosclerotic Heart Disease, Urge Incontinence, Hypertension, and Bilateral Osteoarthritis of Knee.</p> <p>Review of the resident's quarterly MDS (Minimum Data Set) dated 05/21/2024 revealed the resident's BIMS (Brief Interview Mental Status) score was 14 for being cognitively intact.</p> <p>Review of the resident's care plan revealed the resident was at risk for falls. Further review of the resident's care plan revealed the resident had 13 falls since 01/02/2024 to 06/14/2024.</p> <p>On 06/25/2024 at 10:44 a.m., an observation was made of Resident #1. The resident was observed sitting up in wheelchair at the dining room table. The resident had a bruise to the left side of her face around the temporal, orbital and cheek area. The resident stated she fell in the bathroom. The resident stated the CNA (Certified Nursing Assistant) brought her to the bathroom and left her in the bathroom alone. The resident stated she fell in the bathroom while trying to clean her bottom. The resident stated if the CNA had stayed with her she would not have fallen.</p> <p>Review of the resident's nurse's note dated 06/14/2024 at 11:22 a.m. read in part, 8:48 a.m.: During AM med pass, this nurse was outside of resident room when hearing a noise and resident saying 'Oh sh_' and began yelling for help. This nurse walked into resident room and observed resident sitting on bathroom floor leaning to the left side. Pants and diaper to her ankle. When asked what happened, resident stated 'I was wiping and I fell '. Golf ball size hematoma observed to left temple . Assisted resident to commode x 2 (times two) assist. CNA helped resident with wiping her bottom .</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 195321	If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/25/2024 at 12:15 p.m., an interview was conducted with S3ADON (Assistant Director of Nursing). S3ADON stated she was in the facility when the resident fell in the bathroom on 06/14/2024. S3ADON stated she conducted the incident investigation. S3ADON stated she asked the resident what happened in the bathroom and the resident responded that she was wiping her bottom and fell . S3ADON stated she did not ask the resident how she got in the bathroom or if someone brought her to the bathroom. S3ADON stated she thought the resident went to the bathroom on her own.</p> <p>On 06/25/2024 at 12:25 p.m., a telephone interview was conducted with S4LPN (Licensed Practical Nurse). S4LPN stated she was working with Resident #1 on the day she fell in the bathroom on 06/14/2024. S4LPN stated she was passing medications at the time of the resident's fall. S4LPN stated she went in the resident's room to administer her medications but the resident was in the bathroom at the time. S4LPN stated she walked out the resident's room to continue passing medications. S4LPN stated when she walked out of the resident's room she heard the resident say Oh sh__ and was yelling for help. S4LPN stated she went back in the room and the resident was on the floor in the bathroom and had a hematoma to the left temple. S4LPN stated she called for S5CNA. S5CNA entered the room and stated she had just put the resident on the toilet. S4LPN confirmed that S5CNA had left the resident in the bathroom alone.</p> <p>On 06/25/2024 at 1:07 p.m., an interview was conducted with S6MDS (Minimum Data Set). S6MDS stated the resident was assessed as a high risk for falls.</p> <p>On 06/25/2024 at 1:20 p.m., an interview was conducted with S5CNA. S5CNA stated she was familiar with Resident #1. 5CNA stated the resident was a fall risk and the resident told her that she was afraid to fall. S5CNA stated on 06/14/2024 she brought the resident to the bathroom and sat her on the toilet. S5CNA stated she left out of the resident's room once the resident was on the toilet. S5CNA stated later, S4LPN called her to help assist the resident off of the bathroom floor and to help clean her bottom. S5CNA stated the resident had a knot on the left side of her head after the fall occurred.</p> <p>On 06/25/2024 at 3:00 p.m., an interview was conducted S1Admin (Administrator) and S2DON (Director of Nursing). Both confirmed that the resident had several falls and was a high risk for falls and that the policy revealed that if the resident was high risk for falls, the nursing assistant/designee was to remain in the bathroom for resident safety.</p>		