

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 10/30/2024
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 - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354</p> <p>Based on interview, observations, and record reviews, the facility failed to ensure a cognitively impaired resident received adequate supervision during facility transportation which resulted in the resident falling from a wheelchair and sustaining a severe head injury for 1 (#2) of 3 (#2, #3, #R5) sampled residents with impaired cognition investigated for safe transportation via wheelchair.</p> <p>The deficient practice resulted in an Immediate Jeopardy for Resident #2 on 10/08/2024 at 10:00 a.m., when S2D (Driver) left Resident #2 unattended in her wheelchair on a sidewalk outside of an eye doctor's office while S2D moved the transportation van. Resident #2, who was cognitively impaired, fell from her wheelchair during this time, striking her head against the concrete pavement. Resident #2 was transferred to a local hospital (Hospital A) for evaluation on 10/08/2024 at 12:01 p.m. Hospital A's CT (computed tomography) report of the head dated 10/08/2024 at 12:19 p.m., showed the resident sustained post traumatic bilateral parenchymal and subarachnoid hemorrhages. Resident #2 was transferred from Hospital A to a second hospital (Hospital B) for further evaluation and treatment by a neurologist on 10/08/2024 at 3:11 p.m. where she was subsequently admitted for further treatment with coagulation and antihypertensive medication in the ICU (Intensive Care Unit) for three days. Resident #2 returned to the facility on [DATE].</p> <p>The facility implemented an immediate corrective action plan on 10/08/2024 which was completed prior to the State Agency's investigation. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance on 10/09/2024, thus it was determined to be a Past Noncompliance citation.</p> <p>Findings:</p> <p>A request was made for a facility policy regarding supervising residents during transportation appointments. On 10/29/2024 at 1:47 p.m., S1DON (Director of Nursing) stated the facility did not have such policy.</p> <p>Review of the facility's Transportation Attendant Job Summary revealed; as a part of the responsibilities . maintain safety and comfort of residents as much as possible during transportation.</p> <p>Review of the medical records for Resident #2 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Dementia, Anxiety Disorder, and Hemiplegia Following Cerebral Infarction Affecting Right Dominant Side.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 09/24/2024, revealed the following, in part:</p> <p>-BIMS (Brief Interview for Mental Status) interview was unable to be conducted because the resident was never/rarely understood and could never/rarely make herself understood. She was indicated as having a memory problem for both long-term and short-term memory, and her cognitive skill for daily decision making were severely impaired.</p> <p>-Resident #2 utilized a wheelchair and required extensive physical assistance from two or more persons with transferring.</p> <p>Review of Resident #2's current care plan initiated 08/13/2024 revealed the following, in part: Problem: Resident is at risk for falls .Approaches: Cues/reminders as needed for safety.</p> <p>Review of Resident #2's MAR (Medication Administration Record) for October 2024 revealed she received Aspirin 81mg (an antiplatelet medication) and Apixaban 2.5mg (an anticoagulant medication) from 10/1/2024 until the date of her fall on 10/08/2024.</p> <p>Resident #2's Fall Incident Report dated 10/08/2024 revealed the following in part: Resident #2 went out on pass at 0810 (8:10 a.m.) to an appointment via facility transportation in stable condition. S2D called provider to report that resident slid out of chair and hit her head. Resident was driven back to facility at 1040 (10:40 a. m.) as directed by the provider for proper assessment. On assessment a large hematoma with dried blood was noted to right side of Resident #2's forehead. Ambulance was called and Resident #2 was transferred to Hospital A.</p> <p>Review of Resident #2's hospital records from Hospital A revealed a CT of Resident #2's head without contrast was performed. The results revealed a posttraumatic bilateral parenchymal and subarachnoid hemorrhage with a large right scalp hematoma. Resident #2 was transferred to Hospital B on 10/08/2024 for neurology consultation and treatment with IV (intravenous) coagulation and antihypertensive therapy under ICU monitoring.</p> <p>On 10/28/2024 at 1:30 p.m., an attempt was made to interview Resident #2. She did not respond to questioning and was unable to be interviewed.</p> <p>On 10/28/2024 at 10:11 a.m., an interview was conducted with S2D. S2D stated she transported Resident #2 in her wheelchair to an appointment in the facility's van on 10/08/2024. When the appointment was done, she wheeled Resident #2 outside and parked her in her wheelchair on the sidewalk at the van parking spot. S2D stated the van had to be moved to put the wheelchair lift gait down. S2D stated she locked Resident #2's wheelchair then left Resident #2 unattended for approximately one minute to move the van. She returned to find Resident #2 lying on her right side on the concrete with her wheelchair on its side and observed a raised area to the resident's right forehead beginning to form. She stated she immediately notified the facility and was instructed to return to the facility with Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/29/2024 at 11:10 a.m., an interview was conducted with S1DON (Director of Nursing). S1DON stated she was notified by the nursing staff that an incident occurred during Resident #2's transportation where the resident fell out of her wheelchair. She stated that without having full knowledge of incident details, she instructed S2D to return to the facility with the resident so a nursing assessment could be performed. She stated Resident #2's nurse performed an assessment and immediately sent her to the hospital via ambulance services.</p> <p>On 10/29/2024 at 1:20 p.m., S1DON stated the facility administrator immediately suspended S2D for the day and suspended her from driving for a week. They gave a verbal reeducation to all drivers before the next scheduled resident appointment. They immediately removed the resident's wheelchair and ordered a high back chair with a seatbelt. In-services were started the following day (10/09/2024) and also started retraining on the van/transportation with competency demonstrations. She stated they identified other residents that could be affected as every resident that utilizes facility transportation and by monitoring resident transports of both ambulatory and wheelchair bound residents.</p> <p>On 10/30/2024 at 11:40 a.m., a follow up interview was conducted with S1DON. S1DON confirmed that all residents in a wheelchair require supervision during transportation. S1DON confirmed that Resident #2's cognition was severely impaired, and she was left unsupervised which led to Resident #2's injury. S1DON further confirmed S2D should not have left Resident #2 unattended at any point while providing transportation services.</p> <p>The facility implemented the following immediate corrective actions to correct the deficient practice which was completed prior to the State Agency's investigation.</p> <p>10/08/2024 Corrective Action Plan</p> <ol style="list-style-type: none"> 1. Immediate suspension of S2D from work and driving privileges for 1 week post incident. 2. Immediate verbal education provided to drivers after the incident occurred before the next facility transport. 3. Immediate removal of Resident #2's wheelchair. 4. Audit conducted of Resident #2's transportation needs was performed. Implemented high back wheelchair with seatbelt to be used for transportation only. 5. In-services conducted for all facility drivers regarding: Safe transportation of resident including safe loading and unloading procedures; what to do if a resident falls; residents should be supervised and not to left unattended; proper location where residents should wait for safe loading and unloading, accident prevention; and wheelchair securement. 6. Review of the transportation attendant's job summary conducted with S2D. 7. In-serviced drivers on company owned vehicle with return demonstration for competency. 8. Monitoring drivers for adherence to transportation procedures. <p>(continued on next page)</p>		

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