

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER New Iberia Manor South		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Bayard St New Iberia, LA 70560	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419</p> <p>Based on record review, observations and interviews, the facility failed to ensure the resident was adequately supervised and monitored while exiting off the transportation van's wheelchair ramp resulting in the residents sustaining injuries for 1 (#1) of 3 (#1, #2, #3) residents sampled for accidents.</p> <p>Findings:</p> <p>The facility did not have a policy or procedure for unloading residents from the facility's van wheelchair ramp.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to Bipolar, Depression, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of Resident #1's quarterly MDS (Minimum Data Set) dated 04/05/2024 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated he was cognitively intact.</p> <p>Review of the facility's incident report dated 06/10/2024, written by S6LPN (License Practical Nurse), read in part resident was lowered to the ground on ramp on van outside after returning from a doctor's appointment. The resident unlocked his wheelchair when the ramp hit the ground which caused him to roll back falling backwards. S3VD (Van Driver) was present and witnessed the fall. The resident hit his head. Small laceration bleeding to back of head noted. Complaints of left shoulder pain 10/10 and neck pain 7/10. Local ambulance called and resident transported to local hospital.</p> <p>Review of Resident #1's hospital record titled, After Visit Summary, dated 06/10/2024 revealed in part that Resident #1 suffered a blunt head injury with trauma and contusion of the left shoulder, acute neck muscle strain, and a scalp abrasion.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/08/2024 at 11:50 a.m., an observation and immediate interview was conducted with S3VD. She stated on the day of the incident (06/10/2024), Resident #1 was positioned on the van's wheelchair ramp, and she was standing on the side of the ramp with the control in hand letting the van ramp down. She lowered the ramp to the ground. As soon as the ramp hit the ground, Resident #1 unlocked his wheelchair. She stated she remained standing on the side of the van ramp, and did not move behind the resident's wheelchair to assist him off the van ramp. She stated the incident had caught her off guard, and when the resident wheeled himself backwards slightly, his wheelchair flipped over. She stated she was aware Resident #1 locked and unlocked his wheelchair without staff assistance during van unloading procedures. When asked what was the facility's procedure for assisting residents off the van from the ramp. She stated she was trained to stand behind the wheelchair after the ramp contacts the ground, lean forward, unlock the resident's wheelchair, then remove the resident from the ramp. S3VD confirmed on the day of Resident #1's incident, she did not follow the facility's procedure for assisting residents off the van ramp.</p> <p>On 07/08/2024 at 12:20 p.m., an interview was conducted with S1ADM (Administrator) who stated. S3VD was not responsible for Resident #1's fall because Resident #1 unlocked his wheelchair himself which caused him to fall and sustain the injuries. She stated she was unable to provide a policy or procedure on how the van drivers were to assist in unloading residents off the van ramp.</p> <p>On 07/08/2024 at 3:00 p.m., an interview was conducted with Resident #1 who recalled the incident. He stated he was sitting in his wheelchair positioned on the van's wheelchair ramp as it was lowered to the ground. He stated that once the ramp was on the ground he unlocked his wheelchair himself. He stated that that time, S3VD was standing on the side of the ramp, not behind him. He stated that S3VD just looked at him and told him to go. Resident #1 stated staff was supposed to stand behind him after the ramp was lowered, but he didn't realize there was no staff behind him. He stated when S3VD told him to go, he just proceeded to roll himself backward and the wheelchair flipped over with him in it. He stated he fell hard, hitting his head, and hurting his left shoulder.</p> <p>On 07/09/2024 at 9:00 a.m., an interview was conducted with S2MS (Maintenance Supervisor) who is also the Transportation Supervisor, explained the proper procedure for assisting a resident off the van's wheelchair ramp. S2MS stated proper procedure began with the driver parking the van on level ground. The resident should be moved to the wheelchair ramp. The driver should then lower the ramp, stand behind the resident, then transport the resident off the lift. S2MS confirmed that S3VD should have stood behind Resident #1 to assist the resident off the lift ramp. He stated S3VD was responsible for ensuring Resident #1 was safely removed from the van's wheelchair ramp.</p>		