

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Willow Ridge Nursing and Rehabilitation Center, llc		STREET ADDRESS, CITY, STATE, ZIP CODE 660 Factory Outlet Drive Arcadia, LA 71001	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829</p> <p>Based on observations, record review, and interview, the facility failed to have a completed Physical Restraint Informed Consent for 1 (#71) of 2 (#71, #92) sampled residents reviewed for restraints.</p> <p>Findings:</p> <p>Observations on 08/19/2024 at 11:20 a.m. and 08/21/2024 at 08:10 a.m. revealed resident #71 was lying in a geri chair located in the front day room near the nurse's station. The head of geri chair was elevated about 45 degrees and his lower extremities were elevated.</p> <p>Record review revealed resident #71 was admitted to the facility on [DATE] with diagnoses that include essential hypertension, seizures, chronic systolic heart congestive heart failure, tracheostomy status, gastrostomy status, hemiplegia following cerebral infarction affecting right dominant side, dysphagia, anxiety disorder, and unspecified sequelae of cerebral infarction.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated resident #71 had severe cognitive impairment. Resident #71 required extensive assistance with all activities of daily living. Further review revealed resident #71 had a restraint in chair/out of bed: chair stops rising used daily.</p> <p>Review of August 2024 physician's orders revealed an order date 04/25/2024 to monitor resident in geri chair when out of bed, reclining position due to poor body control related to Cerebrovascular Accident (CVA) with hemiparesis. Monitor every 30 minutes and reposition and toileting every 2 hours and prn.</p> <p>Review of Physical Restraint Informed Consent dated 04/25/2024 revealed the following:</p> <p>The following least restrictive, alternative non-restraint approaches have proven to be ineffective: This section was blank.</p> <p>Type: Reclined geri chair.</p> <p>Frequency: When out of bed.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical symptoms: CVA.</p> <p>Release and reposition schedule: Monitor in geri chair when out of bed, reclining position due to CVA. Monitor every 30 minutes and reposition/toileting every 2 hours and prn. (as needed)</p> <p>Statement of Consent section: Did not have the circle marked for I do consent to the use of a physical restraint following review and discussion of benefits and risk as well as the reason for such use of the restraint. The appropriated healthcare professionals have assessed the need for such and a restraint devise is indicated as part of my recommended plan of care. I understand I can exercise my rights to withdraw this permission. I agree to the use of a reclined geri chair physical restraint. Did not have the circle marked for I do not consent for the use of restraints for treatment of medical symptoms.</p> <p>Acknowledgement signatures: Verbal, resident #71's responsible party name was printed.</p> <p>If signed by representative, complete the following: Print name: This section was blank. Relationship: This section was blank.</p> <p>Staff member completing this form: This section was blank.</p> <p>On 08/20/2024 at 1:10 p.m., a review of resident #71's medical record with S2Director of Nursing (DON) revealed the Physical Restraint Informed Consent dated 04/25/2024 for the geri chair when out of bed was not properly completed. S2DON confirmed there was no least restrictive, alternative non-restraint approaches that were proven to be ineffective listed. S2DON confirmed the form did not specify if the responsible party had chosen to consent for the geri chair physical restraint or if the responsible party had chosen not to consent to the use of the restraint. S2DON confirmed the staff member who obtained the informed consent and who completed the form was not listed. S2DON reported she completed resident #71's Physical Restraint Informed Consent. S2DON further confirmed resident #71's Physical Restraint Informed Consent was not properly completed.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 22575</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure residents remained as free of accident hazards as possible for 1 (#92) of 2 (#68, #92) residents reviewed for accidents. The facility failed to ensure 1). a thorough investigation was conducted after each incident involving a resident's laptray and 2). a laptray was not applied to a resident's gerichair after multiple incidents occurred that involved a laptray.</p> <p>Findings:</p> <p>Resident #92</p> <p>Review of the facility policy Accident and Incident Documentation and Investigation Resident Incident revised July 2018 revealed the following in part:</p> <p>Policy: Accidents and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the Long Term Care system. An incident is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventative measures to reduce the occurrence of incidents.</p> <p>Review of the record for resident #92 revealed he was admitted to the facility on [DATE] with diagnoses including restlessness and agitation, senile degeneration of brain, and unspecified dementia with other behavioral disturbance.</p> <p>Review of resident #92's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed he had a Brief Interview for Mental Status (BIMS) score of 99, which indicated he was unable to complete. Further review revealed he required extensive assistance for most activities of daily living.</p> <p>Review of resident #92's fall risk assessment dated [DATE] revealed he was assessed to be at a high risk for falls.</p> <p>Review of resident #92's August 2024 physician's orders revealed an order dated 07/10/2024 for a laptray to his gerichair.</p> <p>Review of resident #92's July 2024 and August 2024 Electronic Flowsheet revealed documentation the resident's laptray to his gerichair was in place every shift from 07/10/2024 - 08/21/2024.</p> <p>On 08/19/2024 at 8:55 a.m., an observation revealed resident # 92 was alert with confusion noted. He was in a gerichair with a laptray in the dining room in the secured unit.</p> <p>On 08/19/2024 at 2:30 p.m., an observation revealed resident # 92 was in a gerichair with a laptray in the dining room in the secured unit. Resident #92 was leaning to the left with his head resting on his arm, and his eyes were closed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/20/2024 at 8:25 a.m., an observation revealed resident # 92 was in the dining room in the secured unit for breakfast and he was in a gerichair with a laptray.</p> <p>On 08/20/2024 at 9:07 a.m., an observation revealed resident # 92 was in the dining room in the secured unit and he was in a gerichair with a laptray.</p> <p>Review of resident #92's July 2024 and August 2024 Nurses' Notes revealed the following:</p> <p>07/10/2024 at 6:41a.m. resident awake entire shift in gerichair. Alert/responsive with confusion noted. Mobile per gerichair due to increased fall risk. Resident extremely difficult to redirect. At 2:53 p.m., orders in place for laptray to gerichair.</p> <p>07/27/2024 at 7:06 p.m. resident was up in gerichair today with lap buddy in place related to resident does not recognize boundaries and will slide out of chair.</p> <p>08/03/2024 at 11:23 a.m. resident up in gerichair with table top in place. Unable to redirect his behaviors.</p> <p>08/05/2024 at 2:33 p.m. resident in dayroom, in gerichair. He constantly gets out of gerichair and crawls on the floor. He appears agitated this shift.</p> <p>08/08/2024 at 3:12 p.m. resident continues to remove laptray and crawl on floor.</p> <p>08/09/2024 at 7:02 p.m. resident makes several attempts to climb out of gerichair. Agitation noted intermittently.</p> <p>08/15/2024 at 3:27 p.m. resident has been agitated and combative with staff most of the shift. He is crawling out of gerichair onto floor. He is non-compliant with staff redirection, signed by S4Licensed Practical Nurse (LPN).</p> <p>On 08/19/2024 at 3:20 p.m., an interview with S4LPN revealed resident #92 took off his laptray before he crawled out of his gerichair on 08/15/2024. S4LPN reported that when resident #92 was first admitted , she saw him slip under the laptray while he was in the gerichair. She reported she failed to complete an incident report (IA) because it happened at shift change and she thought the other nurse filled out the IA report. S4LPN has not observed him slip under his laptray since he was first admitted . She revealed resident #92 has not been injured from incident with his laptray to her knowledge.</p> <p>Further review of resident #92's nurses' notes revealed on 08/18/2024 at 6:08 p.m. the resident was in day room in gerichair. He constantly gets out of gerichair and crawls on the floor. He appears agitated this shift.</p> <p>Review of the facility's Incident/Accident report log from 07/09/2024 - 08/21/2024 revealed there was no documentation resident #92 had an incident and/or fall during this timeframe.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of resident #92's medical record revealed there was no documented evidence the facility completed investigations for resident #92's incidents involving his laptray. Also, documentation revealed the facility continued to use a laptray for resident #92 after multiple incidents occurred of him crawling out of his gerichair or sliding underneath the laptray.</p> <p>On 08/19/2024 at 2:35 p.m., an interview with S5Certified Nursing Assistant (CNA) revealed resident #92 would slide underneath his laptray when he was first admitted , but they know to watch him closely now. They reposition him, especially if he starts sliding down in the gerichair.</p> <p>On 08/19/2024 at 3:25 p.m., an interview with S6LPN revealed when resident #92 was first admitted , she saw him slip under his laptray but has not seen him go under laptray in a while. S6LPN confirmed the resident can take off his laptray and crawl out of the gerichair. S6LPN reported resident #92 has not been injured from an incident with his laptray to her knowledge.</p> <p>On 08/19/2024 at 3:27 p.m., an interview with S7Registered Nurse/Unit Manager (RN Unit Manager) revealed she was aware that resident #92 would slide under his laptray when he was first admitted , but agreed with above nurses that recently he takes laptray off and does not slide under it.</p> <p>Review of resident #92's current care plan revealed on 07/29/2024 he was a high risk for falls and there was no documentation that the above incidents involving resident #92's laptray were identified. Further review of the resident's instant care plan dated 08/06/2024 revealed he would slide out of his gerichair with an intervention to redirect if inappropriate.</p> <p>On 08/21/2024 at 3:00 p.m., interviews with S2Director of Nursing and S3Registered Nurse/Clinical Operations Consultant confirmed the nurses failed to complete IA reports regarding multiple incidents with resident #92's laptray. They also confirmed there were no investigations regarding the incidents and staff should not have continued to use a laptray for resident #92.</p>		