STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195348	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacombe Nursing Centre	28119 Hwy 190 Lacombe, LA 70445

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46308 Based on observations, interviews, and record reviews, the facility failed to ensure residents with hand contractures had an appropriate call light to notify staff for assistance for 1 (#2) of 2 (#2 and R2) residents reviewed with contractures. FINDINGS: A review of Resident #2's record revealed a re-admitted [DATE] and diagnoses which included Hemiplegia following Cerebral Infarct affecting the Right Dominant Side and Mild Bilateral Hand Contractures. A review of the Quarterly MDS with an ARD of 04/10/2024 revealed Resident #2 had a BIMS of 12 which indicated the Resident was moderately cognitively impaired. A review of Resident #2's Care Plan revealed Resident #2 had mild contractures to bilateral hands. A review of Resident #2's call light log revealed no call light usage from April 1, 2024 to May 1, 2024. On 05/01/2024 at 3:55 p.m., an interview and observation was conducted with Resident #2. The resident's hands were observed to be contracted bilaterally. The resident attempted to open and close his hands and was noted to have very little use of his right hand and no use of his left hand. A grey oval shaped squeeze bulb call light was observed on the bed by his side. He used his right hand and attempted to squeeze and press the call bulb. His fingers on the right hand were curled inwards towards his palm preventing him from fully wrapping his hand around the bulb to squeeze or press the call light. The resident was unable to activate the call light. He stated he can't use the call light because of his hands. On 05/01/2024 at 3:45 p.m., an interview was conducted with S7CNA. She said Resident #2 told her he couldn't squeeze or press the bulb call light because his hands were contracted. She said she notified the nurse, but couldn't remember who she notified because it was a while back. On 05/01/2024 at 4:10 p.m., an interview was conducted with S6LPN. She said it was hard for Resident #2 to squeeze or press his bulb call light because of his hands. She said she did not report this to anyone. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/2023 at 10:30 a.m., an observation was conducted of Resident #2 with S8CNA present. Resident #2 attempted to squeeze and press the bulb call light for staff assistance, but was unable to. Immediately following the observation, S8CNA was interviewed. She said Resident #2 could not squeeze or push the bulb call light with enough force to activate it because of his hands. She stated the resident had not been able to use the bulb call light for call light for a while. She said she did not report this to anyone. On 05/02/2024 at 10:00 a.m., an observation was conducted of Resident #2 with S4RN present. She observed Resident #2 attempt to squeeze and press the bulb call light for staff assistance, but he was unable to because his hands were contracted and shaky. Immediately following the observation, S4RN was interviewed. S4RN confirmed Resident #2 was unable to push or squeeze his bulb call light with enough force to activate it because his hands were contracted and shaky. On 05/02/2024 at 10:35 a.m., an observation was conducted of Resident #2 with S2ADON. Resident #2 attempted to squeeze and press his call light for staff assistance, but was unable to. Immediately following the observation, S2ADON was interviewed. She confirmed he was unable to push or squeeze his call light with enough force to activate it because of his hands. On 05/06/2024 at 11:30 a.m., an interview was conducted with S1DON. She said she expected staff to report when a resident was unable to activate their call light for staff assistance. She confirmed there were other call lights available to accommodate resident's needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident's status for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for Resident Assessment. Findings: Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with a diagnosis, which included Repeated Falls. Review of Resident #1's Admission MDS with an ARD of 03/11/2024 revealed the following: Section J-Health Conditions: Falls since admit/reentry/prior assessment: any falls: 1. Yes Falls since admit/reentry/prior assessment: no injury: 1. One Falls since admit/reentry/prior assessment: injury: 0. None Review of the Facility's Incident Log revealed Resident #1 had two falls on 03/10/2024. Review of the Nurses Note dated 03/10/2024 revealed the following, in part: Resident #1 was found on the floor during meal pass around 5:45 p.m. The resident was found lying on his right side in between the bed and the nightstand .After further assessment, skin tears were noted. Signed, S5LPN. On 05/02/2024 at 8:55 a.m., an interview was conducted with S5LPN. She verified she was working when Resident #1 fell on [DATE]. She stated as a result of the fall he had that afternoon, he acquired skin tears on his arms and legs. On 05/02/2024 at 1:15 p.m., an interview was conducted with S3MDS. She stated she completed Resident #1's Admission MDS assessment. She stated she reviewed incident reports and nurses' notes each morning to determine if a resident had a fall and if an injury occurred with the fall. She reviewed the nurse's notes for Resident #1 and confirmed he had two separate falls on 03/10/2024. After reviewing the nurse's notes, she verified Resident #1 acquired skin tears after the second fall. She reviewed Resident #1's Admission MDS assessment and confirmed he was not coded for a fall with injury and should have been. She stated a skin tear was considered an injury, and it should have been coded on the MDS assessment. On 05/06/2024 at 11:34 a.m., an interview was conducted with S1DON. She stated Resident #1 had two falls on 03/10/2024, one in the morning and one in the afternoon. She reviewed the nurse's note for the second fall and verified Resident #1 acquired skin tears from the fall. She reviewed Resident #1's Admission MDS assessment and confirmed a fall with injury was not coded, and should have been.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46308 F689 Based on observations, interviews and record review, the facility failed to implement appropriate interventions, to monitor effectiveness of interventions, and to modify interventions following a fall for 1 (#2) of 3 (#1, #2, and #3) residents reviewed for falls. The facility failed to: 1. Ensure the bed remained in the low position for Resident #2; and 2. Implement new or appropriate safety interventions after each fall for Resident #2. Findings: A review of the facility's policy dated 01/10/2017 and titled, Fall Policy and Procedure revealed in part: Treatment/Management 1. Based on the assessment, the staff will identify pertinent interventions to try to prevent subsequent falls and to mitigate risks of serious injuries associated with falls. Monitoring and Follow Up 1. The staff will monitor the individual's response to interventions intended to reduce falling and/or mitigate the risk of serious injury as a result of a fall. 2. If the resident continues to fall, the staff will continue to re-evaluate and consider other possible sources for the resident's falling and will re-evaluate interventions. A review of Resident #2's clinical record revealed a re-admitted [DATE] and diagnoses which included Hemiplegia following Cerebral Infarct affecting the Right Dominant Side. Further review revealed he had mild contractures to bilateral hands. A review of the Quarterly MDS with an ARD of 04/10/2024 revealed Resident #2 had a BIMS of 12, indicating he was moderately impaired cognitively. A review of Resident #2's Care Plan revealed: Problem: Resident #2 is at risk for falls r/t: Syncope, Left Sided Hemiplegia, and poor judgement Interventions: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/10/2019: Keep personal items in reach and in sight, Resident is non-compliant with safety, place personal items within reach and sight, keep bed in low, locked position, monitor/report any changes or decline in cognitive status or physical function, Resident #2 instructed again to call for assistance, Resident had discussion with the nurse and NP about safety, not falling and getting assistance. 03/15/2024: Resident is non-compliant with safety. Place personal objects in reach and insight. 03/19/2024: Resident again instructed to call and wait for assistance. 04/26/2024: Resident had discussion with nurse about safety, not falling and getting assistance. Problem: Resident #2 requires total assist to complete ADL's. Interventions: 10/10/2019: Be sure call button is in reach, Mild contractures to bilateral hands. Review of the Incident Investigation Reports revealed the following, in part: On 03/15/2024 at 5:50 p.m., S9LPN standing in the hallway near cafeteria when she heard yelling and a loud noise. S9LPN entered room and noted Resident #2 lying face down beside his bed. Resident #2 said he was reaching for his CDs. Resident #2 had fallen from his bed to the floor. On 03/19/2024 at 1:10 p.m., S4RN entered Resident #2's room, to find resident laying on floor on left side with feet facing towards bed. Resident #2 stated that he was reaching for something in his drawer, causing him for fall out of bed. Resident #2's call light within reach of resident and was instructed by CNA to call for assistance. Immediate Action: Resident educated on importance of calling for assistance. On 04/26/2024 at 6:15 a.m., S9LPN notified by Laundry attendant that Resident #2 was on floor in his room. S9LPN entered room and found resident on the floor Resident #2 fell from wheelchair to floor. Immediate Action: Items requested placed within reach. On 05/01/2024 at 8:40 a.m., an observation and interview was conducted with Resident #2. His hands were contracted bilaterally. He was lying in his bed. His bed was in a high position. He had a gray call light bulb on the bed by his side. He said he was unable to use the call light to call for assistance. He attempted to press his call light and was unable to. He said he needs the staff's assistance for all ADL needs. He said he yells for staff to assist him and if they don't come, he tries to get what he needs and sometimes he falls. On 05/01/2024 at 3:45 p.m., an interview was conducted with S7CNA. She said Resident #2 needs total assistance from the staff for all of his needs. She said she is aware he had fallen several times. She said she constantly tells him to use the call light but he told her he couldn't use the call light. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/2024 at 6:40 a.m., an interview was conducted with S10CNA. She said Resident #2 needs total care from the staff. She said to prevent Resident #2 from falling, they put his bed low position. She said there are no other interventions in place to keep him from injuring himself when he falls. On 05/02/2024 at 3:30 p.m., an interview was conducted with S9LPN. She said interventions they have in place are keeping his call light within reach and keeping his bed low position. She said there are no other safety measures in his room to prevent him from being injured. On 05/02/2024 at 10:00 a.m., an interview and observation was conducted with S4RN. She said to prevent Resident #2 from falls, they educate him on using his call light and keeping his bed in the low position. She observed Resident's bed in high position and him trying to use his call light unsuccessfully. She confirmed his bed was in a high position and he was unable to properly use his call light. On 05/02/2024 at 10:35 a.m., an interview and observation was conducted with S2ADON. She said she was responsible for implementing fall interventions. She said Resident #2's bed should not have been in a high position. She observed Resident #2 attempting to press and squeeze the call light bulb. She confirmed Resident #2 was unable to press or squeeze the call light bulb. She said she expected staff to notify her if a resident is unable to use the call light. She said she was not notified Resident #2 could not use his call light. On 05/06/2024 at 12:35 a.m., an interview was conducted with S1DON. She stated staff should have notified her of Resident #2 not being able to properly use his call light. She confirmed Resident #2 had a potential for injury with his bed in the high position. She confirmed Resident #2's current fall prevention interventions listed on his care plan were ineffective.