STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195369	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Prompt Succor Nursing Facility	954 E Prudhomme St 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39319 Based on interviews and record reviews, S4CNA (Certified Nursing Assistant) failed to utilize and implement effective approaches of care for a resident with dementia to assure resident safety as evidenced by the CNA failing to call for assistance when the resident (#1) became combative while providing care, resulting in the resident sustaining injuries to his face and left arm for 1 (#1) out of 3 (#1, #2, and #3) sampled residents. Findings: Review of Resident #1's electronic record revealed he was admitted to the facility on [DATE]. His diagnoses included in part, but not limited to, Dysphasia following other Cerebrovascular Disease, Hypertensive Heart Disease without Heart Failure, Aphasia following Cerebral Infarction, Unsteadiness on feet, Generalized Anxiety Disorder, Repeated Falls, Cognitive Communication Deficit, Unspecified Dementia, severe, with other behavioral disturbance, Muscle Weakness (generalized). Review of the resident's MDS (Minimum Data set) dated 10/23/2024 revealed the resident had a BIMS (Brief Interview of Mental Status) score of 2, indicating severely impaired cognition. Further review of the resident's MDS revealed under Section G-Functional Status, the resident required extensive assistance with 2+ person physical assist for bed mobility and transfers. (continued on next page)

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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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Written documentation from a meeting held with the facility's administrative and S4CNA was reviewed. S2DON (Directed of Nursing), S3ADON Assistant Director of Nursing), and S1ADM (Administrator) were present in the meeting. According to the minutes of the meeting, S4CNA's explained that when she walked in the resident's room, he was lying on his left side facing the door, close to the rail. His incontinence brief was on the floor. His bed alarm was going off. His hands were full of sticky BM (bowel movement). She uncovered the resident and he had BM everywhere, smeared all over his body. He had scratched his body, and had blood on his scrotum. She didn't introduce herself, and just started cleaning him. At one time, he was attempting to get out of the bed. She struggled to keep him in the bed. She used the sheet to turn him from side to side. He was kicking his arms and legs. When asked why she didn't call for help, she stated To be honest, I did this a long time. I'm used to it. S4CNA stated that she peeked at the desk, but didn't see anyone, so she handled the resident herself. She stated she didn't know why she didn't use the call bell. S4CNA stated she and the resident were fighting against one another while she provided care to him. She had to dodge swings and kicks. The resident was positioned by the bed rails at times, moving back and forth during repositioning. She had to turn him a lot to clean him, and to prevent him from falling out of bed. She had to remove his hands from the bed rails. S4CNA stated that she noticed some blood on the fitted sheet, but thought it was from the resident's scrotum area. She stated by trying to prevent the resident from falling, she could have grabbed him too tight. While repositioning him with the sheet, she could have used too much power. When asked what she could have done better, she stated, She should have called for assistance. Physician progress note dated 11/04/2024 read, Resident discovered with bruising right upper face along with laceration along right naso-labial fold about 2 cm (centimeter) in length. Also found he have bruising to inner cheek with open wound appearing to match associated teeth on that side. An interview and observation of the resident was not conducted due to the resident being transferred to the hospital on 11/12/2024 at 10:00 a.m. On 11/12/2024 at 2:15 p.m., an interview was conducted with S6LPN (License Practical Nurse). She confirmed that she was the resident's nurse on 11/04/2024. She stated the CNA reported to her that the resident had blood on his sheets. When she assessed the resident she noted a skin tear to his left arm, bruising to his right ear and a bump in the middle of his forehead. She stated that the resident also had a scratch on the right side of his lip. She stated that the bruising did not look like an old bruise. She asked the resident what had happened and he stated that he did not know. She confirmed that the resident had behaviors and at times was combative with the staff. He would get upset when he had BM on him and he wanted staff to clean him right away. S6LPN stated that S4CNA did not inform her of the incident. On 11/12/2024 at 3:15 p.m., an interview was held with S2DON, S3ADON, S1ADM and S5CorpNurse (Corporate Nurse). S3ADON stated that in the meeting, S4CNA confirmed the resident was agitated and was kicking and fighting with her while she attempted to clean him up after he had a bowel movement. S4CNA reported that she was focused on getting the resident clean and not let him fall out of bed. She didn't think of calling for assistance. S4CNA also reported she didn't notice that the resident had hit his head or that she had caused a skin tear to the resident's left arm when she grabbed him to prevent him from falling out of bed. They all agreed that Resident #1's injuries could have been avoided if S4CNA would have called for assistance when the resident became agitated and use two person assistance as identified in the resident's comprehensive assessment. They all agreed that if a resident became agitated while providing care, the CNA should call for assistance. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/2024 at 8:30 a.m., S1ADM and S2DON confirmed that they had no means of contacting S4CNA. On 11/13/2024 at 9:56 a.m., a phone interview was conducted with S7CNA. She stated she worked with S4CNA on the 10 p.m. to 6 a.m. shift on 11/3/2024. She stated that she had informed S4CNA that the resident could become combative, especially in the evening and night hours (sundowner's). She stated that when the resident was combative, she always got someone to help with him. She also informed S4CNA that if she needed help with the resident to let her know. S7CNA confirmed that S4CNA did not ask her for help the entire shift.