

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Our Lady of Prompt Succor Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - 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** Based on interview and record review, the facility failed to provide adequate supervision and toileting assistance according to the resident's assessed needs in the plan of care to prevent accidents for 1 (#2) out of 3 (#1, #2, #3) sampled residents. This deficient practice resulted in a harm on 05/23/2026 at 4:00 a.m. when S7CNA failed to assist Resident #2 with a transfer to the toilet. As a result, the resident fell prior to getting to the toilet. The resident was transferred to a local hospital emergency room on [DATE] at 1:22 a.m. An x-ray was performed on 05/24/2026 at 9:52 a.m. with findings of a left impacted femoral neck fracture. The resident was admitted to the hospital and underwent a percutaneous screw fixation of left femoral neck fracture on 05/26/2026. Findings: Review of the facility's policy titled, Fall Prevention, with a last review date of 03/19/2026, read in part: Fall Risk Assessments: . 2. Residents who are assessed as being high risk for falls will have individualized interventions implemented as needed to help prevent falls. Assessment and Care Planning Process: A comprehensive assessment will be performed and an interdisciplinary care plan for each resident at high risk for falls to address specific factors that may contribute to his or her risk for falls. Examples. 7. Increased monitoring by staff. Review of Resident #2's EHR (Electronic Health Record) revealed the resident was admitted to the facility on [DATE]. Her diagnoses included, but were not limited to, primary generalized osteoarthritis and unspecified dementia. The resident was diagnosed with fracture of unspecified part of neck of left femur subsequent encounter for closed fracture with routine healing on 05/29/2026. Review of Resident #2's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed in section GG: Functional Abilities, that the resident was coded as needing supervision or touching assistance for toilet transfer (The ability to get on and off the toilet). Review of Resident #2's most recent quarterly MDS assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident's cognition was intact. Review of Resident #2's current care plan, revealed the following focuses and interventions in part: -Focus: Risk for ADL (Activities of Daily Living) self-care performance deficit r/t (related to) generalized weakness, RA (Rheumatoid Arthritis), OA (Osteoarthritis). Intervention: Transfers: Independent, assist as needed. Date Initiated: 8/29/2025. Revision On: 02/10/2026. -Focus: Risk for falls related to unsteady gait, use of assistive device, RA, OA, decreased mobility, history of falls, poor safety awareness. Intervention: 10/12/2025: Staff re-educated to offer, encourage, and assist to toilet on rounds during hours of sleep to reduce risk for falls . Date Initiated 10/31/2025. Revision On: 02/04/2026. Review of Resident #2's ADL task documentation from 05/01/2026 to 05/23/2026 revealed toilet use self- performance was documented as 2 (indicating Limited Assistance- Resident highly involved in activity ; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) 14 times on evening shift (2:00 p.m.-10:00 p.m.) and 19 times on night (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 0689 Level of Harm - Actual harm Residents Affected - Few	shift (10:00 p.m.-6:00 p.m.). Further review revealed toilet use support provided was documented as 2 (indicating One person physical assist) 14 times on evening shift and 19 times on night shift. Review of a facility incident report for Resident #2 completed by S9RN dated 05/23/2026 at 11:55 a.m. revealed in part: Nursing description: Noted resident ambulating in her room with walker. She complained of pain in left hip. After multiple questions, she informed me that she went to the bathroom last night at approximately 2:00 a.m. She was standing near the lavatory, lost her balance, and fell sitting on buttocks. Denies hitting her head. She informed me that staff assisted her off floor and back to bed. Review of Resident #2's nursing progress notes revealed the following note written by S2DON dated 05/23/2026 at 11:57 p.m. that read: Received x-ray results of left hip. Findings concerning for left femoral neck fracture. If clinically warranted it could be correlated with the CT scan. Attempted to reach [Physician] and [Nurse Practitioner]. No response at this time. Sending to ER for evaluation and x-ray findings. Resident has 8/10 pain to left hip. No bruising or discoloration observed. Did notify me that she has been walking back and forth to the bathroom today with walker. Voiced she fell yesterday morning; Saturday morning (05/23/2026) in the bathroom. She had ambulated with her walker to the toilet and lost her balance. Review of Resident #2's fall investigation provided by the facility revealed the following part: Statement written by S7CNA dated 05/24/2026. Saw/assisted resident prior to incident, saw/assisted resident following incident. Statement: I went into Resident #2's room at around 4:00 in the morning to wake her up to go to the restroom. I woke her up, made sure she had her walker before I told her to go to the restroom while I go across the hall to change another resident. When I went back in there to check on her, I found her sitting on the floor. When I asked her what happened, she said she fell on the floor. I asked her if she was hurt and did she hit her head and she said she was fine and still needed to use the restroom. I picked her up and placed her on the toilet when she started to complain of hip pain. I got the nurse to assess her and asked again if she was okay. Review of Resident #2's hospital records dated 05/24/2026 revealed the following in part: Radiology: Examination- X-ray hip with pelvis when performed 2 or 3 views left. Findings: Impacted left femoral neck fracture. Review of an operative report dated 05/26/2026 revealed in part: Preoperative Diagnosis: Left valgus impacted femoral neck fracture. Procedure Performed: Percutaneous screw fixation of left femoral neck fracture. Indications for procedure: Resident #2 had a fall in her nursing facility. She sustained a valgus impacted femoral neck fracture. On 07/14/2026 at 9:50 a.m., an interview was conducted with S2DON. S2DON confirmed that the resident had a fall on 05/23/2026 at 4:00 a.m. while attempting to use the bathroom without staff assistance. S2DON stated that the resident ended up having a femoral neck fracture and surgery was performed. On 7/14/2026 at 10:55 a.m., a phone interview was conducted with S7CNA who stated she had worked with the resident before and was familiar with her care needs. She stated that the resident ambulated with a walker, but she still required standby assistance and required staff in the room with her during transfers for toileting/ambulation because the resident was unsteady on her feet at times. S7CNA confirmed that she was the resident's CNA (Certified Nursing Assistant) on the morning of 05/23/2026 when she fell. S7CNA stated that she went into the resident's room on 05/23/2026 at around 4:00 a.m. to wake her up so that she could get ready for the day. She stated she typically went into the resident's room at this time to help her to get ready. S7CNA stated that she guided the resident to the bathroom and told the resident to go ahead and sit down on the toilet, use the bathroom, and that she would be back to assist her after checking on another resident. S7CNA stated she did not wait to ensure the resident made it to the toilet. When she returned after 5 minutes, she found the resident sitting on the floor in front of the toilet. The resident told her that she was trying to sit down on the toilet and slipped and fell. The resident was begging (continued on next page)		

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