

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Bernice Nursing and Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Reeves Street Bernice, LA 71222	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19121</p> <p>Based on observation, record review and interview, the facility failed to protect the resident's right to be free from physical abuse and psychosocial harm by staff for 1 (#1) of 3 (#1,#2, #3) sampled residents.</p> <p>The deficient practice resulted in actual harm for resident #1 (who was cognitively impaired) on 06/27/2024 at 9:01 p.m. when S4CNA (certified nursing assistant) physically abused resident #1 by using her left hand to grab the back of resident #1's shirt in an attempt to pull him towards his room. At this time resident #1 turned his back to S4CNA and his left elbow made contact with S4CNA's left shoulder. S4CNA used her closed right hand to make contact with the back of resident #1's head and then wrapped both her arms around resident #1's chest. Even though there was no significant decline in mental or physical functioning, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the physical abuse, since a reasonable person would not expect to be treated in this manner in his own home or a health care facility.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.</p> <p>Findings:</p> <p>Review of the facility's Abuse Prevention Policy dated July of 2018 revealed the following: The facility is committed to protecting the residents from abuse by anyone including but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogated, sponsors, friends, visitors or any other individuals. Physical abuse includes hitting, slapping, pinching, and kicking.</p> <p>Review of resident #1's health record revealed an admitted [DATE] with diagnoses of, but not limited to, Schizoaffective disorder, drug induced subacute dyskinesia, bipolar disorder, anxiety disorder, with other behavioral disturbance.</p> <p>Review of resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 99 which indicated the resident was unable to complete the Brief Interview for Mental Status. Further review revealed the resident was independent with all activities of daily living.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #1's care plan revealed the interventions used to prevent escalating agitation and behaviors were to provide 1:1 CNAs on the 6:00 p.m. to 6:00 a.m. shifts; redirection of situations that cause the resident to become agitated and increased behaviors.</p> <p>Review of the facility's investigation documentation revealed the following:</p> <p>The incident was reported to the Administrator and Director of Nurses at 9:23 p.m. by S5LPN (Licensed Practical Nurse) that was working in the unit. S5LPN reported that resident #1 had hit S4CNA and she wanted to go to the emergency room to be evaluated, the administrator instructed the LPN to obtain a urine drug screen and have her fill out the workers comp forms located at the nurses station. S2DON (Director of Nursing) asked S5LPN to get statements from all staff and assign someone else to sit 1:1 with resident #1.</p> <p>On 06/28/2024 at 08:00 a.m. S2DON was reading staff statements on the incident that occurred between resident #1 and S4CNA and she observed a statement by S6CNA that stated S4CNA had grabbed the resident around his neck, for clarification S2DON reviewed the video footage at 8:37 a.m. on 06/28/2024. After viewing the video footage by the S2DON she concluded that resident #1 and S4CNA were walking back from the nurse's station towards resident #1's room. Resident #1 was walking in front of S4CNA when he stopped and turned around and appears to be yelling at her. S4CNA was facing the back door and resident #1 was standing to her left facing her, S4CNA then using her left hand grabs the back of resident #1's shirt and attempts to pull him towards his room. At this time the resident turns and uses (his back is to S4CNA) left elbow to make contact with S4CNA's left shoulder. At this time S4CNA used her closed right hand to make contact with the back of resident #1's head as she wraps both arms around resident #1's chest. After viewing the footage S4CNA was asked to come back to the facility to be interviewed by the DON, Executive Director and Human Resource director.</p> <p>Review of the documentation in regards to the interview on 06/28/2024 at 10:21 a.m. with S4CNA stated she was asked why she went to the emergency room after the incident between her and resident #1. S4CNA responded that her right ear was hurting and it felt like there was fluid behind it after resident #1 hit me five times to that ear. After the interview it was determined that the CNA receive a level one category write up and was suspended until further evaluations could be completed.</p> <p>06/28/2024 at 11:10 a.m. the police were contacted by S1Executive Director and S4CNA left the facility with the police.</p> <p>On 07/11/2024 at 9:45 a.m. review of the video with no date or time stamp revealed footage of resident #1 walking in front of S4CNA, when he stopped and turned around. It appeared he was yelling at her. S4CNA was facing the back door and resident #1 was standing to her left facing her. S4CNA then used her left hand and grabbed the back of resident #1's shirt and attempted to pull him. At this time resident #1 turned with his back to S4CNA, his left elbow, as his body was rotating, made contact with S4CNA's left shoulder. S4CNA used her closed right hand to make contact with the back of resident #1's head as she wrapped both of her arms around resident #1's chest. The video was reviewed with S2DON and S3Corporate Nurse in attendance and verified the video is of the incident that occurred on 06/27/2024 at 9:01 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/12/2024 at 01:30 p.m. S2DON confirmed resident #1 had behaviors on a daily basis and was 1:1 care during the shift of 6:00 p.m. to 6:00 a.m. The resident was in the locked unit due to his behaviors. Resident #1 was accepted and transferred to a local behavioral unit for evaluation and medication adjustments 06/28/2024 due to his increased agitation. S2DON stated resident #1 would be admitted back to the facility today. S2DON confirmed S4CNA was terminated from employment effective 07/01/2024 when the investigation was completed.</p> <p>Interview on 07/15/2024 at 08:40 a.m. S4CNA confirmed she worked in the behavioral unit on the evening of 06/27/2024. S4CNA stated she was assigned to work 1:1 with resident #1. S4CNA stated they had walked to the nurse's station for resident #1 to use the phone, resident #1 was told the phone was not working and he became very agitated and was yelling at her as they walked down the hall. S4CNA stated she attempted to direct resident #1 to his room, by grabbing the back of his shirt and then she remembered trying to place her arms around him to stop him from hitting her. S4CNA stated she did not watch the video of the incident and did not want to see it because she would get upset at seeing it again.</p> <p>During a phone interview on 07/15/2024 at 09:10 a.m. S5LPN stated she worked in the unit the night of 06/27/2024 when the event occurred between S4CNA and resident #1. S5LPN confirmed that she was at the nurse station and heard resident #1 yell. When she went down the hall, S6CNA was attempting to get between S4CNA and resident #1. S5LPN called out the resident's name and he let go of S4CNA. After assessing resident #1, he was then redirected to his room. S5LPN confirmed she then called S1Executive Director and reported the altercation between resident #1 and S4CNA. S5LPN confirmed she told S1Executive Director that S4CNA told her she wanted to be evaluated at the local hospital due to resident #1 hitting her in head during the altercation. S5LPN stated she was directed by S1Executive Director in regards to the workman's comp forms to be completed before S4CNA left to be evaluated at the local hospital.</p> <p>During a phone interview on 07/15/2024 at 09:40 a.m. S6CNA stated she worked in the unit the night of 06/27/2024 when the incident occurred between S4CNA and resident #1. S6CNA confirmed she was coming in from the 9:00 p.m. smoke break and was walking up the hallway. S4CNA and resident #1 were walking back towards his room. Resident #1 turned to S4CNA and said something to her, like stop following me and get away from me. S4CNA grabbed resident #1 telling him let's go to your room and resident #1 hit S4CNA. S6CNA reported she tried to separate resident #1 and S4CNA, then the nurse came. After it was over S6CNA told S4CNA not to grab the resident around the neck.</p> <p>On 07/15/2024 at 8:30 a.m. an observation of resident #1 revealed he was sitting in the television room in the unit. Resident #1 was unable to answer questions asked by the surveyor.</p> <p>The facility implemented the following actions to correct the deficient practice with completion on 07/01/2024.</p> <ol style="list-style-type: none"> 1. Body audits completed on all residents in the unit to ensure residents did not have any new injuries. 2. Social Service Director interviewed all residents in the unit to ensure residents feel safe, asked if they have ever been abused or witnessed abuse. All residents answered they felt safe <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>3. An additional QAPI monitor has been developed to ensure staff is reporting any signs of abuse/neglect/dignity. This monitor will be conducted by reviewing a random sample of nurse's note by the DON three times a week for four weeks then monthly until compliance is reached. Any non-compliance will be addressed.</p> <p>The effectiveness of the corrective actions will be discussed weekly for four weeks at the Quality Assurance and Performance Improvement meeting with findings added to the minutes. Additional in-services and or corrective actions will be implemented as needed.</p>		