

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/07/2024
NAME OF PROVIDER OR SUPPLIER  West Carroll Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  706 Ross Street Oak Grove, LA 71263	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 13974</p> <p>Based on record reviews and interviews, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 (#1) of 5 (#1, 2, 3, 4, 5) sampled residents by failing to ensure resident #1 was safely secured in a lift chair while bathing in the whirlpool room.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation that began on 04/30/2024 at 9:15 a.m., when resident #1 was not properly secured with the seat belt in a lift chair while receiving a whirlpool bath. The resident fell from the chair to the floor and sustained a fractured skull, fractured left arm, laceration to the left side of the head and a brain bleed.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 05/06/2024. It was determined to be a Past Noncompliance Citation.</p> <p>Findings:</p> <p>Review of the facility's current Bath, Shower/Tub policy, which was last revised February 2018 revealed When using the lift system, be sure whirlpool lift is firmly positioned and locked. Assist the resident into the whirlpool chair lift. Secure the safety belts.</p> <p>Review of the resident #1's medical record revealed she was admitted to the facility on [DATE] and had diagnoses which included chronic obstructive pulmonary disease, hypothyroidism, hypertensive heart disease and hyperlipidemia.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1's Brief Interview for Mental Status (BIMS) score was 11. A score of 11 indicated moderate cognitive impairment. The MDS also indicated the resident required partial to moderate assistance with bathing.</p> <p>Review of the care plan for resident #1 revealed she had impaired mobility and required 1 person assistance with bathing. The resident's care plan also indicated she was at high risk for falls.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the nurse's notes dated 04/30/2024 indicated resident #1 fell and was lying face down on the floor with blood around her head when the nurse entered the WP (whirlpool) room. The resident's respirations were shallow at 6-8 beats per minute and her heart rate was slow at 10 beats per minute. She did not respond verbally and S2DON (Director of Nurses) initiated deep sternal stimulation. After being stimulated her respirations and heart rate increased. The resident had a 5-6 centimeter laceration to her left forehead. The resident was placed on a stretcher and taken to the emergency room , which was connected to the facility.</p> <p>Review of the facility's incident report revealed on 04/30/2024 at 9:15 a.m., S3CNA (Certified Nurse Aid) was assisting resident #1 with a whirlpool bath which included using the lift chair attached to the bath. S3CNA failed to properly secure the seat belt and the resident fell to the floor. Nursing staff were called to the whirlpool room. They found the resident was unresponsive. S2DON opened resident #1's airway and applied oxygen. The resident was placed on a stretcher and taken to the local hospital's emergency room .</p> <p>Review of the facility's investigation which began on 04/30/2024 revealed S3CNA failed to use the lift seat belt and while she was looking down to lock the lifts wheels the resident fell to the floor. The investigation also indicated S3CNA was suspended while the investigation was ongoing.</p> <p>On 05/06/2024 at 9:10 a.m., an interview with S2DON revealed S3CNA failed to use the seat belt on the lift chair that was attached to the whirlpool bath, to properly secure resident #1 while bathing. S2DON reported the resident fell from the whirlpool lift chair on 04/30/2024 and sustained a laceration to the left side of the head. S2DON stated she was contacted on 04/30/2024 by the emergency room nurse at the local hospital with an update on the resident's status which included a brain bleed, a fractured skull, and a fractured arm. S2DON reported resident #1 was airlifted to another hospital from the local hospital's emergency room .</p> <p>On 05/06/24 at 10:00a.m., an interview with resident #1 revealed that she thought she passed out. Resident #1 reported the last thing she remembered was seeing the last of the water drain from the tub. The next thing she remembered she was on a stretcher on her way to the emergency room . Resident #1 reported her arm was broken and she had been experiencing pain. Observations at this time revealed resident #1 had a heavily bruised face and she was wearing a cervical neck collar.</p> <p>On 05/07/2024 at 10:25 a.m., an interview with S3CNA was conducted via telephone. S3CNA was upset that she forgot to apply the seat belt. S3CNA reported that resident #1 had been wheeled out of the whirlpool. S3CNA was talking to the resident and she walked to the back of the lift to lock the wheels. As she was looking down to lock the wheels resident #1 fell from the chair landing on the floor. S3CNA reported she immediately called for help.</p> <p>On 05/06/2024 at 11:30 a.m., an observation was made of resident #2 receiving a whirlpool bath using the lift. S5CNA and S6CNA were observed properly applying the seat belt of the lift. Interviews with the CNAs revealed whirlpool baths had recently been suspended. The CNAs reported only after they were retrained and performed competency demonstrations, were they able to resume using the lift to give whirlpool baths. The CNAs also reported a nurse has been supervising seat belt use during whirlpools.</p> <p>On 04/30/2024 the facility implemented the following actions to correct the deficient practice.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. The facility immediately suspended use of the lifts used for whirlpools.</li> <li>2. Signage was placed at the whirlpool instructing staff not to use it until they had received additional training.</li> <li>3. A whirlpool safety assessment was completed for every resident in the facility, even if they did not require a lift or use the whirlpool. The assessments were completed on 05/01/2024.</li> <li>4. All CNAs were trained on: belt safety when using the whirlpool lift chair, locking the lift wheels, keep lift chair in lowest position, proper disinfecting, do not exceed 105 degrees and making sure lift seat is locked when the resident is placed back on the lift. The final in-service was completed on 05/02/2024.</li> <li>5. The CNAs were retrained and performed a demonstration of the proper use of the whirlpool lift chair x 3. Only after each CNA was reeducated and successfully completed the demonstrations were they allowed to resume use of the lift. The first in-service was conducted on 05/01/2024 and the final in-service was completed.</li> <li>6. As part of the facility QA (Quality Assurance), S4RN (Registered Nurse), the person responsible for staff development, monitored for proper lift use by the CNAs when they were using the lift in the whirlpool. Review of the QA checkoff sheet developed to review CNAs' compliance to proper lift use showed there had been no issues found. The facility began using the Safety Belt Usage Log on 05/01/2024.</li> <li>7. Review of the Quality Assurance monitoring logs revealed the monitoring was ongoing and will continue at present time.</li> <li>8. The above actions were all completed as of 05/02/2024.</li> </ol>		