STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195398	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Carroll Care Center, Inc	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on interviews and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice when the nursing staff failed to recognize, assess, intervene, and document a resident's condition after a fall to avoid delayed treatment for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for falls. This deficient practice resulted in an Immediate Jeopardy situation on 01/24/2025 at approximately 3:15 p.m. , when resident #1 had a fall in his room. The resident's nurse failed to assess the resident after the fall, document the incident, and report the incident to the resident's physician and the director of nursing. On 01/28/2025, it was determined that the resident had obtained a left displaced femoral neck fracture, which required surgical repair on 01/29/2025. This deficient practice resulted in a delay of treatment for resident #1. The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 02/11/2025. It was determined to be a Past Noncompliance Citation. Findings: Review of the facility policy, Falls-Clinical Protocol (no date noted), revealed in part: Assessment and Recognition: 2. The nurse shall assess and document/report the following: recent injury, especially fracture or head injury; musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; pain; precipitating factors, and details on how fall occurred. 4. The staff will evaluate and document falls that occur while the individual is in the facility. 6. Falls should also be identified as witnessed or unwitnessed events. Monitoring and Follow-up: 1. The staff will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture have been ruled out or resolved. Delayed complications such as late fracture and major bruising may occur hours or several days after a fall. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy, Accidents and Incidents-Investigating and Reporting (no date noted), revealed in part: All accidents or incidents involving residents occurring on the premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation: 1. The nurse supervisor and/or nurse shall promptly initiate and document an investigation of the accident or incident. 2. The following data shall be included on the Report of Incident/Accident form in part: date and time of incident; nature of the injury/illness; notification of attending physician and family; the condition of the injured person; any corrective action taken; follow-up information; and the signature and title of the person completing the report. 6. Incident/Accident reports will be reviewed for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. Review of the record for resident #1 revealed a [AGE] year old with an admitted [DATE]. Diagnoses included but not limited to the following: unspecified dementia with other behavioral disturbance, major depressive disorder, coronary atherosclerosis, atrial fibrillation, weakness, and left displaced femoral neck fracture. Further review revealed resident #1 was unable to verbally communicate his needs effectively. He also had behaviors (i.e. yelling out, resisting care, combative with staff) and he had increased muscle tone which cause his legs to be stiff. Review of resident #1's quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated severely impaired cognitive skills for daily decision making. Resident #1 was unable to walk and used a wheel chair for locomotion. He also required substantial/maximal assistance for toileting, personal hygiene, chair to bed transfer, and lying to sitting on the side of the bed. Review of the Fall Risk assessment dated [DATE] revealed resident #1 had a score of 10 which indicated he was at a high risk for falls. Review of resident #1's current care plan revealed on 05/24/2024 he was totally dependent on 1 staff for assistance with toileting, personal hygiene, and for transfers. Further review revealed he was at risk for falls. Review of the Electronic Health Record (EHR) Progress Notes dated 01/28/2025 at 6:40 a.m. revealed Certified Nursing Assistants (CNAs) informed this nurse (S5Licensed Practical Nurse [LPN]) that resident #1 had a bruise to left hip and was complaining of pain. When S5LPN assessed resident, there was a small purple bruise noted to his left hip. Resident #1 complained of pain even when not being touched, and kept his left hand at side. S5LPN notified S2Director of Nursing (DON) and the resident's physician assistant. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the resident #1's EHR Progress Notes dated 01/28/2025 at 9:40 a.m. revealed the facility received the resident's left hip x-ray results and he had a displaced femoral neck fracture. The resident's physician was notified and at 10:40 a.m., the resident was transferred to the emergency room . On 01/29/2024 at 11:30 a.m., S2DON was informed by hospital nurse that the resident was supposed to have surgery for his hip today. Review of the S2DON's investigation summary for the resident's incident of unknown injury revealed after interviews were conducted with staff regarding the resident's left hip bruise, initially there was no known incident or cause of the bruise. However, on 01/30/2025, S2DON conducted an interview with S4CNA and she informed S2DON that she was providing care for the resident when he had a fall from his bed on 01/24/2025. S4CNA reported she had asked S6CNA to assist her with transferring the resident. After that, resident #1 was aggravated and he had unplugged the bed, attempting to poke her with the plug. The resident jumped at her and fell out of the bed hitting the floor. Further review of S2DON's notes revealed camera footage was reviewed from 01/24/2025 and the footage supported S4CNA's statement. S4CNA was observed leaving to go to the nurses' station and then she and S3LPN went back into the resident's room. After S2DON further interviewed S4CNA and S6CNA they revealed resident #1 had no apparent injuries and no complaint of pain with transfer or during care. Immediate action taken by facility on 01/28/2025: -A body audit of resident #1 was completed by the S2DON with no other significant findings discovered. -Resident #1 was placed in the dayroom so he could be observed by nursing staff and when the CNA's provided personal care, a management nurse was in attendance. -An investigation regarding the injury of unknown origin was initiated. -Initially, staff interviews initiated with no significant findings noted. -Interviews with residents that resided on resident #1's hall were initiated with no significant findings noted. -Left hip x-ray results received and indicated a displaced femoral neck fracture and resident #1 was transferred to the emergency room for evaluation and transfer for orthopedic care. Review of resident #1's medical record revealed there was no documentation of resident #1's fall on 01/24/2025. Further review revealed there was no documentation the resident was assessed after the 01/24/2025 fall, and the fall was not reported to the resident's physician nor the director of nursing. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/12/2025 at 12:15 p.m., an interview with S2DON revealed she interviewed S3LPN regarding the above incident and S3LPN told her she could not remember S4CNA reporting to her that resident #1 had a fall on 01/24/2025. She confirmed S3LPN viewed video footage from 01/24/2025 with her. They watched as she entered resident #1's room with S4CNA, but S3LPN still could not recall that the resident had a fall on 01/24/2025 or if she had assessed him after the fall. S2DON confirmed S3LPN failed to report the resident's fall to her and there was no documentation in the nurse's notes and no incident report was completed regarding resident #1's fall. S2DON revealed the last day that S3LPN worked at the facility was on 01/30/2025 and after the investigation into the incident, she was terminated on 02/07/2025. On 02/12/2025 at 2:12 p.m., a phone interview was conducted with S3LPN and she was unable to recall S4CNA reporting to her that the resident had a fall on the evening on 01/24/2025. She confirmed she worked on 01/24/25 but could not remember any details regarding resident # 1's fall or if she had assessed him after the fall. On 02/12/2025 at 3:58 pm, a phone interview with S4CNA revealed she was trying to change resident #1 and he unplugged the bed and he was trying to poke her or hit her with the plug. He lunged at her with the plug and this caused him to fall out of his bed (that was in low position) onto his left side on the floor. She yelled for S6CNA to come stay with the resident while she went to get his nurse. S4CNA revealed she informed the nurse at the nurse's station that she needed the resident's nurse. She reported that S3LPN came quickly to the room and instructed S4CNA and S6CNA to transfer resident #1 back to bed. S4CNA reported she did not observe S3LPN assess the resident but she had left the room soon after the resident was transferred back to bed. During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. On 01/28/2025, the facility implemented the following actions to correct the deficient practice with a completion date of 01/31/2025: 01/28/2025 - Weekly body audits reviewed for 01/27/2025 to determine if there were any unknown injuries or significant findings. Body audits will continue until full facility body audits are completed. Statewide Incident Management System (SIMS) report opened. 01/28/2025- Staff education initiated: Abuse and neglect, staff rounding requirements: CNA even hours/nurses odd hours, ensure staff using proper transfer techniques, report changes in condition, change in behavior, change in skin condition to the nurse in a timely manner and any issues identified with a resident should be assessed immediately and addressed in a timely manner. 01/29/2025- Investigation continues regarding resident #1's injury of unknown origin, and full facility body audits continued. 01/30/2025- Video footage was reviewed by S1Administrator and S2DON. The video footage supported S4 CNA's statement. S3LPN was witnessed entering the resident's room after being notified of the incident. There were no issues identified with review of the footage and routine care rounds were being provided. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	01/30/2025- S3LPN was suspended pending investigation. 01/30/2025- Incidents and accidents for resident #1's hall reviewed, no injuries of unknown origin noted; no additional incidents/accidents were noted. 01/30/2025- QA started on reviewing nurse's notes and 24-hr report to ensure that incidents/accidents are reported, processed, and completed. QA will be done 5x a week x 8 weeks then 3x a week x 4 weeks then as needed. 01/30/2025- Residents that resided on resident #1's hall were assessed to identify any potential significant changes, any recent hospitalization s, or other abnormal findings and there were no concerns noted. 01/30/2025 - Staff members who worked with resident #1 through the weekend were re-interviewed in order to gain more details regarding his care, complaints, and activity level. No signs or report of distress or pain was noted. Resident appeared to continue normal activities, including being out of bed, in day room watching television, interacting with others and meal intake was normal. 01/30/2025 - Safety measures were assessed and found to be functioning properly. Included in these were the following: 1) Resident #1's call light was activated, the light lit up in the hall and at the switchboard (the clerk at the desk and nurse in the room could clearly hear each other speaking). 2) Wedge cushion was in place and properly fit the resident's wheelchair. 3) Assist bar was properly attached to resident #1's bed and raised/lowered correctly. 4) Functions of the bed were checked. The head and foot of the bed raised and lowered properly. The bed raised and lowered also with no issues. 5) The mattress fit was checked and was correct. There was no physical damage noted to the exterior of the mattress (no rips, tears or sunken spots). 01/30/2025- Resident #1's incidents were reviewed for the last six months and all prior interventions were assessed and found to be in place. 01/31/2025- Staff in-service for CNAs: Reporting any incident or accidents that occur with a resident. If unsure if something is new or if you should report, always report to the nurse or supervisor. If you feel like an additional assessment may need to be done then report to a management nurse. 01/31/2025- Staff in-service for nurses: An incident report should be done for any of the following (bruises, skin tears, falls, unintentional change in plane, setting a resident in the floor from getting weak, sliding out of bed or wheelchair, etc). Physician, responsible party, and DON should all be made aware. Proper documentation should be done and include any new orders or treatment. If any immediate actions should be put into place, then make sure those are done (increase supervision, increase monitoring, etc.). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	01/31/2025- Staff in-service: Abuse & Neglect, reporting any change in condition or change in status to nurse/nurses station. 01/31/2025- QA initiated to ensure nurse competency and return demonstration for incident/accident reporting and completion of appropriate documentation. 01/31/2025- Resident #1 returned to the facility with orders for non-weight bearing status and hip rehab exercises. He is a two person assist with lift transfer. Nursing assessment completed. 01/31/2025- As an immediate protective action, S6CNA sat near the resident's door providing additional supervision due to him having had a fall and behaviors. On 01/30/2025, once the facility was aware of resident #1's fall, corrective action was initiated immediately, staff was suspended with subsequent termination, and all staff education and QA was initiated. Compliance was met on 01/31/2025 after the determination was made that no other residents were affected and the QA process was in place. Date facility asserts the likelihood for serious harm to any recipient no longer exists: 01/31/2025.