STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195401	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Oaks Nursing & Rehabilitation Center	711 W. Cornerview Road Gonzales, LA 70737

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 22609 Based on observations, interviews, and record review, the facility failed to ensure a resident's call light button was within reach for 1 (Resident #55) of 4 (Resident #32, Resident #47, Resident #55, and Resident #94) sampled residents reviewed for environment. Findings Review of Resident #55's current Care Plan with a start date of 06/08/2022 revealed, in part, Resident #55's call light button was to remain within reach per Certified Nursing Assistant (CNA) staff. Observation on 06/23/2024 at 9:15 a.m., revealed Resident #55's call light button was not within reach as it was located at the base of his bed. Observation on 06/24/2024 10:44 a.m. revealed Resident #55 was in his bed and the call light button was at his feet. In an interview on 06/24/2024 at 10:45 a.m., S19Certified Nursing Assistant (CNA) indicated Resident #55 was able to use the call light button, and the call light button should not be positioned down by his feet, as he was bed bound and unable to reach it. In an interview on 06/24/2024 at 11:05 a.m., Resident #55 indicated with a head shake of yes, that he can use his call bell. Observation on 06/25/2024 at 3:19 p.m. revealed Resident #55 was in his bed and the call light button was at his feet, and not within reach. In an interview on 06/25/2024 at 3:20 p.m., S20CNA indicated Resident #55's call light button should not be by Resident #55's feet, and should be within reach. In an interview on 06/26/2024 at 10:20 a.m., S2Assistant Director of Nursing indicated Resident #55's call light button should be within reach.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on record reviews and interviews, the facility failed to ensure a resident's code status was consistent with a resident's wishes for 1 (Resident #86) of 21 (Resident #1, Resident #8, Resident #13, Resident #15, Resident #16, Resident #22, Resident #27, Resident #28, Resident #32, Resident #38, Resident #46, Resident #47, Resident #49, Resident #52, Resident #55, Resident #61, Resident #69, Resident #76, Resident #86, Resident #94 and Resident #96) sampled residents reviewed for advanced directives. Findings: Review of Resident #86's Electronic Medical Record (EMR) revealed, in part, Resident #86 was admitted to the facility on [DATE] with diagnoses of aphasia and dementia. Review of Resident #86's clinical record revealed, in part, an Authorization to Withdraw or Withhold Life-Prolonging Treatment From for An Incompetent Resident was signed by Resident #86's attending physician on [DATE] and the consulting physician on [DATE]. Further review revealed Cardiopulmonary Resuscitation (CPR) was not to be performed on Resident #86. Review of Resident #86's EMR on [DATE] at 1:30 p.m., revealed, in part, the Advanced Directives tab had Resident #86 listed as requiring Cardiopulmonary Resuscitation (CPR). Review of Resident #86's Physician's Orders on [DATE] at 1:30 p.m., revealed an order to initiate CPR was active. In an interview on [DATE] at 2:27 p.m., S22Licensed Practical Nurse (LPN) Medicare Nurse Manager indicated she was notified by S17Social Services on [DATE] that Resident #86's code statues was changed to Do Not Resuscitate late in the day, and did not change Resident #86's code status to Do Not Resuscitate until [DATE]. S22LPN Medicare Nurse Manager further indicated Resident #86's code status order should have been updated in Resident #86's EMR when she was notified of the change. S22LPN Medicare Nurse Manager indicated it was important that a resident's code status in their EMR matches their Advance Directive, so the resident's wishes would be followed. In an interview on [DATE] at 2:35 p.m., S1Administrator confirmed Resident #86's code status should have been changed since [DATE].

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47487 Based on record reviews and interviews, the facility failed to ensure a resident was able to participate in care plan meetings for 2 (Resident #32 and Resident #46) of 2 (Resident #32 and Resident #46) sampled residents reviewed for care plan attendance in a total sample of 20 residents reviewed for Care Plans. Findings: Resident #32 Review of Resident #32's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/2024 revealed, in part, Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #32 was cognitively intact. Review of the facility's list of care plan meetings for Resident #32 for 09/14/2023, 12/14/2023, and 03/14/2024, revealed no time noted next to Resident #32's name. In an interview on 06/23/2024 at 11:31 a.m., Resident #32 indicated she had never been invited to a care plan meeting and would go to one if the facility invited her. Resident #46 Review of Resident #46's MDS with an ARD of 05/17/2024 revealed, in part, Resident #46 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #46 was cognitively intact. Review of the list of care plan meetings for Resident #46 for 09/21/2023, 12/21/2023, and 03/21/2024, revealed no time noted next to Resident #46's name. In an interview on 06/23/2024 at 11:11 a.m., Resident #46 indicated that she was not invited to care plan meetings. In an interview on 06/26/2024 at 8:30 a.m., S17Social Services indicated a time would be noted next to a resident's name on the facility's list of residents scheduled for care plan meetings, if the resident or their representative went to the care plan meeting. In an interview on 06/26/2024 at 8:40 a.m., S17Social Services indicated the Interdisciplinary team (IDT) members met with the residents individually before the care plan meeting to assess the residents, and the IDT team met afterwards without the residents to review the resident's care plans. S17Social Services further indicated she had no documented evidence Resident #32 and Residents #46 were invited to care plan meetings. There was no documented evidence and the facility did not present any documented evidence of Resident #32 and Resident #46 were invited to the above mentioned care plan meetings.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 47487 Based on observation, interview and record review, the facility failed to provide supervision to the facility's staff to keep a resident's environment free of accidents/hazards by failing to ensure: 1. The facility's staff transferred a resident with a [NAME]- Lift (a mechanical lift used to transfer residents) per the facility's policy (Resident #69); and, 2. The facility's staff properly laundered [NAME]-Lift slings (slings used to transfer residents with the mechanical lift). This deficient practice resulted in an Immediate Jeopardy situation on 04/14/2024 at 6:05 p.m. for Resident #69, when staff failed to inspect Resident #69's entire [NAME]-Lift sling prior to using and failed to ensure to unlock the [NAME]-Lift's [NAME] brakes when Resident #69 was raised and transferred with the [NAME]-Lift. During Resident #69's transfer, the straps of the [NAME]-Lift sling broke, which caused Resident #69 to fall to the floor. This resulted in Resident #69 being sent to a hospital emergency room where it was determined Resident #69 sustained a left temporoparietal subarachnoid hemorrhage (bleeding in the area between the brain and the protective tissues that cover and protect it). S1Administrator was notified of the Immediate Jeopardy on 06/25/2024 at 7:50 p.m. The Immediate Jeopardy was removed on 06/26/2024 at 2:18 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit. This deficient practice had the likelihood to cause more than minimum harm to the 14 residents who resided in the facility and required the use of a [NAME]-Lift for transfers. Findings: 1. Review of the provider's undated policy titled, Hydraulic Lift, revealed, in part, staff were to consult the manufacturer's recommendations for the specific procedure for each lift. Review of the [NAME]-Lift's Operating Manual dated November 2017, revealed, in part, before each patient transfer, the [NAME]-Lift sling must be inspected for signs of damage, for loose and missing stitching, and for tears and excessive wear that might cause the [NAME]-Lift sling to fail. Further review revealed, the [NAME]-Lift transfer procedure indicated the [NAME] brakes of the [NAME]-Lift should be left unlocked when a resident was transferred. Further review revealed, leaving the [NAME]-Lift [NAME] brakes unlocked would allow the [NAME]-Lift to walk forward to center itself over the resident's center of gravity as it was raised. Further review revealed, this procedure increased the stability of the [NAME]-Lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #69's Electronic Medical Record revealed, in part, Resident #69 was admitted to the facility on [DATE]. Further review revealed Resident #69 had diagnoses of Down syndrome and Alzheimer's disease. Review of Resident #69's nurse's note dated 04/15/2024 at 12:14 a.m. revealed, in part, on 04/14/2024 at 6:05 p.m., S3Licensed Practical Nurse (LPN) was called to Resident #69's room by S8Certified Nursing Assistant (CNA). Further review revealed, S8CNA, indicated Resident #69 had fallen from the [NAME]- Lift due to the straps on the [NAME]-Lift sling breaking. Further review revealed, Resident #69 was found lying flat on the floor on her back. Further review revealed, S8CNA indicated, when the strap to the [NAME]-Lift sling broke, Resident #69 flipped out the [NAME]-Lift, hit the back of her head on the floor, and hit her back on the leg of the lift. Further review revealed, Resident #69 had a superficial wound on the right side of her head. Review of Resident #69's hospital note dated 04/16/2024 revealed, in part, Resident #69 was seen in the emergency roiagnom on [DATE], due to a fall during transfer from a mechanical lift. Review of Resident #69's medical record indicated Resident #69 fell when she was transferred with a mechanical lift, and the mechanical lift sling's strap broke. Further review revealed a Computed Tomography (CT) scan (a medical imaging technique used to obtained detailed internal images of the body) was completed on Resident #69. Further review revealed the CT scan results revealed Resident #69 had a left temporoparietal subarachnoid hemorrhage. In an interview on 06/25/2024 at 12:42 p.m., S8CNA indicated the straps of the [NAME]-Lift sling broke when she and S9CNA were transferring Resident #69 from her chair to her bed. S8CNA further indicated the [NAME] brakes to the [NAME]-Lift were locked when Resident #69 was raised from her chair with the [NAME]-Lift. S8CNA further indicated the [NAME]-Lift sling was already positioned under Resident #69 prior to the transfer on 04/14/2024. S8CNA further indicated that she did not inspect the parts of the [NAME]-Lift sling that were under Resident #69 prior to beginning Resident #69's transfer with the [NAME]-Lift. In an interview on 06/25/2024 at 2:20 p.m., S9CNA indicated she was in the room when she and S8CNA were transferring Resident #69, and the [NAME] brakes to the [NAME]-Lift were locked when Resident #69 was raised from her chair with the [NAME]-Lift on 04/14/2024. Observation on 06/24/2024 at 2:54 p.m., revealed S5CNA and S6CNA were preparing to transfer Resident #69 from her Geri-chair to her bed with a [NAME]-Lift. Further observation revealed S5CNA locked the [NAME] brakes of the [NAME]-Lift, positioned Resident #69 in the [NAME]-Lift sling, and raised Resident #69 up with the [NAME]-Lift with the [NAME] breaks of the [NAME]-Lift locked. In an interview on 06/25/2024 at 11:50 a.m., S5CNA confirmed she had the [NAME] brakes to the [NAME]-Lift locked when she was raising/transferring Resident #69 on 06/24/2024. In an interview on 06/25/2024 at 2:00 p.m., S13CNA Supervisor, indicated staff were to visually check the entire [NAME]-Lift sling for any rips, holes, and/or loose threads prior to the [NAME]-Lift slings being used to transfer residents. S13CNA Supervisor further indicated, if a [NAME]-Lift sling was already under a resident prior to transfer, the staff should move the resident, and do a full visual inspection of the [NAME]-Lift sling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/25/2024 at 2:58 p.m., S1Administrator indicated the facility's staff should transfer the facility's residents according to the manufacturer's instructions. S1Administrator further indicated he was aware the [NAME]-Lift's [NAME] brakes should not be locked when a resident was raised with the lift. S1Administrator offered no explanation or comment related to the above mentioned deficient practice. 2. Review of the [NAME]-Lift's Operating Manual dated November 2017, revealed, in part, [NAME]-Lift slings must be tumble-dried on the delicate temperature cycle in the dryer. Further review revealed, if the facility's dryer does not have a delicate cycle, [NAME]- Lift slings should be hung to air dry. Further review revealed a warning that bleach may not be used as it can weaken the stitching and fabric, and that it was important that the laundry department was told how to care for slings correctly. Observation on 06/25/2024 at 8:54 a.m., revealed no signage indicating the facilities dryers had delicate cycle. In an interview on 06/25/2024 at 8:55 a.m., S7Housekeeping/Laundry Supervisor indicated after the [NAME]-Lift slings were washed, they were placed in the facility dryer. S7Housekeeping/Laundry Supervisor further indicated the facility's dryer did not have a delicate cycle. S7Housekeeping/Laundry Supervisor further indicated she was unaware of the manufacture's guidelines for drying [NAME]-Lift slings. In an interview on 06/25/2024 at 10:45 a.m., S14Regional Director of Operations indicated the facility's staff should be following the manufacturer's guidelines for laundering the [NAME]- Lift slings. In an interview on 06/25/2024 at 10:52 a.m., S1Administrator indicated the facility's staff should be following the manufacturer's guidelines for [NAME]-Lift sling care. S1Administrator offered no explanation or comment related to the above mentioned deficient practice.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877 Based on observations, interviews, and record reviews, the facility failed to ensure a resident's urinary catheter was cared for in a sanitary manner for 2 (Resident #16 and Resident #76) of 2 (Resident #16 and Resident #76) sampled residents with catheters and investigated for urinary catheter use. Findings: Resident #16 Review of Resident #16's record revealed, in part, Resident #16 was admitted to the facility on [DATE] with diagnosis of urinary retention. Observation on 06/23/2024 at 10:13 a.m. revealed Resident #16's catheter bag was on the floor. In an interview on 06/26/2024 at 12:40 p.m., S15Staff Development Nurse indicated a resident's catheter bag should never be on the floor. In an interview on 06/26/2024 at 3:50 p.m., S18Infection Preventionist confirmed a resident's catheter bag should never be on the floor. Resident #76 Review of Resident #76's record revealed, in part, Resident #76 was admitted to the facility on [DATE] with a diagnosis which included a history of urinary tract infections (UTIs). Observation on 06/24/2024 at 12:16 p.m., revealed S21Certified Nursing Assistant (CNA) performed catheter care for Resident #76. Further observation revealed S21CNA had two wash basins, one filled with soapy water and one with clean rinsing water. Further observation revealed S21CNA wet two towels with the soapy water, cleaned Resident #76's catheter and perineal area, and placed the used towels into the clean rinsing water basin after they were used on Resident #76. Further observation revealed S21CNA removed the two used towels she had placed into the clean rinsing water, and then wet another towel with the water in the rinsing water basin, and cleaned Resident #76's perineal and catheter area. In an interview on 06/24/2024 at 12:19 p.m., S21CNA indicated she should not have performed the procedure as above where she contaminated the water in the rinsing basin with soiled towels used to clean Resident #67, and then used that water to wet a towel to clean Resident #76. In an interview on 06/26/2024 at 8:30 a.m., S2Assistant Director of Nursing indicated S21CNA should not have used the contaminated rinsing water to clean Resident #76's vaginal and catheter area. 47487

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48855 Based on observation, interview and record review, the facility failed to ensure: 1. The facility's staff (S8Certified Nursing Assistant [CNA]) was trained and deemed competent to transfer a resident using a [NAME]-Lift (a mechanical lift used to transfer residents) as per the manufacturer's guidelines (Resident #69); and, 2. A qualified individual, who was trained and competent, was assigned the task of evaluating if the facility's staff were competent with transferring residents using a [NAME]-Lift per the manufacturer's guidelines (S13CNA Supervisor). This deficient practice resulted in an Immediate Jeopardy situation on 04/14/2024 at 6:05 p.m. for Resident #69, when staff failed to inspect Resident #69's entire [NAME]-Lift sling prior to using and failed to ensure to unlock the [NAME]-Lift's [NAME] brakes when Resident #69 was raised and transferred with the [NAME]-Lift. During Resident #69's transfer, the straps of the [NAME]-Lift sling broke, which caused Resident #69 to fall to the floor. This resulted in Resident #69 being sent to a hospital emergency room where it was determined Resident #69 sustained a left temporoparietal subarachnoid hemorrhage (bleeding in the area between the brain and the protective tissues that cover and protect it). S1Administrator was notified of the Immediate Jeopardy on 06/25/2024 at 7:50 p.m. The Immediate Jeopardy was removed on 06/26/2024 at 2:18 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit. This deficient practice had the likelihood to cause more than minimum harm to the 14 residents who resided in the facility and required the use of a [NAME]-Lift for transfers. Findings: Review of the provider's undated policy titled, Hydraulic Lift, revealed, in part, staff were to consult the manufacturer's recommendations for the specific procedure for each lift. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the [NAME]-Lift's Operating Manual, dated November 2017, revealed, in part, before using the [NAME]-Lift to transfer residents, all staff must be trained and authorized to use the [NAME]-Lift. Further review revealed a video demonstrating transfer techniques was sent to the facility with the lift and this video, along with hands on training led by a nurse or professional rehabilitation staff member. Further review revealed only staff members who have been trained according to the procedures in this manual, by a manufacturer's representative, by a nurse, or by a professional rehabilitation staff member designated as your facility's mechanical lift trainer, should be allowed to use the [NAME]-Lift. Further review revealed a warning of staff members who have not had hands on training may not use the [NAME]-Lift. The above mentioned manual also revealed only staff members who have been trained according to the procedures in this manual, by a manufacturer's representative, by a nurse, or by a professional rehabilitation staff member designated as your facility's mechanical lift trainer, should be allowed to use the [NAME]-Lift. Further review revealed, the [NAME]-Lift transfer procedure indicated the [NAME] brakes of the [NAME]-Lift should be left unlocked when a resident was transferred. Further review revealed, leaving the [NAME]-Lift [NAME] brakes unlocked would allow the [NAME]-Lift to walk forward to center itself over the resident's center of gravity as it was raised. Further review revealed, this procedure increased the stability of the [NAME]-Lift. Further review revealed [NAME]-Lift slings must be tumble-dried on the delicate temperature cycle in the dryer, and if the facility's dryer does not have a delicate cycle, [NAME]-Lift slings should be hung to air dry. Further review revealed a warning that bleach may not be used as it can weaken the stitching and fabric, and that it was important that the laundry department was told how to care for slings correctly. Observation on 06/24/2024 at 2:54 p.m., revealed S5CNA and S6CNA were preparing to transfer Resident #69 from her Geri-chair to her bed with a [NAME]-Lift. Further observation revealed S5CNA locked the [NAME] brakes of the [NAME]-Lift, positioned Resident #69 in the [NAME]-Lift sling, and raised Resident #69 up with the [NAME]-Lift with the [NAME] breaks of the [NAME]-Lift locked. Review of Resident #69's nurse's note dated 04/15/2024 at 12:14 a.m. revealed, in part, on 04/14/2024 at 6:05 p.m., S3Licensed Practical Nurse (LPN) was called to Resident #69's room by S8Certified Nursing Assistant (CNA). Further review revealed, S8CNA, indicated Resident #69 had fallen from the [NAME]-Lift due to the straps on the [NAME]-Lift sling breaking. Further review revealed, Resident #69 was found lying flat on the floor on her back. Further review revealed, S8CNA indicated, when the strap to the [NAME]-Lift sling broke, Resident #69 flipped out the [NAME]-Lift, hit the back of her head on the floor, and hit her back on the leg of the lift. Further review revealed, Resident #69 had a superficial wound on the right side of her head. Review of Resident #69's hospital note dated 04/16/2024 revealed, in part, Resident #69 was seen in the emergency roiagnom on [DATE] due to a fall during transfer from a mechanical lift. Review of Resident #69's medical record indicated Resident #69 fell when she was transferred with a mechanical lift, and the mechanical lift sling's strap broke. Further review revealed a Computed Tomography (CT) scan (a medical imaging technique used to obtained detailed internal images of the body) was completed on Resident #69. Further review revealed the CT scan results revealed Resident #69 had a left temporoparietal subarachnoid hemorrhage. In an interview on 06/25/2024 at 11:50 a.m., S5CNA confirmed she had the [NAME] brakes to the [NAME]-Lift locked when she was raising/transferring Resident #69 on 06/24/2024. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/25/2024 at 12:42 p.m., S8CNA indicated the straps of the [NAME]-Lift sling broke when she and S9CNA were transferring Resident #69 from her chair to her bed. S8CNA further indicated the [NAME] brakes to the [NAME]-Lift were locked when Resident #69 was raised from her chair with the [NAME]-Lift. S8CNA further indicated the [NAME]-Lift sling was already positioned under Resident #69 prior to the transfer on 04/14/2024. S8CNA further indicated that she did not inspect the parts of the [NAME]-Lift sling that were under Resident #69 prior to beginning Resident #69's transfer with the [NAME]-Lift. In an interview on 06/25/2024 at 2:00 p.m., S13CNA Supervisor indicated she, the Director of Nursing, and the Assistant Director of Nursing were responsible for training the nursing staff on resident transfers using a [NAME]-Lift and on evaluating the CNA's competency for the use of the [NAME]-Lift when transferring residents. S13CNA Supervisor further indicated the [NAME]-Lift [NAME] breaks must be locked when a resident was being lifted up in the [NAME]-Lift. S13CNA Supervisor further indicated she used the CNA Skill Check Off for [NAME]-Lifts when evaluating CNAs for competency and reiterated the [NAME]-Lift was to be locked when a resident was being lifted up. S13CNA Supervisor further indicated she did not train the facility's staff per the [NAME]-Lift's Operating Manual and was unaware the [NAME]-Lift's [NAME] brakes needed to be unlocked when a resident was being raised up. In an interview on 06/25/2024 at 2:20 p.m., S9CNA indicated that the [NAME] brakes to the [NAME]-Lift were locked when Resident #69 was raised from her chair with the [NAME]-Lift on 04/14/2024. Review of S8CNA's personnel record revealed, in part, no documented evidence, and the facility did not present any documented evidence, S8CNA was evaluated for competency of transferring residents with a [NAME]-Lift. In an interview on 06/25/2024 at 2:58 p.m., S1Administrator indicated he was aware the [NAME]-Lift's [NAME] brakes should not be locked when a resident was raised with the [NAME]-Lift. S1Administrator offered no other explanation or comment related to the above mentioned deficient practice. In an interview on 06/25/2024 at 3:40 p.m., S13CNA Supervisor indicated the facility was unable to produce any documented evidence S8CNA was evaluated and deemed competent to transfer a resident with a [NAME]-Lift.

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	195401	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Oaks Nursing & Rehabilitation Center	711 W. Cornerview Road Gonzales, LA 70737

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 48855 Based on record reviews and interviews, the facility failed to complete an annual performance review of Certified Nursing Assistant (CNA) staff and/or provide training education on performance review outcomes for 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor of 7 S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNASupervisor personnel records reviewed. Findings: Review of S4CNA's facility personnel record revealed, in part, S4CNA was hired on 06/06/2022. There was no documented evidence and the facility did not present any documented evidence that S4CNA had a yearly performance evaluation and/or received training based on performance evaluation outcomes. Review of S5CNA's facility personnel record revealed, in part, S5CNA was hired on 02/20/2016. There was no documented evidence and the facility did not present any documented evidence that S5CNA had a yearly performance evaluation and/or received training based on performance evaluation outcomes. Review of S8CNA's facility personnel record revealed, in part, S8CNA was hired on 07/26/2023. There was no documented evidence and the facility did not present any documented evidence that S8CNA had a yearly performance evaluation and/or received training based on performance evaluation outcomes. Review of S10CNA's facility personnel record revealed, in part, S10CNA was hired on 07/16/2019. There was no documented evidence and the facility did not present any documented evidence that S10CNA had a yearly performance evaluation and/or received training based on performance evaluation outcomes. Review of S11CNA's facility personnel record revealed, in part, S11CNA was hired on 06/21/2023. There was no documented evidence and the facility did not present any documented evidence that S11CNA had a yearly performance evaluation and/or received training based on performance evaluation outcomes. Review of S12CNA's facility personnel record revealed, in part, S12CNA was hired on 05/04/2021. There was no documented evidence and the facility did not present any documented evidence that S12CNA had a yearly performance evaluation and/or received training based on performance evaluation outcomes. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of S13CNASupervisor, personnel record revealed, in part, S13CNASupervisor was hired on 07/15/2014. There was no documented evidence and the facility did not present any documented evidence that S13CNA Supervisor had a yearly performance evaluation and/or received training based on performance evaluation outcomes. In an interview on 06/25/2024 at 1:16 p.m., S13CNASupervisor indicated she did not complete performance evaluations on the above mentioned Certified Nursing Assistant (CNA) staff. In an interview on 06/26/2024 at 2:45 p.m., S1Administrator indicated he conducted performance evaluations on certain staff within the facility, but did not conduct performance evaluations on CNA staff.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on observations, record reviews, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by failing to have an adequate system in place to ensure: 1. The facility's staff transferred a resident with a [NAME]-Lift (a mechanical lift used to transfer residents) per the facility's policy (Resident #69); 2. The facility's staff properly laundered [NAME]-Lift slings (slings used to transfer residents with the mechanical lift); and 3. Facility administration ensured competency of assigned trainers and staff on the use and care of the [NAME]-Lift and slings prior to allowing staff to transfer residents. This lack of administrative oversight resulted in Immediate Jeopardy situation on 04/14/2024 at 6:05 p.m. for Resident #69, when staff failed to inspect Resident #69's entire [NAME]-Lift sling prior to using and failed to ensure to unlock the [NAME]-Lift's [NAME] brakes when Resident #69 was raised and transferred with the [NAME]-Lift. During Resident #69's transfer, the straps of the [NAME]-Lift sling broke, which caused Resident #69 to fall to the floor. This resulted in Resident #69 being sent to a hospital emergency room where it was determined Resident #69 sustained a left temporoparietal subarachnoid hemorrhage (bleeding in the area between the brain and the protective tissues that cover and protect it). S1Administrator was notified of the Immediate Jeopardy on 06/25/2024 at 7:50 p.m. The Immediate Jeopardy was removed on 06/26/2024 at 2:18 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit. This deficient practice had the likelihood to cause more than minimum harm to the 14 residents who resided in the facility and required the use of a [NAME]-Lift for transfers. Findings: Cross reference F689 and F726. In an interview on 06/25/2024 at 8:55 a.m., S7Housekeeping/Laundry Supervisor indicated after the [NAME]-Lift slings were washed, they were placed in the facility dryer. S7Housekeeping/Laundry Supervisor further indicated the facility's dryer did not have a delicate cycle. S7Housekeeping/Laundry Supervisor further indicated she was unaware of the manufacture's guidelines for drying [NAME]-Lift slings. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/25/2024 at 10:45 a.m., S14Regional Director of Operations indicated the facility's staff should be following the manufacturer's guidelines for laundering the [NAME]- Lift slings. In an interview on 06/25/2024 at 10:52 a.m., S1Administrator indicated the facility's staff should be following the manufacturer's guidelines for [NAME]-Lift sling care. S1Administrator offered no explanation or comment related to the above mentioned deficient practice. In an interview on 06/25/2024 at 2:00 p.m., S13CNA Supervisor, indicated staff were to visually check the entire [NAME]-Lift sling for any rips, holes, and/or loose threads prior to the [NAME]-Lift slings being used to transfer residents. S13CNA Supervisor further indicated, if a [NAME]-Lift sling was already under a resident prior to transfer, the staff should move the resident, and do a full visual inspection of the [NAME]-Lift sling. In an interview on 06/25/2024 at 2:58 p.m., S1Administrator indicated the facility's staff should transfer the facility's residents according to the manufacturer's instructions. S1Administrator further indicated he was aware the [NAME]-Lift's [NAME] breaks should not be locked when a resident was raised with the lift. In an interview on 06/25/2024 at 3:40 p.m., S13CNA Supervisor indicated the facility was unable to produce any documented evidence S8CNA was evaluated and deemed competent to transfer a resident with a [NAME]-Lift.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30587 Based on record review and interview, the facility failed to have a facility-wide assessment which addressed all components. Findings: Review of the Facility assessment dated [DATE] and reviewed 06/14/2024 revealed the following sections were not addressed in the facility-wide assessment: 1. Staff competencies; 2. The physical environment and equipment; 3. Any ethnic, cultural, or religious factors; and, 4. The facility's resources. In an interview on 06/26/2024 at 12:47p.m., S14Regional Director of Operations indicated as of today (06/26/2024), the facility had not completed Section 3 of the facility-wide assessment. In an interview on 06/26/2024 at 1:27 p.m., S14Regional Director of Operations indicated there was a part 3 which covered the remaining sections of competencies, staff needs, equipment, and contracts that the facility missed; therefore, the facility-wide assessment did not contain the following required components: staff competencies, the physical environment and equipment, any ethnic, cultural, or religious factors, and the facility's resources.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47487 Based on record reviews and interview, the facility failed to ensure a resident had an accurate blood glucose record for 1 (Resident #32) of 21 (Resident #1, Resident #8, Resident #13, Resident #15, Resident #16, Resident #22, Resident #27, Resident #28, Resident #32, Resident #38, Resident #46, Resident #47, Resident #49, Resident #52, Resident #55, Resident #61, Resident #69, Resident #76, Resident #86, Resident #94 and Resident #96) sampled residents reviewed for accurate record documentation. Findings: Review of Resident #32's June 2024 physician's orders revealed, in part, an order dated 08/19/2024 to administer Resident #32's Novolog (a medication used to treat diabetes) 100 Units (u)/Milliliter (ml) injection per sliding scale. Review of Resident #32's June 2024 electronic Medication Administration Record (eMAR) revealed, in part, Resident #32 was administered 3 units of Novolog 100 u/ml on 06/17/2024 for a blood glucose level of 173, 0 units of Novolog 100 u/ml administered with blood glucose documented as high, and no documentation of the blood glucose levels were documented on 06/09/2024. In an interview on 06/26/2025 at 12:27 p.m., S2Assistant Director of Nursing indicated Resident #32's above mentioned eMAR documentation on 06/17/2024 was inaccurate. S2Assistant Director of Nursing further indicated the facility's nurses should be documenting the actual blood glucose levels instead of documenting high to ensure an accurate record of Resident #32's blood glucose levels was being conducted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47487 Based on observation and interviews, the facility failed to ensure soiled linen was bagged or contained in sanitary manner at the location where it was collected. This deficient practice was identified for 1 (Resident #94) of 21 (Resident #1, Resident #8, Resident #13, Resident #15, Resident #16, Resident #22, Resident #27, Resident #28, Resident #32, Resident #38, Resident #46, Resident #47, Resident #49, Resident #52, Resident #55, Resident #61, Resident #69, Resident #76, Resident #86, Resident #94 and Resident #96) sampled residents reviewed for soiled linens in their environment. Findings: Observation on 06/23/2024 at 9:18 a.m., reveled soiled linens were seen on Resident #94's floor and a urine odor was present in Resident #94's room. In an interview on 06/23/2024 at 9:18 a.m., Resident #94 indicated she did not want the soiled linen on the floor, and stated someone needed to come pick them up. In an interview on 06/23/2024 at 9:20 a.m., S23Certified Nursing Assistant (CNA) indicated the soiled linen should not be on the floor of Resident #94's room. In an interview on 06/24/2024 at 2:40 p.m., S1Administrator indicated he was happy with S23CNA's response. S1Administrator would provide no further explanation related to the above mentioned deficient practice.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 48855 Based on interview and record reviews, the provider failed to ensure Certified Nursing Assistant (CNA) staff received the required training on resident rights and facility responsibility for 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor of 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor) personnel records reviewed. Findings: Review of S4CNA's personnel record revealed, in part, S4CNA was hired on 06/06/2022. There was no documented evidence and the facility did not present any documented evidence that S4CNA received the required training on resident rights and facility responsibility for caring of residents. Review of S5CNA's personnel record revealed, in part, S5CNA was hired on 02/20/2016. There was no documented evidence and the facility did not present any documented evidence that S5CNA received the required training on resident rights and facility responsibility for caring of residents. Review of S8CNA's personnel record revealed, in part, S8CNA was hired on 07/26/2023. There was no documented evidence and the facility did not present any documented evidence that S8CNA received the required training on resident rights and facility responsibility for caring of residents. Review of S10CNA's personnel record revealed, in part, S10CNA was hired on 07/16/2019. There was no documented evidence and the facility did not present any documented evidence that S10CNA received the required training on resident rights and facility responsibility for caring of residents. Review of S11CNA's personnel record revealed, in part, S11CNA was hired on 06/21/2023. There was no documented evidence and the facility did not present any documented evidence that S11CNA received the required training on resident rights and facility responsibility for caring of residents. Review of S12CNA's personnel record revealed, in part, S12CNA was hired on 05/04/2021. There was no documented evidence and the facility did not present any documented evidence that S12CNA received the required training on resident rights and facility responsibility for caring of residents. (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of S13CNA Supervisor's personnel record revealed, in part, S13CNA was hired on 07/15/2014. There was no documented evidence and the facility did not present any documented evidence that S13CNA Supervisor received the required training on resident rights and facility responsibility for caring of residents. In an interview on 06/26/2024 at 2:45 p.m., S1Administrator indicated he could not produce documented evidence of the above mentioned required training for the above mentioned facility staff was completed as required.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48855 Based on interview and record reviews, the provider failed to ensure Certified Nursing Assistant (CNA) staff were trained on the requirements for Quality Assurance Performance Improvement (QAPI) for 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor of 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor) personnel records reviewed. Findings: Review of S4CNA's personnel record revealed, in part, S4CNA was hired on 06/06/2022. There was no documented evidence and the facility did not present any documented evidence that S4CNA received the required training on the elements and goals of the facility's QAPI program. Review of S5CNA's personnel record revealed, in part, S5CNA was hired on 02/20/2016. There was no documented evidence and the facility did not present any documented evidence that S5CNA received the required training on the elements and goals of the facility's QAPI program. Review of S8CNA's personnel record revealed, in part, S8CNA was hired on 07/26/2023. There was no documented evidence and the facility did not present any documented evidence that S8CNA received the required training on the elements and goals of the facility's QAPI program. Review of S10CNA's personnel record revealed, in part, S10CNA was hired on 07/16/2019. There was no documented evidence and the facility did not present any documented evidence that S10CNA received the required training on the elements and goals of the facility's QAPI program. Review of S11CNA's personnel record revealed, in part, S11CNA was hired on 06/21/2023. There was no documented evidence and the facility did not present any documented evidence that S11CNA received the required training on the elements and goals of the facility's QAPI program. Review of S12CNA's personnel record revealed, in part, S12CNA was hired on 05/04/2021. There was no documented evidence and the facility did not present any documented evidence that S12CNA received the required training on the elements and goals of the facility's QAPI program. Review of S13CNA Supervisor's, personnel record revealed, in part, S13CNA Supervisor was hired on 07/15/2014. There was no documented evidence and the facility did not present any documented evidence that S13CNA Supervisor received the required training on the elements and goals of the facility's QAPI program. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/26/2024 at 2:45 p.m., S1Administrator indicated he could not produce documented evidence of the above mentioned required training for QAPI for the above mentioned facility staff.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 48855 Based on interviews and record reviews, the facility failed to ensure Certified Nursing Assistant (CNA) staff were trained on an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor) of 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor) personnel records reviewed. Findings: Review of S4CNA's personnel record revealed, in part, S4CNA was hired on 06/06/2022. There was no documented evidence and the facility did not present any documented evidence that S4CNA received training on the requirements for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Review of S5CNA's personnel record revealed, in part, S5CNA was hired on 02/20/2016. There was no documented evidence and the facility did not present any documented evidence that S5CNA received training on the requirements for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Review of S8CNA's personnel record revealed, in part, S8CNA was hired on 07/26/2023. There was no documented evidence and the facility did not present any documented evidence that S8CNA received training on the requirements for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Review of S10CNA's personnel record revealed, in part, S10CNA was hired on 07/16/2019. There was no documented evidence and the facility did not present any documented evidence that S10CNA received training on the requirements for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Review of S11CNA's personnel record revealed, in part, S11CNA was hired on 06/21/2023. There was no documented evidence and the facility did not present any documented evidence that S11CNA received training on the requirements for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Review of S12CNA's personnel record revealed, in part, S12CNA was hired on 05/04/2021. There was no documented evidence and the facility did not present any documented evidence that S12CNA received training on the requirements for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of S13CNA Supervisor, personnel record revealed, in part, S13CNA Supervisor was hired on 07/15/2014. There was no documented evidence and the facility did not present any documented evidence that S13CNA Supervisor received training on the requirements for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. In an interview on 06/26/2024 at 2:45 p.m., S1Administrator indicated he could not produce documented evidence of the above mentioned required training for an infection control system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases being completed for the above mentioned facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195401	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Oaks Nursing & Rehabilitation Center	711 W. Cornerview Road Gonzales, LA 70737

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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 48855 Based on interview and record reviews, the facility failed to ensure Certified Nursing Assistant (CNA) staff were trained on the requirements for Compliance and Ethics for 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor) of 7 (S4CNA, S5CNA, S8CNA, S10CNA, S11CNA, S12CNA, S13CNA Supervisor) personnel records reviewed. Findings: Review of S4CNA's personnel record revealed, in part, S4CNA was hired on 06/06/2022. There was no documented evidence and the facility did not present any documented evidence S4CNA was trained on the requirements for compliance and ethics program as required. Review of S5CNA's personnel record revealed, in part, S5CNA was hired on 02/20/2016. There was no documented evidence and the facility did not present any documented evidence S5CNA was trained on the requirements for compliance and ethics program as required. Review of S8CNA's personnel record revealed, in part, S8CNA was hired on 07/26/2023. There was no documented evidence and the facility did not present any documented evidence S8CNA was trained on the requirements for compliance and ethics program as required. Review of S10CNA's personnel record revealed, in part, S10CNA was hired on 07/16/2019. There was no documented evidence and the facility did not present any documented evidence S10CNA was trained on the requirements for compliance and ethics program as required. Review of S11CNA's personnel record revealed, in part, S11CNA was hired on 06/21/2023. There was no documented evidence and the facility did not present any documented evidence S11CNA was trained on the requirements for compliance and ethics program as required. Review of S12CNA's personnel record revealed, in part, S12CNA was hired on 05/04/2021. There was no documented evidence and the facility did not present any documented evidence S12CNA was trained on the requirements for compliance and ethics program as required. Review of S13CNA Supervisor's, personnel record revealed, in part, S13CNA Supervisor was hired on 07/15/2014. There was no documented evidence and the facility did not present any documented evidence S13CNA Supervisor was trained on the requirements for compliance and ethics program as required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195401	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Oaks Nursing & Rehabilitation Center	711 W. Cornerview Road Gonzales, LA 70737

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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/26/2024 at 2:45 p.m., S1Administrator indicated he could not produce documented evidence of training for compliance and ethics was completed for the above mentioned facility staff as required.