

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Natchitoches Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 781 Highway 494 Natchitoches, LA 71457	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>Based on record review and interview, the facility failed to ensure a resident was treated with respect and dignity for 1 (Resident #1) of 3 (Resident #1, Resident #2, & Resident #3) sampled residents.</p> <p>Findings:</p> <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included in part . Cerebral Infarction, Gout, Hypertension, and Major Depressive Disorder.</p> <p>Review of Resident #1's annual MDS with an ARD of 05/14/2024 revealed a BIMS score of 12 which indicated the resident had moderately impaired cognition. Review of the MDS revealed Resident #1 was independent with eating, toilet hygiene, and rolling left and right. Resident #1 required set up assistance with sitting to lying or lying to sitting on the side of the bed and with transferring from chair/bed to chair.</p> <p>Review of Resident #1's care plan with a target completion date of 08/25/2024 revealed a problem area of having a behavior problem that stated the resident occasionally uses profanity and aggressive language when irritated. Interventions included I will be assisted to develop more appropriate methods of coping and interacting, I will be encouraged to express feelings appropriately, Approach/speak to me in a calm manner, and Monitor my episodes of behavior and attempt to determine underlying cause.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/28/2024 at 10:10 a.m., Resident #1 said she wanted to move out of this facility because Everything is wrong here. Resident #1 explained she was supposed to get a thyroid pill every morning but recently she didn't get it so she went to the nurses' station to tell the nurse. Resident #1 said the nurse told her she had given it to her and she just didn't remember because she was sleeping. Resident #1 stated S3 LPN/ADON slammed the nurses' station door in her face. Resident #1 stated this made her mad and she began to bang on the door until S3 LPN/ADON opened it. Resident #1 stated she called the nurse a liar and the nurse pushed her on her shoulders and she said she pushed the nurse back. Resident #1 stated she fell down, hurt her left hip, and bruised the back of her right hand. Resident #1 said when the nurse put her hands on her, it made her feel bad. Resident #1 said, She shoved on me to get me out of the way and I got mad. Resident #1 said, I just don't want to stay here. Resident #1 said she did tell a nurse that she didn't want S3 LPN/ADON to take care of her anymore because I don't think she'll take good care of me. Resident #1 said, I just want to call my family to come get me. Resident #1 stated when a nurse came in this morning to give her the purple pill, she remembered the incident again and it made her mad all over again.</p> <p>In an interview on 08/28/2024 at 11:05 a.m., S5 LPN stated on morning of 08/23/2024, she was getting report from S3 LPN/ADON who had worked the night shift. S5 LPN stated Resident #1 came up to them and said she didn't receive her purple pill this morning. S5 LPN stated S3 LPN/ADON told Resident #1 that she gave it to her. S5 LPN stated Resident #1 called her a liar. S5 LPN stated S3 LPN/ADON told Resident #1 she had left it on the table with some water. S5 LPN said Resident #1 went back to her room to look and came back to them and was pointing her finger and said, You're lying. S5 LPN stated Resident #1 told S3 LPN/ADON You are in my space and then S3 LPN/ADON told Resident #1, No, you're in my space. S5 LPN stated S3 LPN/ADON then slammed the door in Resident #1's face while Resident #1's hands were on the door facing. S5 LPN stated Resident #1 then began beating on the glass in the nurses' station door and said she was afraid it would break and told S3 LPN/ADON she'd better open the door. S5 LPN stated S3 LPN/ADON opened the door, walked to Resident #1, put her hands on the resident's shoulders and tried to turn her around. S5 LPN stated Resident #1 began to resist and said, You don't touch me and they began to scuffle and Resident #1 fell .</p> <p>In an interview on 08/28/2024 at 11:10 a.m., S6 CNA reported she heard the commotion at the nurses' station door on the morning of 08/23/2024. S6 CNA stated she saw S3 LPN/ADON close the door in Resident #1's face. S6 CNA stated a minute later she could hear S3 ADON/LPN and Resident #1 both yelling and saw arms flying. S6 CNA stated she could hear that Resident #1 was loud and agitated. S6 CNA stated Resident #1 ended up on the floor.</p> <p>The facility's video surveillance footage from the incident on 08/23/2024 was observed on 08/28/2024 at 1:02 p.m. with S1 Administrator and S2 DON. The footage revealed at 7:03 a.m. on 08/23/2024, Resident #1 walked to the doorway of nurses' station and held a conversation with people inside the nurses' station. Resident #1 then walked back to her room. Resident #1 was seen walking back to the doorway of the nurses' station at 7:04 a.m. and was standing in the doorway talking to the people in the nurses' station again. At 7:05 a.m., the nurses' station door was abruptly shut closed by someone inside the nurses' station, while Resident #1 was still standing in the doorway. Resident #1 began to hit the glass in the door with her fist. S3 LPN/ADON opened the door and reached out toward Resident #1 with both hands and was seen holding Resident #1's arms and walking the resident backwards away from the doorway toward the day room. They began moving together with their arms locked together and Resident #1 fell to the floor inside the doorway of the nurses' station.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/28/2024 at 2:45 p.m., S4 RN/CC (Clinical Coordinator) for Hall 1 stated she arrived to work on 08/23/2024 about 8:00 a.m. S4 RN/CC stated S3 LPN/ADON had already left and staff reported the incident to her. S4 RN/CC stated she assessed Resident #1 and found a left hip bruise that Resident #1 said was tender to the touch. S4 RN/CC stated she got an x-ray order from S7 NP and called x-ray to come. S4 RN/CC stated she, S8 ADON, and S5 LPN went in together to talk to Resident #1. S4 RN/CC stated Resident #1 told them she went back to the nurses' station and called S3 LPN/ADON a liar and S3 LPN/ADON closed the door in her face, which made her mad and that was why she banged on the glass. S4 RN/CC stated Resident #1 told them when S3 LPN/ADON put her hands on her shoulders, she got nervous and dizzy and fell down. S4 RN/CC stated Resident #1 said S3 LPN/ADON was trying to get her to go back to her room. S4 RN/CC stated she asked Resident #1 if she wanted S3 LPN/ADON to take care of her again and Resident #1 said No. S4 RN/CC stated she watched the surveillance video with S1 Administrator and saw S3 LPN/ADON close the door in Resident #1's face, which was very inappropriate.</p> <p>In an interview on 08/28/2024 at 3:23 p.m., S8 ADON reported on 08/23/2024 she arrived to work around 8:00 a.m. and S5 LPN informed her that S3 LPN/ADON had an altercation with Resident #1 and explained what happened. S8 ADON stated she reported it to S1 Administrator and they watched the surveillance video from the camera inside the team room/nurses' station and could visualize the inside of the team room, the door, the two nurses, and Resident #1 in the doorway. S8 ADON stated on the video she observed S3 LPN/ADON slam the door in Resident #1's face. S8 ADON stated Resident #1 was close to being hit by the door. S8 ADON stated S3 LPN/ADON later opened the door and she and Resident #1 got into an altercation and Resident #1 ended up falling. S8 ADON confirmed S3 LPN/ADON slammed the door in Resident #1's face. S8 ADON stated Resident #1 was standing in the doorway with her hands on the door facing and she didn't know how her fingers didn't get slammed in the door. S8 ADON explained Resident #1 then began to hit the door window with her fist. S8 ADON explained S3 LPN/ADON then opened the door, walked toward Resident #1 and touched her, and Resident #1 fell. S8 ADON reported she, S4 RN/CC, and S5 LPN then went in to assess Resident #1 and interview her. She said Resident #1 told them S3 LPN/ADON touched her first and pushed her on the shoulders stating she didn't know if she was trying to push her back to her room or what.</p> <p>In a telephone interview on 08/28/2024 at 4:06 p.m., S9 CNA stated she observed Resident #1 walk to the nurses' station and tell S3 LPN/ADON she didn't give her the medicine she was supposed to get. S9 CNA stated S3 LPN/ADON told the resident she gave it to her. S9 CNA stated S3 LPN/ADON pushed Resident #1 out the door and slammed the door in Resident #1's face. S9 CNA stated Resident #1 started hitting the glass on the door with her fist. S9 CNA stated S3 LPN/ADON opened the door and Resident #1 swung at S3 LPN/ADON and then they began tussling. S9 CNA stated S3 LPN/ADON pushed the resident down to the ground.</p> <p>In an interview on 08/29/2024 at 7:14 a.m., S10 CNA stated on 08/23/2024 she heard Resident #1 and S3 LPN/ADON having a conversation about medicine. S10 CNA stated the conversation got loud with both of them yelling and then S3 LPN/ADON slammed the door hard in Resident #1's face. She said Resident #1 got mad and started pounding on the door, then she saw S3 LPN/ADON open the door and she saw them both swinging at each other. S10 CNA stated she and another CNA ran over as Resident #1 fell to the floor. S10 CNA stated they assisted the resident up and to the couch. S10 CNA stated Resident #1 was really upset saying she couldn't stay here.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/29/2024 at 7:52 a.m., S3 LPN/ADON stated on the morning of 08/23/2024 when she was counting narcotics with S5 LPN, Resident #1 came and told S5 LPN she needed her purple pill, and said she told her she had given it to her. S3 LPN/ADON said Resident #1 left, went to her room and returned a few minutes later and said, No you didn't and said she told her, Yes I did. She said Resident #1 stated the cups were not on her table and she said she explained to Resident #1 that she woke her up, she took the medicine, and she took the cups back out to her medicine cart. S3 LPN/ADON stated Resident #1 said, You're lying. S3 LPN/ADON stated Resident #1 said to stop saying her name and was adamant that she didn't get her medication. S3 LPN/ADON stated she closed the door by pushing it to and said the door shuts loudly. S3 LPN/ADON stated Resident #1 was standing right outside the doorway when she closed it. S3 LPN/ADON stated Resident #1 started beating the glass with a hand with a ring on it with her fist, her right one. S3 LPN/ADON stated it was loud and she was afraid it would break the glass so she opened the door. S3 LPN/ADON stated she put her right hand on Resident #1's upper left arm and said, Let me bring you back to your room. S3 LPN/ADON stated Resident #1 called her a white b#@*# and swung at her with her right fist. S3 LPN/ADON stated she grabbed Resident #1's right forearm to stop it. S3 LPN/ADON stated Resident #1 spun around to try to get her hand free and landed on her behind. S3 LPN/ADON stated she did close the nurses' station door on Resident #1 to try to deter the resident, but, looking back it was probably not a good idea.</p> <p>In an interview on 08/29/2024 at 8:56 a.m., S1 Administrator stated the slamming of the door could have been avoided. S1 Administrator stated she didn't feel like S3 LPN/ADON abused Resident #1 but S3 LPN/ADON was placed on a 30 day improvement plan and retrained on Handling Aggressive Behaviors, Management of Behavioral Challenges, Abuse, Neglect, and Exploitation in the Elder Care Setting, and Managing Anger prior to returning to work.</p>		