STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195416	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosepine Retirement & Rehab Center, LLC	18364 Central Avenue Rosepine, LA 70659

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 47004 Based on interview and record review, the facility failed to ensure facility staff used a mechanical lift with two person assist during transfer from the bed to chair for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) residents sampled for accidents. The facility census was 84. This deficient practice resulted in an Immediate Jeopardy for Resident #2 on 05/19/2024 between 10:00 a.m. and 11:00 a.m., when S3 CNA attempted to transfer Resident #2, who required a Mechanical lift with 2 person assistance, without the use of the lift and assistance of another staff. Resident #2 sustained a fall during the attempted transfer by S3 CNA. Resident #2 was sent to the local ER following the fall due to complaint of pain to both knees. Resident #2 was diagnosed with a fracture of the Left Femur and Right Tibia, and sent to another facility for a higher level of care. Resident #2 required Closed Reduction surgery to Left Femur on 05/24/2024. The facility implemented corrective actions prior to the State Agency's investigation therefore, it was determined to be a Past Noncompliance citation. Findings: Review of the facility's undated policy titled Safe Lifting and Movement of Residents, read in part . In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Nursing staff, in conjunction with the rehabilitation staff, shall assess the individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. Review of Resident #2's medical record revealed an admitted [DATE], with diagnoses that included in part . Generalized Muscle Weakness, Difficulty in Walking, Unsteadiness on Feet, Other Specified Disorders of Bone Density and Structure. Review of Resident #2's Comprehensive Risk Assessment completed on 04/03/2024, revealed Resident #2 was high risk for falls, and required mechanical lift for transfers. The assessment revealed a score of 10 or higher indicated a high risk for falls. Resident #2's score was 12. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Quarterly MDS Assessment with an ARD of 04/03/2024, revealed Resident #2 had a BIMS score of 9 (Moderate Cognitive Impairment). Resident #2 was totally dependent upon staff, and required 2 + person physical assist for transfers. Review of Resident #2's Care Plan with a target date of 07/12/2024, revealed a problem of: 1. Extensive assistance with ADL's - Wheelchair for Mobility, Does not ambulate, and History of falls. Interventions included: Assist as needed, and Mechanical lift x 2 people. 2. Falls - History of falling. Interventions included: Hoyer mechanical lift X 2 people for transfers. Review of Resident #2's Progress Notes read in part . 05/19/2024 at 11:25 a.m., documented by S5 LPN, read in part . Resident #2 complained of increased pain to bilateral knees and nausea. Three loose bowel movements this morning. S8 NP made aware, and received orders to apply Biofreeze (topical analgesic) to bilateral knees x 1, KUB, and check for impaction. 05/19/2024 at 2:50 p.m. - Radiology in facility. During X-rays Resident #2 complained of severe pain to left knee. Moaning and guarding noted during repositioning. S8 NP made aware, and received orders to X-ray bilateral knees. Swelling noted above left knee. S8 NP ordered x1 dose of Norco (pain medication). 05/19/2024 at 5:32 p.m. - Contacted imaging in regard to x-ray results, results not finalized at this time. S8 NP made aware and voiced understanding. 05/19/2024 at 6:38 p.m. - Resident #2 noted with increased pain at this time to legs. Restless in bed. Reporting severe pain behind left leg. S8 NP made aware and gave orders to send to ER with family permission. 05/19/2024 at 7:24 p.m. - Resident #2 left facility via ambulance. 05/20/2024 at 5:52 a.m., documented by S6 LPN - Called for update. Resident #2 sent to higher level of care hospital for further evaluation and surgery consideration. 05/31/2024 at 12:36 p.m., documented by S7 LPN - Received report from nurse at hospital. Resident #2 was admitted for Left Femur Fracture, Right Proximal Tibia Periprosthetic Fracture, Anemia, and Elevated Troponin. Resident #2 required surgery and received a Left Intramedullary Nail on 05/24/2024, and has staples in place from the outer top hip to knee. Follow up needed for orthopedic in 2-3 weeks. Right leg has an immobilizer in place, with order to be non-weight bearing to left and right side lower extremities. Review of a statement dated 05/19/2024, and written by S3 CNA, read as follows in part .I (S3 CNA) attempted to get Resident #2 up for bible study. I (S3 CNA) called S4 CNA for help for a 2 person transfer from bed to chair. As we attempted, her knees buckled. We did not get her up; we put her back in the bed. I (S3 CNA) reported to S5 LPN. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a statement dated 05/19/2024, and written by S4 CNA, revealed in part . I (S4 CNA) was asked to assist with Resident #2's transfer. S4 CNA documented that she entered the room, and Resident #2 was sitting on the side of the bed with wheelchair nearby. S3 CNA and I (S4 CNA) started 2 person assist. Resident #2 bared weight then started to fall. S3 CNA and I (S4 CNA) helped Resident #2 to the floor, and got Resident #2 back to the bed, then went to tell the nurse. Review of a statement dated 05/19/2024 written by S5 LPN, revealed in part . Notified by S3 CNA that Resident #2 had difficulty transferring, increasing bilateral knee pain, nausea, and diarrhea. S3 CNA and S4 CNA reported when Resident #2 complained of pain during transfer, they stopped and placed her back in bed. Upon assessment, Resident #2 did complain of bilateral knee pain and nausea. S8 NP made aware, and orders received. Continuous monitoring of Resident #2 was performed. No deformities noted to bilateral lower extremities during assessment. S8 NP requested CNA's be asked if any fall had occurred to which both denied. S3 CNA summoned nurse during KUB, and increase pain to left lower extremity noted at this time, with swelling above left knee. S8 NP made aware and received further x-ray orders. A dose of pain medication administered. Telephone interview on 06/11/2024 at 11:00 a.m. with S3 CNA, revealed on Sunday 05/19/2024, she went to get Resident #2 up for bible study at approximately 10:00 a.m. S3 CNA stated she dressed resident in bed, then called for S4 CNA to come assist her with transferring Resident #2 from her bed to wheelchair. S3 CNA stated she and S4 CNA did not use the mechanical lift to transfer Resident #2, but should have. S3 CNA stated she did know that a lift was to be used for Resident #2, but the resident had previously been able to bear weight on other occasions for transfers, so she attempted to transfer without the lift. S3 CNA stated Resident #2 did not fall. S3 CNA stated Resident #2's knees buckled when she stood, but she did not touch the ground. S3 CNA stated she immediately put Resident #2 back to bed when they could not transfer her. S3 CNA stated she called S5 LPN to Resident #2's room to come assess Resident #2, as the resident complained of knee pain. S3 CNA stated she was trained by the facility on using the lift and on how to transfer residents. S3 CNA stated she had not followed the plan of care for Resident #2, and she should have used the lift with 2 person assist to transfer Resident #2. Interview on 06/10/2024 at 12:10 p.m. with S1 Administrator, confirmed on 05/19/2024, Resident #2 had a fall in room when S3 CNA attempted to transfer Resident #2 by herself without the assistance of another staff member, and without the mechanical lift. S1 Administrator stated initially, the facility did not know Resident #2 had a fall, as S3 CNA and S4 CNA denied a fall occurred. S1 Administrator stated S3 CNA and S4 CNA informed S5 LPN that they attempted to transfer Resident #2, but she began to complain of knee pain, so resident was put back to bed. S1 Administrator stated S5 LPN notified S8 NP and got x-rays ordered. S1 Administrator stated when the facility was informed Resident #2's X-ray reports, the facility immediately began an investigation on 05/19/2024. S1 Administrator stated the facility had staff write statements, and S2 DON began in-services. S1 Administrator stated during the investigation, S4 CNA informed them that she was coming to assist S3 CNA with transferring Resident #2. S4 CNA stated as she entered the room, she saw Resident #2 on her knees. S4 CNA stated she helped S3 CNA get Resident #2 into bed, and that S3 CNA had attempted to transfer Resident #2 alone, without a lift. Interview on 06/11/2024 at 2:20 p.m. with S2 DON, revealed staff were to follow residents' plans of care in regards to transfers. S2 DON stated that staff failed to do so on 05/19/2024 resulting in a fall for Resident #2. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Throughout the survey from 06/10/2024 thru 06/12/2024, random interviews of staff were conducted. Staff stated that they had previously received training on transferring residents with mechanical lifts, and had been recently in-serviced on the use of mechanical lifts. Review of a list of residents who required a mechanical lift for transfers, revealed 18 residents required the use of a lift for transfers. Random interviews with cognitive residents who required the use of a lift for transfers were conducted, and revealed staff utilized the mechanical lift with 2 people when transferring them. The facility has implemented the following actions to correct the deficient practice: 1. A Root Cause Analysis was completed, and it was determined that S3 CNA did not request assistance with mechanical lift transfer x 2 person assist, and attempted to transfer Resident #2 independently without a lift. 2. All residents requiring use of mechanical lift for transfers were audited to ensure the following was within their medical record: physician order, care plan, Smart Chart documentation, signage above head of bed, and information on transfer type added to resident specific rounding sheet. Results: all 18 residents who require a lift for transfer were in compliance. Completed 05/20/2024. 3. Staff in-services immediately initiated regarding where to find transfer status, proper use of lift, reporting of falls, reporting of lowering residents to ground, and accurate charting of ADL's. Initiated 05/19/2024 and completed 05/23/2024. 4. Policy/Procedure: Lift transfer policy reviewed on 05/202/2024 with no changes. 5. Monitoring: DON, or Designee will observe and supervise as necessary 8 lift transfers per week for 8 weeks. Any concerns identified will be reported and appropriate action taken to include retraining, further observations etc. The results of the observations will be reviewed with the QA Committee weekly for review of continued compliance. Monitoring initiated 05/27/2024 and is ongoing. 6. Corrective Action Plan effective as of 05/19/2024 with completion date of 05/23/2024.