STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195420	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Naomi Heights Nursing & Rehabilitation Center	2421 E. Texas Avenue Alexandria, LA 71301

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51596 Based on interviews and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene by failing to provide incontinence care for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: Record review revealed Resident #2 was admitted on [DATE] with diagnoses including Traumatic Subdural Hemorrhage with Loss of Consciousness, Muscle Wasting and Atrophy, Overactive Bladder, and Lack of Coordination. Review of Resident #2's Significant Change Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 02/21/2025 revealed, in part, a Brief Interview for Mental Status (BIMS) score was not conducted as resident was rarely or never understood. The resident was dependent for toileting hygiene. Toilet transfer was not attempted due to the resident's medical condition or safety concerns. Resident #2 was always incontinent of urine. Review of Resident #2's current physician orders revealed, in part, an order dated 10/25/2024 for incontinence care, indicating Resident #2 was to be checked for incontinence at least every 2 hours. Review of Resident #2's current care plan revealed, in part, bladder incontinence with a diagnosis of Overactive Bladder. Interventions included, in part, 2-person assist with incontinence care, incontinence care every 2 hours and as needed, and to keep skin clean and dry. Review of the facility's Record of Complaint dated 01/14/2025 at 1:00 p.m. revealed, in part, on 01/13/2025 Resident #2 did not receive incontinence care from 10:40 a.m. until 6:44 p.m. Review of the facility's Personnel Action form dated 01/14/2025 revealed, in part, S9 CNA was counselled because she failed to provide incontinence care for Resident #2 from 11:00 a.m. until 3:00 p.m. Review of the facility's Personnel Action form dated 01/14/2025 revealed, in part, S8 CNA was counselled because she failed to provide incontinence care for Resident #2 from 3:00 p.m. until 6:44 p.m. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 04/08/2025 at 2:50 p.m. with S2 DON who confirmed Resident #2 did not receive incontinence care on 01/13/2025 from 10:40 a.m. until 6:44 p.m. S2 DON confirmed Resident #2 should have received incontinence care at least every 2 hours, but did not.

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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** 46773 Based on observations, interviews, and record review the facility failed to ensure a resident remained free from falls, by failing to ensure proper practices were followed while using a lift during a transfer for 1 (#1) of 2 (#1 and #2) sampled residents reviewed for incidents and accidents. This deficient practice resulted in an Immediate Jeopardy for Resident #1 on 03/27/2025 at 1:57 p.m., when Resident #1 fell from a mechanical lift onto the floor while being transferred by S3 CNA and S4 CNA. Resident #1 sustained a complete displacement fracture of the proximal left femur, and a subarachnoid hemorrhage as a result of the fall. The facility determined that S3 CNA and S4 CNA failed to use the appropriate sling size, and failed to place the sling loops appropriately on the lift to transfer Resident #1. 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 12/2019 policy titled [NAME]- Lift Transfer Procedure, read in part 1. Make sure you understand which size sling and which method of connecting the sling to the hanger bars is to be used to transfer patient. 13. Double check the sling loop connection to the hanger bar hooks to make sure the sling is securely attached with the loops in the bottom of the hanger bar hooks. Review of the facility's 12/2019 policy titled [NAME]- Lift -Using the Uni-fit Sling, read in part . each resident who uses the Vander-Lift for transferring should have a sling size (and color) listed on their wall care plan. The recommended sling size is what is to be used for the specific resident's transfer. Procedure Checkoff: 1. CNA correctly identified correct lift and sling size appropriate for the residents and identified sling part. 11. The CNA connects each of the shoulder sling loops to the hanger bar hooks on the mast using the same loop position on both sides of the sling. Review of Resident #1's medical record revealed an admitted [DATE], with diagnoses that included, in part . Schizoaffective Disorder, Bipolar Disorder, Diabetes Mellitus, Muscle Wasting with Atrophy, and Parkinson's disease. Review of a Quarterly MDS with ARD of 01/01/2025, revealed Resident #1 had a BIMS score of 11 (Moderate Cognitive Impairment). Resident #1 was dependent upon staff and required 2 + person physical assist for transfers. Review of Resident #1's Care Plan with a target date of 03/10/2025, revealed, in part . Resident #2 is at high risk for falls due to decreased mobility and diagnosis of Parkinson's. Interventions in place prior to incident: Vander-Lift x 2 person assist. Incident: 03/27/2025 Fall in room from Vander-Lift with head injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: 03/28/2025 Vander-Lift x2 person assist with all transfers Medium (RED) lift pad. Observation on 04/07/2025 at 11:15 a.m. of Resident #1's wall care sheet posted in Resident #1's room, read in part .Vander-Lift x 2 person assist for all transfers. A red sticker was noted on the wall care sheet, which indicated a red (medium) sling was needed for transfers using a lift. Review of the facility incident report completed by S1 ADM, revealed on 03/27/2025 at 1:57 p.m., S5 Clinical Coordinator and S6 ADON were called into Resident # 1's room where she was found lying flat on floor between the legs of the Vander-Lift, and with blood under her head. S3 CNA and S4 CNA stated Resident #1 had fallen out of the lift sling and onto the floor during transfer. S5 Clinical Coordinator and S6 ADON applied pressure to Resident #1's head and had staff call an ambulance, the physician, and Resident #1's daughter. External rotation of the left leg was noted after the ambulance arrived, and Resident #1 was placed on the stretcher. Resident #1 was sent to the emergency room , where she was diagnosed with a subarachnoid hemorrhage, and complete displacement fracture involving the proximal left femur. The facility's investigation revealed the wrong size sling was used and the top right strap of the sling was hooked in the middle loop, rather than the loop closest to the pad, like the other 3 straps. Resident #1 was admitted to the hospital. She returned to the facility on [DATE]. Review of the employee written statement by S5 Clinical Coordinator revealed, in part .on 3/27/2025 at 1:57 p.m. Nurse stat was called to Resident #1's room. Resident #1 was observed lying on the floor between the legs of the Vander-Lift. The lift pad on the lift was a size large pad, and was trimmed in blue. Resident #1's care sheet included a red sticker, indicating her weight required the use of a red, or size medium, lift pad. All the straps were attached to the lift. The right strap at the head of the pad was attached in a higher notch further away from the sling, and the other 3 straps were attached to the bracket at the lowest level, closest to the lift pad. S3 CNA and S7 CNA were in the room at the time of the incident. S4 CNA had assisted with the transfer, but was no longer in the room. First aid was provided for Resident #1's head injury until the ambulance arrived. Review of the employee written statement by S4 CNA read in part S3 CNA hooked the lift up and she pulled it out, and Resident #1 then slipped out of the lift. Review of the employee written statement by S3 CNA read in part .Resident #1's dressed in blue jeans and a sweater with her socks and shoes with the lift pad under her. I went out to get assistance. I hooked up the 2 ends at the top, the other aide hooked up the 2 bottom ends. When lifting Resident #1 and moving her to sit her into her chair, she comes sliding out of the lift pad falling onto the floor. The sling was in her recliner chair. Review of the employee written statement by S7 CNA, read in part . I went in the room to go wait on the lift to get another resident up. S4 CNA and S3 CNA hooked the lifter pad on the lift. S3 CNA went to pull the lift from the bed and S4 CNA backed up the wheelchair to left of her bed. As soon as S3 CNA pulled the Vander-Lift out, the resident fell on her right side. S4 CNA then ran out the room while S3 CNA and I stayed with the resident'. Review of a written interview between S3 CNA and S1 ADM on 03/28/25: S1 ADM - Did you realize that you had placed one? loop higher than the other loop? (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	S3 CNA - Yes, I do know all the loops are to be the same on each side and when hooking up the lift pad I thought they were on the same loop on each side. S1 ADM - The lift pad was large and she uses a medium size. Were you aware of this? S3 CNA - The sling was already in the room so I used the sling that was already in the room. Review of S3 CNA's personnel file revealed a new hire in-service and checkoff dated 02/27/2025 regarding use of the Vander-Lift for transfers, correct sling sizes, and attaching the hooks properly. Review of S4 CNA's personnel file revealed an in-service and checkoff dated 07/08/2024, and 10/07/2024, regarding use of the Vander-Lift for transfers, correct sling sizes, and attaching the hooks properly. Interview on 04/08/2025 at 9:55 a.m. with S5 Clinical Coordinator, revealed on 03/27/2025 at 1:57 p.m., she heard nurse stat announced for Resident #1's room. Upon entering the room she observed Resident #1 lying on the floor between the legs of the lift, and with blood under her head. S5 Clinical Coordinator stated a blue-trimmed sling was attached to the lift. S5 Clinical Coordinator revealed Resident #1's wall care sheet indicated she required a red sling. S5 Clinical coordinator stated the top right strap of the sling was not hooked in the loop closest to the pad, like the other 3 straps. S5 Clinical Coordinator stated that she is in charge of ensuring the right sling size is care planned and revealed that the red sling size was appropriate for Resident #1 according to her weight. Interview on 04/08/2025 at 10:21 a.m. with S6 ADON, revealed on 03/27/2025 at 1:57 p.m., she heard nurse stat yelled loudly for Resident #1's room. S6 ADON observed Resident #1 on the floor between the legs of the Vander-Lift. She stated there was blood under Resident #1's head. S6 ADON stated Resident #1's left leg was rotated outwardly, and she complained of pain to her back and left hip. S6 ADON stated after Resident #1 was transferred to the hospital, she immediately began in-servicing staff on correct use of lifts. She required all CNAs and nursing staff be checked-off on the task prior to using the lift. S6 DON stated she continued to monitor S3 CNA, S4 CNA, and random CNAs daily. Interview on 04/08/2025 at 1:11 p.m. with S7 CNA, revealed on 03/27/2025 at 1:57 p.m. she was in Resident #1's room when the fall occurred because she was waiting on the lift. S7 CNA revealed Resident #1's lift pad was already underneath her, but she could not recall the color. S7 CNA stated S3 CNA connected the top sling straps to the lift, and S4 CNA connected the bottom sling straps to the lift. S7 CNA stated S3 CNA began lifting Resident #1. S4 CNA put her foot on the lift, turning the lift towards the wheelchair. As S4 CAN turned the lift, Resident #1 fell out of the right side of the sling, and onto the floor. S7 CNA revealed staff were to use the sling size indicated on the residents' care sheets, and ensure all straps were connected properly prior to using the lift. Interview on 04/08/2025 at 1:32 p.m. with S4 CNA, revealed on 03/27/2025, she went into Resident #1's room to assist S3 CNA with transfer of the resident. S4 CNA stated the lift pad was already under Resident #1, but she could not recall the color of the lift pad. S4 CNA connected the lower straps to the lift, and S3 CNA connected the upper straps to the lift. S4 CNA stated that as S3 CNA moved the lift, Resident #1 fell out the right side of the sling and onto the floor. S4 CNA stated she had been trained on proper use of the lift, and had been checked off on the skill. S4 CNA stated two staff members were required to use and operate the lift. She was to refer to the residents' care sheets to determine the correct size lift pad for each resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/08/2025 at 1:45 p.m. with S3 CNA, revealed prior to the incident, she had gotten Resident #1dressed and had put the lift pad, that was already in the room, underneath her for the transfer. S3 CNA stated she retrieved the lift and requested assistance from S4 CNA. S3 CNA stated that S7 CNA came into the room to wait for the lift. S3 CNA stated she connected the top straps of the lift pad to the lift, and S4 CNA connected the bottom straps of the lift pad to the lift. S3 CNA stated she lifted Resident #1, and was guiding the sling to the chair when Resident #1 slid out of the sling and onto the floor. S3 CNA stated she thought the straps were hooked to the lift correctly at the time of transfer. S3 CNA stated she was to look at the resident's wall care sheet to identify what color/size sling they were to use for transfer. S3 CNA stated she did not look at the wall care sheet to determine the correct sling size, but instead used the sling that was already in Resident #1's room. She did not remember what size sling was used for the transfer. Interview on 04/08/2025 at 3:05 p.m. with S2 DON, revealed she was on vacation at the time of the incident, but had been notified by S1 ADM. S2 DON ensured all staff were trained on use of lifts since the incident. S2 DON stated all existing staff had been in-serviced, and new staff were trained upon hire. Nurses were to monitor CNAs to ensure correct lift pads and lift technique were utilized. Interview on 04/09/2025 at 9:45 a.m. with S1 ADM, revealed on 03/27/2025 she was notified that Resident #1 had been sent to the hospital after falling while being transferred with a lift. Investigation by S1 ADM and S5 Clinical Coordinator revealed the correct sling size had not been used for the transfer and one of the sling straps was not correctly connected to the lift. The facility had implemented the following actions to correct the deficient practice: 1. On 03/27/2025, the administrative team began in-servicing all CNAs and nurses on proper lift technique and correct sling use. The in-services were completed on 04/05/2025. 2. On 03/27/2025, the administrative nursing team began checking-off all CNAs and nurses on the lift and slings, using return demonstration technique. The check-offs were completed on 4/5/25. 3. On 03/27/2025, all lifts were inspected by the assistant administrators to ensure they were in safe working order. 4. On 03/28/2025, S3 CNA and S4 CNA received individual counseling and in-service. Skills check-off was completed, with follow-up questions, to ensure complete understanding. 5. Beginning 03/28/2025 and continuing x 7 days, S3 CNA and S4 CNA were to ensure a nurse was present during any transfer of a resident with a lift. The nurse completed a check-off sheet, documenting use of the correct sling size and correct connection of the sling to the lift. 6. On 03/28/2025, S2 ADON ensured all residents requiring use of the Vander-Lift had the correct sling size indicated on the care sheet in their room. To provide additional clarification, the size/color of sling to be used was added to each order for the Vander-Lift which was completed on 03/28/2025 7. On 03/31/2025, the housekeeping supervisor checked all the slings in the building, ensuring they were not frayed or torn, and were in good working condition. Completed on 03/21/2025. (continued on next page)

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