STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195438	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Nursing & Rehabilitation Ctr of West Mon	1611 Wellerman Road West Monroe, LA 71291

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 - Actual harm 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** 19098 Based on record review and interviews, the facility failed to ensure 1 (#1) of 3 (#1, #2, #3) residents reviewed for accidents received the necessary supervision to prevent avoidable accidents including a fall. The deficient practice resulted in an actual harm for Resident #1 on 08/22/2024 at 12:25 p.m. when Resident #1 suffered major injuries from falling out of the bed to the floor while left unattended during a bed bath. S4 CNA (Certified Nursing Assistant) was providing a bed bath to Resident #1. S4 CNA left the room to get more supplies for the bath and Resident #1 rolled off the bed and to the floor. Resident #1 was sent to a local hospital ER (emergency room) on 08/22/2024. Review of the hospital records revealed Resident #1 suffered bilateral supracondylar fractures of the right and left femurs requiring ORIF (open reduction internal fixation) of the right femur and a closed reduction and Ex-Fix application of the left distal femur on 08/22/2024. Resident #1 remained in the hospital at the time of the investigation. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. The Completion date was 08/26/2024. Findings: On 09/03/2024, review of the record for Resident #1 revealed an admitted [DATE]. Further review of the record for Resident #1 revealed diagnoses in part of atresia and stenosis of urethra and bladder neck, schizoaffective disorder, seizures, multiple sclerosis, muscle wasting and atrophy, lack of coordination, cognitive communication deficit, aphasia and a past history on 01/09/2020 of non-displaced extra-articular fracture of the left calcaneus, and displaced fracture of medial malleolus of left tibia. Review of the August 2024 Physician orders revealed to use the Vander-Lift with 2 people for transfers and 2 person total assist with bed mobility. Further review of the record revealed on 08/04/2024 Resident #1 weighed 256 pounds. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the quarterly MDS (Minimum Data Set) dated 05/10/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 9 indicating Resident #1 had moderate cognitive impairment. Further review of the MDS revealed Resident #1 had the following functional abilities: limited range of motion to bilateral upper extremities and lower extremities. Review of Resident #1's MDS revealed Resident #1 required total dependence for bed mobility with two person assist. Resident #1 was always incontinent of bowel and bladder. Review of the current plan of care revealed Resident #1 was at risk for falls. Review of the approaches in part revealed transfer using 2 person assist with Vander-Lift. Review of the facility incident report dated 08/22/2024 at approximately 12:25 p.m. revealed Resident #1 was receiving personal care by S4 CNA. During the care, Resident #1's bowels had moved and S4 CNA realized she did not have enough supplies to complete the care, so she left the room to gather more. While she was gathering supplies, she heard Resident #1 yell out and she immediately returned to the room. S4 CNA found Resident #1 beside the bed, on the floor, on her knees, between the bed and the wall. S4 CNA immediately called for assistance. S5 LPN (Licensed Practical Nurse) arrived to find Resident #1 on her knees, on the floor, with her hands on top of the mattress, complaining of pain to both of her legs. Resident #1 reported that she fell out of the bed. S5 LPN assessed the resident for injuries and noted a skin tear to her right knee. S5 LPN contacted the physician and orders were received to send to hospital for further evaluation. On 08/22/2024 at 9:35 p.m., S9 LPN received a call from the emergency room informing her that Resident #1 had fractures in bilateral legs and would be having surgery to repair them. S9 LPN immediately notified the DON (Director of Nurses) who then informed the Administrator. Review of the hospital record regarding the injuries sustained from this incident revealed Resident #1 received supracondylar fractures of the right and left femurs. Treatment received was an ORIF to the right and closed reduction and Ex-Fix application of the left distal femur fracture on 08/22/2024. On 09/04/2024 at 11:30 a.m., an interview with S4 CNA revealed on 08/22/2024 about 12:25 p.m. she was assisting the CNAs on the hall. The CNA that normally cares for Resident #1 was on lunch break and had already put supplies in the room for Resident #1 to get a bath. S4 CNA said this was only the second time she had provided care to Resident #1 and said she was giving Resident #1 a bath by herself and was not aware Resident #1 required a 2 person assist with bathing and transferring and failed to review the wall care plan in the resident's room that noted Resident #1 was a 2 person assist. S4 CNA said during the bath, Resident #1 had a bowel movement and she did not have enough supplies in the room. S4 CNA said she turned Resident #1 to face the wall and the resident's hands were touching the wall. S4 CNA lowered the bed and stepped out of the room. S4 CNA said she was not sure if the bed was locked and she did not check the break on the bed before she started the bath or before leaving the room. S4 CNA said she did not even have enough time to get the towel off the cart in the hall when she heard Resident #1 hollering for help. S4 CNA said when she came back in the room, Resident #1 was on her knees between the wall and the bed and Resident #1 was complaining of her right knee hurting. S4 CNA said the bed had moved away from the wall. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/04/2024 at 1:30 p.m., an interview with S5 LPN revealed she was at the main desk and S4 CNA came and told her that Resident #1 was on the floor. S5 LPN said she went to the room and Resident 1 was on her knees between the bed and the wall with her hands on the mattress. S5 LPN reported Resident #1 only complained of her right knee hurting and she noticed a skin tear to her right knee. S5 LPN said they got multiple staff, lowered Resident #1 to the floor and then used the lift to get her up off the floor. Resident #1 was sent to the hospital. S5 LPN said she was not sure if the bed was in the lock position when the accident occurred. On 09/03/2024 at 2:30 p.m., an interview with S8 CNA Assistant Supervisor confirmed there should have been 2 staff present when providing care for resident #1 and S4 CNA should not have left the bed unlocked when she left the room. On 09/04/2024 at 2:00 p.m., an interview with S3 DON confirmed S4 CNA should not have been providing care to Resident #1 without another staff member present and S4 CNA should have ensured the bed was locked before leaving the room. During the survey, in-service records and QA (Quality Assurance) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. The facility implemented the following actions to correct the deficient practice with the completion date of 08/26/2024: 1. Resident #1 was sent to the hospital for evaluation. 2. S4 CNA was suspended pending investigation. 3. S4 CNA was in-serviced on 08/22/2024 on care of residents in bed, to read the wall care plan. The wall care plan is a piece of paper that is placed on each resident's wall by the bed that has the specific care needs for the resident. To make sure all supplies are obtained prior to beginning care, ensure bed wheels are locked, ensure resident in safe position in bed before leaving room (not close to edge of bed but in middle of bed). 4. All nurses and CNAs were in-serviced from 08/23/2024 to 08/26/2024 on the resident wall care plan, 2 person assist with mobility in the bed, toileting, incontinent care, turning and reposition, bathing, a CNA should be on each side of bed. Check with nurse if any questions. Never leave a room with the resident not in safe position, ensure the wheels are locked on the bed. 5. Baseline assessments of all residents functional capabilities performed, care plans updated for all residents with changes to baseline functional status, all in room resident care plans were updated and monitors were put in place to ensure compliance of corrective action. 6. QAPI (Quality Assurance/Performance Improvement) monitors were conducted to ensure that care received while in bed reflects what the baseline review of functional status and needs assessment are followed. 7. QAPI Monitor - Locks on bed monitored 3 times per week.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 19098 Based on record review and interview, the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 1 (#1) of 3 (#1, #2, #3) residents reviewed. S4 CNA (Certified Nursing Assistant) failed to provide 2 person assistance during bed mobility for Resident #1 and failed to ensure the bed was in the locked position prior to exiting Resident #1's room. The facility implemented corrective actions prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. The Completion date was 08/26/2024. Findings: On 09/03/2024 review of the record for Resident #1 revealed an admitted [DATE]. Further review of the record for Resident #1 revealed diagnoses in part of atresia and stenosis of urethra and bladder neck, schizoaffective disorder, seizures, multiple sclerosis, muscle wasting and atrophy, lack of coordination, cognitive communication deficit, aphasia and a past history on 01/09/2020 of non-displaced extra-articular fracture of the left calcaneus, and displaced fracture of medial malleolus of left tibia. Review of the August 2024 Physician orders revealed to use the Vander-Lift with 2 people for transfers and 2 person total assist with bed mobility. Further review of the record revealed on 08/04/2024 Resident #1 weighed 256 pounds. Review of the quarterly MDS (Minimum Data Set) dated 05/10/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 9 indicating Resident #1 had moderate cognitive impairment. Further review of the MDS revealed Resident #1 had the following functional abilities: limited range of motion to bilateral upper extremities and lower extremities. Review of Resident #1's MDS revealed Resident #1 required total dependence for bed mobility with two person assist. Resident #1 was always incontinent of bowel and bladder. Review of the current plan of care revealed Resident #1 was at risk for falls. Review of the approaches in part revealed transfer using 2 person assist with Vander-Lift. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility incident report dated 08/22/2024 at approximately 12:25 p.m. revealed Resident #1 was receiving personal care by S4 CNA. During the care, Resident #1's bowels had moved and S4 CNA realized she did not have enough supplies to complete the care, so she left the room to gather more. While she was gathering supplies, she heard Resident #1 yell out and she immediately returned to the room. S4 CNA found Resident #1 beside the bed, on the floor, on her knees, between the bed and the wall. S4 CNA immediately called for assistance. S5 LPN (Licensed Practical Nurse) arrived to find Resident #1 on her knees, on the floor, with her hands on top of the mattress, complaining of pain to both of her legs. Resident #1 reported that she fell out of the bed. S5 LPN assessed the resident for injuries and noted a skin tear to her right knee. S5 LPN contacted the physician and orders were received to send to hospital for further evaluation. On 08/22/2024 at 9:35 p.m., S9 LPN received a call from the emergency room informing her that Resident #1 had fractures in bilateral legs and would be having surgery to repair them. S9 LPN immediately notified the Director of Nurses (DON) who then informed the Administrator. Review of the hospital record regarding the injuries sustained from this incident revealed Resident #1 received supracondylar fractures of the right and left femurs. Treatment received was an ORIF (open reduction internal fixation) to the right femur and closed reduction and Ex-Fix application of the left distal femur fracture on 08/22/2024. On 09/04/2024 at 11:30 a.m., an interview with S4 CNA revealed on 08/22/2024 about 12:25 p.m. she was assisting the CNAs on the hall. The CNA that normally cares for Resident #1 was on lunch break and had already put supplies in the room for Resident #1 to get a bath. S4 CNA said this was only the second time she had provided care to Resident #1. S4 CNA said she was giving Resident #1 a bath by herself and was not aware Resident #1 required a 2 person assist with bathing and transferring and failed to review the wall care plan in the resident's room that noted Resident #1 was a 2 person assist. During the bath Resident #1 had a bowel movement and she did not have enough supplies in the room. S4 CNA said she turned Resident #1 to face the wall and the resident's hands were touching the wall lowered the bed and stepped out of the room. S4 CNA said she was not sure if the bed was locked and she did not check the break on the bed before she started the bath or before leaving the room. S4 CNA said she did not even have enough time to get the towel off the cart in the hall when she heard Resident #1 hollering for help. S4 CNA said when she came back in the room Resident #1 was on her knees between the wall and the bed and Resident #1 was complaining of her right knee hurting. S4 CNA said the bed had moved away from the wall. On 09/04/2024 at 1:30 p.m., an interview with S5 LPN revealed she was at the main desk and S4 CNA came and told her that Resident #1 was on the floor. S5 LPN said she went to the room and Resident #1 was on her knees between the bed and the wall with her hands on the mattress and only complained of her right knee hurting and she noticed a skin tear to her right knee. S5 LPN said they got multiple staff, lowered Resident #1 to the floor and then used the lift to get her up off the floor. Resident #1 was sent to the hospital. S5 LPN said she was not sure if the bed was in the lock position when the accident occurred. On 09/03/2024 at 2:30 p.m., an interview with S8 CNA Assistant Supervisor confirmed there should have been 2 staff present when providing care for resident #1 and S4 CNA should not have been providing care by herself and should have checked the locks on the bed prior to exiting the room. (continued on next page)

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