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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195449 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY COMPLETED<br><br>11/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lafourche Home for Aged & Infirm |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1002 Tiger Drive<br>Thibodaux, LA 70301 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34060</p> <p>Based on interviews and record review, the facility failed to immediately notify the resident's Responsible Party (RP) after a resident sustained a fall for 1 (Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for falls.</p> <p>Findings included:</p> <p>Review of the facility's incident log dated 10/27/2024 at 12:40AM, revealed, in part, Resident #3 was found sitting on the floor next to her bed with no visible injuries noted. Further review revealed Resident #3's RP was notified on 10/27/2024 at 6:00AM.</p> <p>In an interview on 11/15/2024 at 11:26AM, Resident #3's RP indicated that the facility staff did not notify her that Resident #3 had a fall on 10/27/2024. Resident #3's RP further indicated that she was the person who was notified via telephone or in person of any changes in Resident #3's condition. Resident #3's RP further indicated that she did not know Resident #3 had a fall on 10/27/2024 until today, 11/15/2024.</p> <p>In an interview on 11/15/2024 at 11:36AM, S2Director of Nursing (DON) indicated S3Agency Licensed Practical Nurse (LPN) attempted to contact Resident #3's RP about the fall without success.</p> <p>In a telephone interview on 11/15/2024 at 11:40AM, S3Agency LPN indicated she was unable to reach Resident #3's RP to inform him/her of the fall when she attempted to call.</p> <p>In an interview on 11/15/2024 at 1:35PM, S1Administrator and S2DON indicated Resident #3's Responsible Party was not notified verbally of Resident #3's fall on 10/27/2024, and should have been.</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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