

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Lafourche Home for Aged & Infirm		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 Tiger Drive 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>22609</p> <p>Based on interviews and record reviews, the facility failed to develop a plan of care after a fall for 1 (Resident #55) of 3 (Resident #44, Resident #55, Resident #65) sampled residents investigated for falls.</p> <p>Findings:</p> <p>Review of Resident #55's Minimum Data Set with an Assessment Reference Date of 12/26/2024 revealed, in part, a Brief Interview for Mental Status assessment score of 11, which indicated moderate cognitive impairment. Further review revealed Resident #55 had recent falls.</p> <p>Review of Resident #55's Nursing Progress note dated 01/10/2025 at 2:38PM revealed, in part, a Certified Nursing Assistant (CNA) reported to the nurse that Resident #55 was found lying on the floor near Resident #55's recliner, on his back.</p> <p>Review of Resident #55's Plan of Care with a goal date of 05/12/2025 revealed, in part, Resident #55 was at risk for falls related to weakness, use of psychotropic (medications that affect mental status) medications, impaired safety awareness, cognitive impairments, lacks safety awareness and awareness of his own physical limitations, forgetful and confused at times. Further review of Resident #55's Plan of Care revealed no new intervention was developed for the fall dated 01/10/2025.</p> <p>In an interview on 02/18/2025 at 11:52AM, S4Minimum Data Set/Licensed Practical Nurse indicated Resident #55 had a fall on 01/10/2025 from his recliner. S4Minimum Data Set/Licensed Practical Nurse further indicated Resident #55's plan of care was not updated to include an intervention for his fall on 01/10/2025, and should have been.</p> <p>In an interview on 02/18/2025 at 12:15PM, S2Director of Nursing indicated Resident # 55's Plan of Care should have been updated with a fall intervention after his fall on 01/10/2025, but had not been updated as required.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51373</p> <p>Based on observation, interviews, and record reviews, the facility failed to provide adequate supervision to prevent a fall for 1 (Resident #65) of 3 (Resident #44, Resident #55, Resident #65) sampled residents reviewed for falls.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 01/17/2025 at 6:35AM, when Resident #65, who required supervision with showers/bathing and had diagnoses, which included, osteoporosis, dementia, and a traumatic brain injury, was able to enter shower room A unattended due to S3Certified Nursing Assistant (CNA) leaving the door propped opened. Resident #65 was found on the floor in shower room A after an unwitnessed fall and had sustained an injury resulting in a C7 (7th cervical vertebrae in the neck) displaced fracture. Resident #65 was required to wear a cervical collar (a device to maintain neck alignment), experienced increased neck pain, depression, decreased mobility and decreased independence as a result of the fall.</p> <p>S1Administrator (ADM) and S2Director of Nursing (DON) were notified of the Immediate Jeopardy on 03/10/2025 at 12:04PM.</p> <p>The Immediate Jeopardy was removed on 03/11/2025 at 3:39PM, after it was verified through observations, interviews, and record reviews, the provider implemented an acceptable Plan of Removal prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimal harm to the 24 current residents who were assessed by the facility to be at high risk for falls and were able to ambulate and/or self-propel themselves in a wheelchair.</p> <p>Findings:</p> <p>Review of the facility's undated Resident Bathing/Shower Policy and Procedure, revised in 11/2024, revealed, in part, the facility staff should never leave a resident unattended in the tub or the shower room.</p> <p>Review of Resident #65's medical record revealed, in part, Resident #65 was admitted to the skilled nursing facility on 03/26/2024 with a diagnoses of osteoporosis, dementia, and traumatic brain injury.</p> <p>Review of Resident #65's Annual Minimum Data Set with an Assessment Reference Date of 12/12/2024 revealed, in part, Resident #65 had a Brief Interview for Mental Status score of 12, which indicated Resident #65 had mild cognitive impairment. Further review revealed Resident #65 required staff supervision during showers/baths.</p> <p>Review of Resident #65's Fall Risk assessment dated [DATE] revealed, in part, Resident #65 had a score of 18, which indicated Resident #65 was at high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #65's progress note dated 01/17/2025, revealed, in part, on 01/17/2025 at 6:35AM, further review revealed Resident #65 was found on the floor of shower room A. Further review revealed Resident #65's right eyelid was swollen with a laceration to the right eyebrow that was actively bleeding.</p> <p>Review of the facility's Incident, Investigation, and Follow-up report dated 01/17/2025 revealed, in part, on 01/17/2025, S3CNA left shower room A unattended and unsupervised. Further review revealed Resident #65 entered the unsupervised shower room A and was found on the shower room floor.</p> <p>Review of Resident #65's hospital record dated 01/17/2025 revealed, in part, Resident #65 was diagnosed with a C7 displaced fracture. Further review revealed an order for Resident #65 to keep the cervical collar on at all times.</p> <p>Review of Resident #65's Physical Therapy Screening dated 01/20/2025 revealed, in part, Resident #65 required increased assistance with Activities of Daily Living (ADLs) following her fall on 01/17/2025 compared to before the fall.</p> <p>Review of Resident #65's electronic Medication Administration Records (eMAR) revealed, in part, Resident #65 had 11 instances of mild to moderate pain after the fall on 01/17/2025 and required administration of acetaminophen (a medication used to treat pain) 650 milligrams (mg) 2 325 mg tablets by mouth on the following dates and times:</p> <ul style="list-style-type: none"> -01/19/2025 at 9:29AM; -01/19/2025 at 3:09PM; -01/21/2025 at 1:47AM; -01/23/2025 at 11:09AM; -01/28/2025 at 5:17PM; -01/29/2025 at 4:39AM; -01/30/2025 at 5:57AM; -02/05/2025 at 7:33AM; -02/05/2025 at 7:33AM; -02/13/2025 at 8:51AM; -02/15/2025 at 5:47AM; and, -02/17/2025 at 1:57PM. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #65's eMAR revealed, in part, Resident #65 had 3 instances of severe pain after the fall on 01/17/2025 and required a Norco (an opioid medication used to treat severe pain) 7.5-325 mg tablet by mouth to be administered on the following dates and times:</p> <p>-02/09/2025 at 10:36PM for a pain scale of 5/10;</p> <p>-02/12/2025 at 5:37AM for a pain scale 5/10; and,</p> <p>-02/17/2025 at 2:58AM for a pain scale 5/10.</p> <p>Review of Resident #65's Psychiatric Progress Note dated 01/29/2025, revealed, in part, Resident #65 experienced depression related to the fall that occurred on 01/17/2025, which resulted in a C7 neck fracture requiring Resident #65 to wear a neck brace for 6 weeks.</p> <p>In an interview on 02/17/2025 at 9:30AM, Resident #65 indicated she was independent with most ADLs until she sustained a fall in the shower on 01/17/2025. Resident #65 further indicated that as a result of her C7 fracture, she had to wear a cervical collar and had not been able to ambulate as she did before the fall on 01/17/2025.</p> <p>In an interview on 02/18/2025 at 8:45AM, Resident #65 indicated she had experienced increased pain in her head and neck since the fall on 01/17/2025.</p> <p>In an interview on 02/19/2025 at 2:50PM, S6Registered Nurse (RN) MDS Coordinator indicated Resident #65 had a significant change in status due to Resident #65's increased need for assistance with ADLs and mobility following Resident #65's fall on 01/17/2025.</p> <p>In an interview on 02/19/2025 at 2:58PM, S2DON indicated the facility's practice was to ensure residents were not left unattended in the shower room.</p> <p>In an interview on 02/19/2025 at 3:16PM, S5LPN confirmed Resident #65 had multiple complaints of pain in her head and neck during the evening shift after her fall on 01/17/2025.</p> <p>In an interview on 02/19/2025 at 3:21PM, S2DON confirmed at the time of Resident #65's fall on 01/17/2025, Resident #65 was unattended in shower room A and should have been supervised with baths and showers.</p> <p>In an interview on 02/19/2025 at 3:23PM, Resident #65 indicated she did not want to be alone, participate in activities, and get up to go to the bathroom independently since the fall that occurred on 01/17/2025. Resident #65 further indicated she was afraid to ambulate out of fear of falling again. Resident #65 also indicated she felt embarrassed to wear the cervical collar.</p> <p>In an interview on 02/19/2025 at 3:41PM, S8Rehabilitation Director indicated before Resident #65's fall on 01/17/2025, Resident #65 was mobile for long distances using her wheelchair, could mobilize short distances by walking, and was able to transfer with little to no assistance. S8Rehabilitaion Director further indicated since Resident #65's fall on 01/17/2025 and her use of a cervical collar, Resident #65 required increased mobility assistance from staff and had become more rigid.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 02/13/2025, an Activity Assessment was completed for Resident #65. S7Activities Director discussed alternative options to provide meaningful social, spiritual, recreational, and leisure activities to prevent loneliness and boredom. S7Activities Director offered Resident #65 the following in-room activities: word searches, word puzzles, color by number, adult coloring sheets, reading material (books, magazines, spiritual literature), daily newspaper, music on iPods, bedside games and cards, spot the different sheets, busy booklets, 1 on 1 visits, reminiscing time and pet therapy.</p> <p>On 02/19/2025, all shower/whirlpool room doors were evaluated for proper function, no issues were identified.</p> <p>On 02/20/2025, the facility revised a Policy and Procedure on Resident Bathing/Shower as it related to shower room doors.</p> <p>On 02/24/2025 at 8:15AM, door audits were initiated by S1ADM or a designee at least 5 times per week for four weeks, monitoring for proper function and adherence to the policy and procedure, and documented on the Bathroom Door Random Audit form. Once the daily audits were completed, S2DON, S11Assistant Director of Nursing (ADON), or designee would conduct audits as needed to assure compliance.</p> <p>On 03/10/2025 at 2:00PM, an in-service was initiated by the facility leadership to ensure that all staff (all departments) were educated on the Policy and Procedure on Resident Bathing/Shower.</p> <p>In-servicing with all scheduled staff would have been educated in person and/or via telephone and witnessed by two staff members, or prior to the next scheduled shift. The in-servicing of staff would have been completed on 03/10/2025. The Policy and Procedure on Resident Bathing/Shower would have been included during the new hire orientation.</p> <p>On 03/10/2025 at 4:00PM, S12Maintenance Supervisor visually inspected all shower/whirlpool doors to assure that all doors were functioning properly. No issues were identified.</p> <p>On 03/10/2025 at 2:30PM, the Incident/Accident policy and procedure were revised to include the psychosocial aspect of residents post incident.</p> <p>On 02/10/2025 at 2:30PM, a post-incident QA initiated related to psychosocial monitoring was created, and education was provided to staff on recognizing psychosocial changes. In-services were initiated on Identifying Residents with Psychosocial Status Changes with staff. In-servicing with all scheduled staff would have been educated in person and/or via telephone or prior to the next scheduled shift. The in-services of staff would be completed on 02/11/2025. The Identifying Residents with Psychosocial Status Changes in-service of staff would have been included during the new hire orientation.</p> <p>All data and findings will be reviewed by the QAPI committee as necessary.</p> <p>The facility asserted the likelihood for serious harm to any recipient no longer existed effective 03/11/2025 at 12:30PM.</p>		