STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195464	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellington	308 Amelia Street Rayne, LA 70578

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** 47965 Based on interviews, observations, and record reviews, the facility failed to ensure a resident was free from accidents hazards during a chair to bed transfer for 1 (#1) of 4 (#1, #2, #3, and #R1) sampled residents. This deficient practice resulted in actual harm for Resident #1 on 03/25/2024 at 5:37 p.m. when S5CNA (Certified Nursing Assistant) transferred the resident from chair to bed without assistance of another person and without the use of a mechanical lifter as required by his plan of care. On 03/26/2024 at 10:30 a.m., S3ADONWC observed Resident #1's right lower leg as discolored and painful upon movement. X-ray of the resident's right lower leg, dated 03/26/2024, revealed a tibia (shin bone) fracture. On 03/29/2024 at 11:26 a.m., S9MD (Medical Doctor) observed swelling and discoloration to the resident's left lower leg and ordered an x-ray. X-ray of the resident's left lower leg, dated 03/29/2024, revealed a fracture of the distal tibial metaphysis (lower part of the shin bone). Resident #1 was on hospice services and received treatment for the fractures in the facility. The facility implemented a corrective action plan on 03/26/2024 which was prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: A review of the medical records for Resident #1 revealed he was admitted to the facility on [DATE] with diagnoses including Parkinsonism, Age-related Osteoporosis, Pain, and Paranoid Schizophrenia. The resident was on hospice care. Review of Resident #1's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 01/12/2024, revealed the following, in part: BIMS (Brief Interview for Mental Status) of 11, which indicated the resident, had moderate cognitive impairment. Bed mobility - dependent (staff does all the effort); Sit to stand - Not attempted due to medical condition or safety concerns; Chair/bed to chair transfer (ability to transfer to and from a bed to a chair or wheelchair) - dependent. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's current care plan revealed the following, in part: The resident has an ADL (activity of Daily Living) self-care performance deficit r/t (related to) End stage Parkinson's disease, impaired mobility . Osteoporosis, Osteogenesis Imperfecta. Interventions: The resident requires total assistance by two staff with the use of a mechanical lifter to move between surfaces. Review of Resident #1's nursing notes revealed the following, in part: 03/26/2024 at 10:38 a.m., S6LPN (Licensed Practical Nurse) was called to the resident's room by S3ADONWC (Assistant Director of Nursing/Wound Care Nurse). S3ADONWC stated that while performing the resident's treatments she discovered discoloration to his right lower extremity (RLE) and the resident complained of pain when moved. The resident was unable to say what happened. She notified the hospice RN (Registered nurse). Vital signs: Bp (Blood pressure)-115/58, P (Pulse) - 93, R (Respirations) - 18, T (Temperature) - 98.3. Further review revealed the resident's doctor ordered X-ray of RLE at 11:00 a.m. 04/01/2024, a late entry by S2DON (Director of Nursing) for 03/26/2024 at 2:19 p.m., revealed that she received the X-ray results of fracture to the right tibia. She notified the resident's doctor and responsible party. 03/29/2024 at 11:26 a.m., S6LPN wrote that the resident's doctor placed a splint to the RLE and ordered an X-ray for his left foot and ankle d/t (due to) swelling and discoloration . 03/29/2024 at 4:40 p.m., S2DON wrote that she received a call from the x-ray facility stating that the resident had a fracture to his left ankle. She notified the resident's doctor and responsible party. Review of Resident #1's x-ray results revealed: 03/26/2024 - X-ray of right knee, tibia and fibula revealed a non-displaced acute fracture of the proximal tibia. 03/29/2024 - X-ray of left ankle and foot revealed an acute mildly displaced fracture, distal tibial metaphysis. Review of the facility's investigative report revealed the following, in part: On 03/26/2024 at 10:19 a.m., S3ADONWC called S6LPN to Resident #1's room. S3ADONWC informed S6LPN that while she was performing the resident's treatments, she observed discoloration to his RLE and the resident complained of pain when she moved him. The resident was unable to state what happened. Video surveillance by the facility on 3/25/2024 revealed that S5CNA entered the resident's room to put him to bed at 5:37 p.m., alone and without a lifter. When questioned she S5CNA stated that she transferred the resident using a pivot method, placing one leg in between the resident's legs and lifting him up under his arms and pivoting him into his bed. She stated the resident did not complain of pain until her last round at 9:00 p.m. Based on witness statements, review of training records and a signed probation form, S5CNA understood the procedures involved for properly transferring the resident. The facility suspended S5CNA during the investigation, performed employee counseling and re-training, and she was placed on 90 days probation. S5CNA failed to secure a second person and a lifter to transfer the resident. A finding of neglect is substantiated, as this aide failed to follow the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/09/2024 at 8:16 a.m., an observation was made of Resident #1 with S3ADONWC of the resident in his room. S3ADONWC removed the resident's covers and revealed a clean soft splint to his right leg with ace wrap up to his knee. The resident has a knee high black boot splint to his left leg. The resident stated he was experiencing no pain when asked. On 04/09/2024 at 8:08 a.m., an interview was conducted with S3ADONWC who stated that she discovered the resident's first injury on 3/26/2024. S3ADONWC stated that on 3/25/2024, S4CNA and the shower aide showered the resident and used the lifter to put him back in bed. She stated she changed the resident's dressing and did not notice any bruising or swelling in his legs, and the resident did not complain of pain. S3ADONWC stated that the next day she went into the resident's room for wound care and assessment. When she pulled back the resident's covers, she noticed his right lower leg was swollen and bruised and the resident complained of pain. S3ADONWC stated she asked the resident what happened and he said, That girl hurt my leg. S3ADONWC stated that she called S6LPN to see if she knew anything and she said she did not. S3ADONWC stated she finished the resident's dressing change while S6LPN called the hospice nurse and doctor to report the findings. S3ADONWC stated his doctor ordered an x-ray which revealed a fracture. On 04/09/2024 at 8:25 a.m., an interview was conducted with S4CNA who stated that she has been working at the facility for about two years and is familiar with the resident. She stated that the resident is transferred with two people and a lifter. S4CNA stated that on 03/25/2024, she got the resident up for his shower with the lifter and assistance from the shower aide. She stated they got him back in bed then went to get S3ADONWC to do his skin assessment and dressing. S4CNA stated that the resident had no bruising or swelling on his legs and did not complain of any pain. She stated that the next day S2DON and S6LPN asked her if she had noticed any bruising, swelling, on the resident's legs when she cared for him the previous day and she told them she had not. On 04/09/2024 at 10:05 a.m., an interview was conducted with S2DON. She stated that she started the investigation into the incident immediately after it was discovered on 03/26/2024. She stated that video surveillance identified S5CNA going into the resident's room on 03/25/2024 at 5:37 p.m., with the resident in his Geri-chair. She stated S5CNA was alone and did not come out to get help or a lifter. S2DON stated S5CNA confessed to transferring the resident by herself without a lifter and assistance from other staff, and was suspended during investigations. She stated that after three days suspension she was counseled and is currently on 90 days of probation that ends in July 2024. S2DON further stated that S1AsstADM (Assistant Administrator) started a QAPI (Quality Assessment and Improvement) project. On 04/09/2024 at 10:13 a.m., an interview and review of the facility's plan of correction was conducted with S1AsstADM. S1AssitADM stated that after S2DON investigated the incident, they agreed there was a problem, and a QAPI was started on 03/26/2024. She stated that in-services began on 03/26/2024 and monitoring began the following day. S1AsstADM was asked when the plan of correction will be completed and she stated that on the last week of monitoring the committee will determine if compliance was achieved and whether they need to end or extend the monitoring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/16/24 at 09:10 a.m., a phone interview was conducted with S5CNA. She did not normally work on Resident #1's hall and in the past he was always in bed when she saw him. She was not used to seeing him in a chair. When she put him back in the bed on 03/25/2024, she did so by herself using a pivot method. She stated that she should have looked in his care plan before she transferred him. She stated when she returned to work she was in-serviced on 2 person transfers using a lift and on checking the chart for direction on what type of transfer assistance the resident required before providing caring to any resident. During the training, a demonstration was provided and she performed a return demonstration on lift transfers and checking the care plan. She stated that S2DON and S10CNASup randomly monitor transfers and they are usually the ones that watched her when she was transferring residents. On 04/16/2024 at 9:45 a.m., during an interview with S2DON, she stated that S5CNA's first day back at work was 04/06/24. She was in-serviced prior to providing care to residents and continues to be monitored for transfers and for using the care plan to determine how residents are to be transferred. She stated that S5CNA told her there was no lifter pad under the resident when she went to transfer but that when they reviewed the video footage, they could clearly see the big blue lifter pad under the resident as she brought him into the resident's room.``` Multiple staff members were interviewed regarding transfer of residents and how to find the instructions for each resident they care for. All staff members stated they were trained on hire and had yearly competency checks on using mechanical lifts. They were also knowledgeable on where to find care instructions in the kiosk for each resident. Observations were made on 04/08/2024 and 04/09/2024 of nursing staff transferring residents using mechanical lifts. No concerns noted. The facility has implemented the following actions to correct the deficient practice: 03/26/2024- Clinical/Administrative Corrective Action Plan: 1. S5CNA, who improperly transferred resident, was suspended immediately. 2. Employee Counseling on 03/28/2024 and signing of probation after suspension on 04/06/2024. 3. Staff in-serviced to follow care plan on 03/26/2024 4. Building wide in-service on following the care plan and looking at special instructions in grey area of chart on 03/26/2024. 5. Proper Transfer Use Monitoring Tool started on 03/27/2024. This will be checked 5 times each week for 2 weeks, 2 times each week for 2 weeks and 1 time a week for 1 week by administration staff. 6. Review of the monitoring 03/27/2024 through 04/11/2024 revealed it was being conducted as care planned. No issues with transfers noted. Review of a separate monitoring sheet revealed S5CNA was monitored to ensure residents were transferred according to their care plan on 04/06/2024, 04/08/2024, 04/10/2024, and 04/14/2024. Monitoring was conducted by S2DON and S10CNASup. 32512