

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER The Ellington		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 47251</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure resident's remained free from accidents for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) investigated for falls. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. night staff got resident out of bed during last rounds, and 2. the resident's wheel chair alarm was properly working. <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included, but not limited to Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety, Repeated Falls, Cognitive Communication Deficit, and Unsteadiness on Feet.</p> <p>Review of Resident #1's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/29/2024 revealed he had a BIMS (Brief Interview for Mental Status) score of 05, indicating he had severe cognitive impairment. Section GG Functional Abilities and Goals revealed he used a walker and required supervision for toilet transfer, sit to stand, chair/bed-to-chair transfer and walking 10 feet. Further review of Resident #1's MDS revealed he had a history of falls in the last 2 - 6 months.</p> <p>Review of Resident #1's care plan revealed the following focus areas and interventions:</p> <p>Increased risk for falls (initiated 05/21/2024) related to diagnosis of dementia, confusion, psychoactive drug use, unaware of safety needs, wandering and unsteady gait. Interventions included but not limited to, be sure the resident's call light is within reach (dated 05/21/2024 and revised on 06/24/2024) and encourage the resident to use it for assistance as needed (dated 05/21/2024 and revised on 06/24/2024). He was also care planned for having actual falls initiated on 06/24/2024 with revision on 07/09/2024. Interventions for the actual falls included in part, staff to redirect as needed (initiated 06/24/2024 with revision on 06/27/2024); staff to remind resident to allow them to assist with needs and encourage resident to call for assistance initiated 06/24/2024 with revision on 06/27/2024);</p> <p>(continued on next page)</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #1's care plan revealed special instructions on only the first page of the 43 page care plan that included: Wanderguard (elopement prevention bracelet), Bed mobility=Supervision, Transfers=Supervision, Toileting=Supervision, Eating=Supervision, Bed/Chair Alarm, Fall Mats x 2 (times two), and night shift to get resident up around 05:00 a.m. There were no dates next to the items listed in the special instructions. Per facility incident report reviews, night shift to get resident up around 05:00 a.m. was on initiated 07/01/2024.</p> <p>Resident #1's facility incident investigation reports revealed the following:</p> <p>07/01/2024 at 7:00 a.m., Unwitnessed Fall. Resident found on floor in his room with bed alarm sounding. Resident confused per usual. No injuries observed post incident. Post fall interventions: Continue Physical Therapy and Physical Therapy evaluation, increase supervision due to frequent falls, night shift advised to get resident out of bed on 5:00 a.m. rounds if he is awake.</p> <p>07/04/2024 at 05:05 a.m., Unwitnessed Fall. Resident found sitting on floor on floor mat next to bed with no injuries. Bed alarm was sounding. Confused per his usual. Post fall interventions: Physical Therapy evaluation and provided urinal at bedside.</p> <p>07/06/2024 at 06:00 a.m., Unwitnessed Fall. Resident found lying on floor on floor mat beside bed. Bed alarm activated. Confused per his usual. No injuries observed post incident. Post fall interventions: Physical Therapy evaluation, collect Urine Analysis, in-service night shift that resident needs to be assisted out of bed and into wheelchair on last rounds.</p> <p>07/06/2024 at 03:56 p.m., Witnessed fall. Resident fell trying to go from wheelchair to regular chair in lounge room. Confused per his usual. There were no new injuries. Post fall interventions: Physical Therapy evaluation and staff in-serviced to assist resident with all transfers due to increased weakness.</p> <p>Review of an in-service dated 07/01/2024 (with no time listed) revealed the summary of subject was to provide increased supervision and assist with all transfers for Resident #1 due to increased pain and weakness. The summary of subject for the in-service did not include to get the resident out of bed on 5:00 am rounds which was listed as an intervention in response to the fall he had on 07/01/2024 at 7:00 a.m.</p> <p>Review of an in-service dated 07/08/2024 revealed the summary of subject was that the night shift needed to get Resident #1 up into wheelchair during last rounds. The in-service occurred after the resident sustained 3 falls in his room on 07/01/2024, 7/4/2024, and on 7/06/2024 between the hours of 5:05 a.m. and 7:00 a.m. (night shift).</p> <p>On 07/10/2024 at 10:39 a.m., a phone interview was conducted with S6ACNA (Agency Certified Nursing Assistant) whom was working the morning of 07/04/2024 at 5:05 a.m. when Resident #1 had an unwitnessed fall in his room. She stated that Resident #1 was trying to go to the bathroom. She stated that she was not aware that Resident #1 was supposed to be gotten up on her last rounds of the night shift. S6ACNA stated that it had not been reported to her.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/10/2024 at 1:28 p.m., surveyor observed Resident #1 in his room lying face down on the floor next to his roommate's bed. His wheelchair was at the foot of the roommate's bed with his chair alarm attached. There was no audible sound coming from the alarm. Resident #1 was saying Help me up. Surveyor then pressed the resident's call light to summon help. S3LPN and S4LPN reported to the resident's room to assist the resident. S3LPN confirmed that the resident's alarm was not functioning and removed the resident's chair alarm.</p> <p>On 07/10/2024 at 2:31 p.m., an interview was conducted with S3LPN. She confirmed that Resident #1's wheelchair alarm did not produce a sound when he fell out of his wheelchair. She stated when she opened the alarm, there were no batteries in the chair alarm for it to sound.</p> <p>On 07/10/2024 at 2:55 p.m., a phone interview was conducted with S4LPN. She confirmed that Resident #1's chair alarm was not working when he fell .</p> <p>On 07/10/2024 at 4:16 p.m., an interview was conducted with S2ADON. A review was conducted of all incident investigations regarding Resident #1's falls. She stated an in-service had been conducted on 07/08/2024 for night shift getting Resident #1 up into his wheelchair on their last rounds because she did not believe that they were getting the resident up due to having two more falls in the early morning hours. She confirmed that Resident #1 had fell today and that his wheelchair alarm did not have any batteries.</p>		