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	11/06/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39319 Based on record review and interview, the facility failed to ensure that nursing services were provided to meet standards of quality as evidenced by failing to ensure nurses conducted a fall risk assessment after each time a resident had a fall, and accurately assessed a resident's fall risk status for 1 (#3) out of 4 (#1, #2, #3, and #4) resident's investigated for falls. Findings: Review of the facility's Fall Assessment and Prevention policy (no date) revealed in part . Purpose: To ensure the safety of the resident residing in the facility. Procedure: 1. Resident will be assessed using the Fall Risk Assessment Form upon admission, re-admission, at the time of the MDS/Care Plan review, and prn (as needed) .4. If a resident has a fall the Fall Assessment Form should be completed. 5. Attempt should be made to determine the cause of the fall document findings. Review of Resident #3's records revealed she was admitted to the facility on [DATE]. Her diagnoses included in part, Age-related Osteoporosis without current Pathological Fracture, Restless Leg Syndrome, History of Falls (02/28/2024), Lack of Coordination, Unsteadiness on Feet, Multiple Fracture of Pelvis with stable disruption of pelvis ring subsequent encounter for fracture, Other specified Disorder of Bone Density and Structure, multiple sites. Review of Resident #3's care plan revealed she had a fall on 05/10/2024, 05/13/2024, and 6/15/2024, 07/28/2024, 08/01/2024, 09/08/2024, 09/13/2024, 09/15/2024, 10/03/2024, and 10/25/2024. Review of the resident's Fall Risk Assessments revealed the facility completed an assessment on 07/03/2024, 08/20/2024 and 10/31/2024, which was at the time of the resident's quarterly Minimum Data Set/Care Plan review. Further review of Resident #3's electronic record revealed there was no fall risk assessment conducted after each of the above falls. Review of the Fall Risk Assessments completed on 07/03/2024 revealed a fall risk score of 9. Under Section A. #2., no falls in past 3 months was selected. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/2024 at 1:15 p.m., an interview and review of the facility's Fall Assessment and Prevention policy was conducted with S1DON (Director of Nursing). She stated that fall risk assessments were to be completed when a resident was admitted , readmitted and at the time of the Minimum Data Set /Care Plan review. S1DON confirmed a fall risk assessment was not conducted for Resident #3 after each fall. On 11/6/2024 at 1:51 p.m., an interview and review of Resident #3's Fall Risk assessment dated [DATE] was conducted with S1DON. She confirmed that the resident had a fall on 05/10/2024, 05/13/2024 and 6/15/2024, which was prior to the assessment on 07/03/2024. She reviewed the fall risk assessment and stated that Section A . #2 was selected, which indicated that the resident had no falls in the past 3 months prior to the assessment. She stated that the staff should have selected that the resident had 3 or more falls. She confirmed this was an inaccurate assessment of the resident's fall status.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17364 Based on record review and interview, the facility failed to ensure the residents received all care and treatment in accordance with professional standards of practice as evidenced by nurses failing to assess the resident after receiving reports of bruising, swelling, and pain to the resident's right leg for 1 (#4) out of 4 (#1, #2 #3, #4) sampled residents. Findings: Review of Resident #4's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Cerebrovascular Disease, Aphasia, and Displaced Oblique Fracture of Shaft of Right Femur (10/30/2024). Review of the resident's annual MDS (Minimum Data Set) dated 08/06/2024 revealed the resident was coded 3 for being severely impaired for cognition. The resident was coded requiring extensive assistance with 2 plus person assist for bed mobility, and coded requiring total dependence with 2 plus person assist for transfers. Review of the resident's nurse's note dated 10/23/2024 at 9:48 a.m. revealed, Resident c/o (complain of) right hip and leg pain when CNA (Certified Nursing Assistant) changing her under pad and brief this am (morning). (Medical Doctor) notified and ordered Right hip x-ray . Review of the resident's right hip x-ray report dated 10/23/2024 revealed, . Negative for fracture or lytic lesion . There was no x-ray report or order for evaluation of the resident's right leg. Review of the resident's nurse's note dated 10/30/2024 at 8:15 p.m., revealed Late entry---4pm Resident continues to c/o pain to Rt (Right) leg with no effectiveness from pain medicine. Resident also c/o hallucinating and states she feels like she is going to die. Family at bedside and request to go to ER (emergency room). MD (Medical Doctor) . notified with new order noted to send to ER to eval (evaluate) and tx (treat) . Review of the nurse's note dated 10/30/2024 at 8:23 p.m. revealed, Resident admitted to (hospital) with Rt leg Fracture. On 11/06/2024 at 11:55 a.m., an interview was conducted with S2CNA (Certified Nursing Assistant). S2CNA stated that she worked with the resident the week of 10/21/2024 to 10/25/2024. S2CNA stated that she was assisting another CNA with changing and repositioning the resident in the bed. S2CNA stated that she remembered the resident complaining of pain to the whole right side of her body. S2CNA could not recall the exact date the resident complained of pain. S2CNA stated that she did not know if the resident was complaining of pain to her right arm or right leg because the resident did not communicate verbally and could only gesture that the pain was on the right side from the arm down to her right leg. S2CNA stated the resident's complaint of pain to her right side was reported to the nurse multiple times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 12:28 p.m., an interview was conducted with S3LPN (Licensed Practical Nurse). S3LPN stated the resident was nonverbal. S3LPN stated that on 10/23/2024 the CNA reported to her the resident was complaining of pain to her right hip and leg. S3LPN was asked if she asked the resident where the pain was. S3LPN demonstrated on her body how the resident moved her hands from her right hip area down to her right leg was where her pain was. S3LPN stated that she notified the physician and the physician ordered an x-ray of the right hip. S3LPN was asked if she communicated to the physician that the resident's complaint of pain was not related to just the hip, but rather extended down the resident's right leg due to the way the resident demonstrated the location of the pain which would also require an x-ray of the resident's right leg. S3LPN stated she did not ask the physician about getting an x-ray of the right leg because she did not see any swelling to the resident's right leg. On 11/06/2024 at 2:30 p.m., a telephone interview was conducted with S4CNA. S4CNA stated that on 10/23/2024 she assisted S5CNA with changing the resident in bed. S4CNA stated the resident was complaining of pain in her right leg. S4CNA stated that it was reported to the nurse. On 11/06/2024 at 2:40 p.m., an interview was conducted with S5CNA. S5CNA stated the resident was nonverbal. S5CNA stated that on 10/23/2024 she was going to change the resident and the resident was complaining of pain. S5CNA stated the resident pointed to her right side. S5CNA stated that she went to get S4CNA to help her change the resident. S5CNA stated the resident started hollering out in pain while changing her. S5CNA stated the resident complained of pain to the right leg. S5CNA stated the resident's right leg was swollen, and she noticed a bruise to the side of the resident's right leg. S5CNA stated she reported the pain and the bruise to the nurse. S5CNA stated that she worked with the resident again on 10/24/2024. S5CNA stated the swelling to the resident's right leg had increased in size and that the bruise was larger in size from the previous day she worked with the resident. S5CNA stated that she reported the swelling and the bruise to the nurse again on 10/24/2024. Another review of the resident's nurse's notes revealed no evidence the nursing staff assessed the resident's right leg from 10/24/2024 to 10/26/2024 based on the reports of the resident's condition from the CNAs. On 11/06/2024 at 4:46 p.m., an interview and record review was conducted with S1DON (Director of Nursing). S1DON stated that reviewing internal investigations including resident #4's fracture were her responsibility. S1DON confirmed that she reviewed S5CNA's written statement from the investigation conducted regarding the resident's fractured right leg. S1DON confirmed that S5CNA documented she reported that the resident's right leg was swollen and bruised to the nurse on 10/24/2024. S1DON confirmed that there was no evidence the nurse documented an assessment of the resident's right leg in the clinical record from 10/24/2024 to 10/26/2024. S1DON stated that she did not expect her nursing staff to document daily assessments if there were no changes in the resident's status. S1DON stated that she trusted her licensed staff assessments and observations over what the CNAs report to the licensed staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 5:15 p.m., an interview was conducted with S6LPN regarding Resident #4's leg for the dates 10/24/2024-10/26/2024. S6LPN stated S5CNA did report the bruising and swelling to the resident's right leg. S6LPN stated that she went in the resident's room to assess the resident's right leg. S6LPN stated the resident did not have any new swelling and that the bruise was an old bruise. S6LPN could not recall the date of the old bruise was first identified. She confirmed that she did not document an assessment of the resident's leg in the resident's clinical record. S6LPN stated that she should have documented the assessment in the resident's clinical record. Review of the resident's medical records and assessments from September 2024 - present revealed no evidence of the resident having a bruise prior to 10/24/2024.