

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/27/2024
NAME OF PROVIDER OR SUPPLIER  Jefferson Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9919 Jefferson Hwy. Baton Rouge, LA 70809	

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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872</b></p> <p>Based on interviews and record reviews, the facility failed to ensure a resident's significant change in status was reported to the physician for 1 (#1) of 3 (#1, #2 and #3) sampled residents reviewed for notification of change.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at approximately 1:12 p.m. for Resident #1, a resident requiring mechanical lift with 2 person assistance for transfers, when S8CNA transferred the resident without another staff member's assistance. The transfer resulted in Resident #1 falling from the lift to the floor. On [DATE] from 1:48 p.m. to 1:53p.m., Resident #1 told S5CNA, S6CNA and S7CNA, I am going to die and showed symptoms of increased anxiety. None of the CNAs reported this to the nurse. Resident #1 was found unresponsive at 1:55 p.m., CPR initiated, and transferred to the hospital via emergency transportation. Resident #1 expired in the hospital at 2:24 p.m. from cardiac arrest.</p> <p>The facility implemented corrective actions, which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.</p> <p>S1ADM was notified of the Past Noncompliance Immediate Jeopardy on [DATE] at 1:30 p.m.</p> <p>Findings:</p> <p>Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Guillain-Barre Syndrome, Lack of Coordination, Contracture of Right and Left Hand, Hypertensive Heart Disease with Heart Failure, Generalized Pain, Muscle Wasting and Atrophy, Schizoaffective Disorders, Bipolar Disorder, Severe Recurrent Major Depressive Disorder with Psych Symptoms, and Generalized Anxiety Disorder. Review of Resident #1's MDS with an ARD of [DATE] revealed Resident #1 had a BIMS of 10, which indicated her cognition was moderately impaired. Further review of the MDS revealed Resident #1 had speech difficulty with communicating some words or finishing thoughts, and if prompted or given time, made herself understood.</p> <p>Review of Resident #1's current Care Plan revealed the following, in part:</p> <p>Problem: [DATE] Mood Disorder related to diagnosis of Depression, Schizophrenia, and Anxiety.</p> <p>Intervention: Assess for changes in mood status.</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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Investigation Report dated [DATE] at 1:05 a.m. revealed:</p> <p>S8CNA transferred Resident #1 by herself with the mechanical lift. Resident #1 fell from the lift and landed with her shoulders/back on the leg of the lift. S8CNA immediately called for assistance, and nurses assessed Resident #1. At that time, the only complaint Resident #1 had was she felt she had cracked some ribs. Resident #1 maintained her normal faculties and was able to appropriately, answer all questions. Approximately forty minutes later, S2DON made a round on Resident #1 and found her to be unresponsive. At that time, CPR was started and Resident #1 was taken to a local hospital for evaluation and treatment.</p> <p>Review of the facility's surveillance video footage on [DATE] at 1:30 p.m. with S1ADM and S2DON revealed the following:</p> <p>Date: [DATE]</p> <p>1:48 p.m. S6CNA entered Resident #1's room.</p> <p>1:49 p.m. S6CNA exited Resident #1's room.</p> <p>1:50 p.m. S7CNA and S5CNA entered Resident #1's room.</p> <p>1:52 p.m. S7CNA and S5CNA exited Resident #1's room.</p> <p>1:52 p.m. S5CNA re-entered Resident #1's room.</p> <p>1:53 p.m. S5CNA exited Resident #1's room.</p> <p>1:55 p.m. S2DON entered Resident #1's room and Resident #1 was found unresponsive.</p> <p>Review of the hospital's Emergency Department Provider's Notes for Resident #1 dated [DATE] at 2:31 p.m. revealed the following, in part:</p> <p>Resident #1 was a level 1 trauma activation after a fall and cardiac arrest in the field per ambulance, Resident #1 had a fall at her nursing home and was transported back to her room. Approximately 15 minutes later, she was found pulseless. Ambulance arrived and performed ACLS with 3 rounds of Epinephrine and pulseless electrical activity consistently. Resident #1 arrived with supraglottic airway in place and compressions being performed. Total time of ACLS prior to arrival 35 minutes. At that time bedside cardiac ultrasound showed no cardiac activity, patient's pupils were fixed and dilated, no spontaneous breathing noted, no pulses palpable. Time of death called on [DATE] at 2:24 p.m.</p> <p>An interview was conducted on [DATE] at 8:27 a.m. with S8CNA. She stated, on [DATE], during transfer of Resident #1 with the mechanical lift, the resident fell from the lift. S8CNA stated, after the fall, Resident #1 was agitated and anxious, but easily consoled.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on [DATE] at 9:46 a.m. with S6CNA. S6CNA stated, on [DATE] Resident #1 fell from the mechanical lift. S6CNA stated at 1:48 p.m., Resident #1 said she fell off the mechanical lift and thought her ribs were broken. The resident then stated, I think I am going to die. S6CNA stated Resident #1 was hyperventilating and seemed anxious. S6CNA stated she did not report the resident's statement or appearance to the nurse.</p> <p>An interview was conducted on [DATE] at 11:26 a.m. with S7CNA. S7CNA stated, on [DATE], Resident #1 fell from the mechanical lift. S7CNA stated at 1:50 p.m., she checked on Resident #1, and when she entered the room, Resident #1 looked panicked. S7CNA stated Resident #1 said her ribs were broken, call my sister, and I am about to die. S7CNA stated she did not report Resident #1's statement or appearance to the nurse.</p> <p>An interview was conducted on [DATE] at 2:52 p.m. with S5CNA. S5CNA stated, on [DATE], Resident #1 fell from the mechanical lift. S5CNA stated at 1:50 p.m., she checked on Resident #1, and when she entered the room, Resident #1 was nervous and fidgety and asking to call her sister. S5CNA stated she tried to calm Resident #1 down and was unsuccessful. S5CNA stated Resident #1 said, I am about to die, I am about to die. S5CNA stated at 1:52 p.m., she reentered Resident #1's room and the resident was screaming call my sister, call my sister. She stated she did not report Resident #1's statements or appearance to the nurse.</p> <p>An interview was conducted on [DATE] at 11:08 a.m. with S16RN. S16RN stated she was made aware Resident #1 fell from the mechanical lift soon after the incident happened. S16RN stated she did not receive report Resident #1 was showing signs of increased anxiety and difficult to calm or that Resident #1 was saying I am about to die. S16RN stated if a resident stated to a CNA I am about to die, she would expect the CNA to report it to the nurse immediately. She confirmed she would have assessed the resident and contacted the doctor had she known.</p> <p>An interview was conducted on [DATE] at 1:16 p.m. with S3LPN. S3LPN stated, on [DATE], Resident #1 fell from the mechanical lift. S3LPN stated when she got to Resident #1's room, the resident was on the floor. S3LPN stated Resident #1 complained of pain to her upper back at first and then her right flank area. S3LPN stated she did not receive report from nursing staff that Resident #1 had increased anxiety and was difficult to calm or that Resident #1 was saying I am about to die. S3LPN confirmed she would have contacted the doctor had she known.</p> <p>An interview was conducted on [DATE] at 11:07 a.m. with S12NP. S12NP stated Resident #1 was cognitive and able to communicate her needs. S12NP stated, on [DATE] at 1:15 p.m., she was notified Resident #1 fell from the mechanical lift and complained of back pain. S12NP said she was again contacted on [DATE] at 1:40 p.m. about Resident #1's complaint of rib pain. S12NP stated she was not notified of Resident #1's increased anxiety, hyperventilation, inability to be calmed, or the resident's statements that she thought she was going to die. She stated she received a text on [DATE] at 1:56 p.m. reporting Resident #1 was receiving CPR.</p> <p>An interview was conducted on [DATE] at 3:14 p.m. with S2DON. S2DON stated, on [DATE], she was made aware Resident #1 fell from the mechanical lift. S2DON stated she entered Resident #1's room at 1:55 p.m. and found her with eyes open, agonal breathing and a faint, thready pulse. S2DON stated Resident #1 was unresponsive. S2DON stated she started CPR. S2DON stated if a resident were to state to staff I am about to die, she would expect the staff to notify the nurse immediately. S2DON stated she started the plan of correction immediately on [DATE] after the incident with Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility implemented the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was sent out to local hospital for evaluation and treatment on [DATE].</li> <li>2. A root cause analysis and 5 Whys was completed by the Administrator/DON on [DATE] to help identify the reason for the employee non-compliance.</li> <li>3. Lift and lift pad were both checked by DON on [DATE] after the incident - no issues noted with lift and the lift pad was in good repair.</li> <li>4. S8CNA was immediately pulled from the section on [DATE]. She gave a statement and was sent home pending investigation.</li> <li>5. A list of Physician Orders were printed to determine lift status for all residents. All residents who require assistance via lifts have the potential to be affected on [DATE].</li> <li>6. All lifts were immediately taken out of service on [DATE] by DON/Maintenance until re-education and lift check-offs of present staff were completed.</li> <li>7. No staff were allowed to use a lift until after education and check-off by DON/nursing administration.</li> <li>8. The lift competency check-off created by Central Management (and a part of orientation) was used to re-educate staff beginning [DATE]. A post-test was created from the check-off, and was utilized to help ensure understanding.</li> <li>9. Throughout the evening of [DATE] and the weekend of [DATE] through [DATE], the Administrative Nursing staff came to the facility to re-educate, test, and check-off all CNA, LPN, and RN prior to using a lift to ensure compliance. Return demonstrations were observed on all above-listed staff. Hours were staggered by the Nursing Administration to ensure supervisor and training on all shifts.</li> <li>10. A new protocol by DON/nursing administration was implemented on [DATE] that all lifts must be completed with at least 3 certified/licensed/registered staff members (and 2 CNAs must have an LPN or RN present to perform a lift transfer) to ensure compliance with protocol.</li> <li>11. Effective [DATE], the hall LPNs were required to sit on the hall to do documentation to help ensure availability and accessibility during transfers if needed.</li> <li>12. All lifts and lift pads were inspected on [DATE] by mechanical lift medical supply company- no issues noted with lift operability or lift pads. One lift did have a part ordered and was taken out of commission until [DATE] to ensure maximum safety.</li> <li>13. All wall care plans were checked by MDS on [DATE] to ensure that transfer status was correct for each resident.</li> <li>14. Monitors were implemented beginning [DATE] by Nursing Administration to help ensure lifts were being done per care plan and safely. Re-educated provided as needed.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>15. An in-service staff on the reporting of changes of resident condition was begun on [DATE] in regards to a different matter, but was applicable to this plan of correction also.</p> <p>16. A multifaceted monitor on nurse's notes, treatment notes, physician orders, incident/accidents, and verbal notifications was put into place to help ensure the reporting of potential changes of resident status. This was implemented on [DATE].</p> <p>17. A QAPI monitor had been developed to ensure that lift transfers were done correctly and per care plan. This monitor was to be performed twice weekly for 6 weeks on a random sample by the DON or their designee, and then monthly thereafter until compliance was maintained.</p> <p>18. Effectiveness of the corrective actions will be discussed weekly for 6 weeks at the Quality Assurance and Performance Improvement Meeting with findings added to the QAPI minutes. Additional in-services and/or corrective actions will be implemented as needed.</p> <p>19. Date of completion [DATE].</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43133</p> <p>48872</p> <p>Based on interviews and record reviews, the facility failed to ensure an allegation of neglect resulting in serious bodily injury was reported immediately, but no later than two hours to the facility Administrator and to the State Survey Agency for 2 (#1 and #2) of 3 (#1, #2, and #3) residents sampled for allegations of neglect.</p> <p>Findings:</p> <p>IV. Reporting Requirements: Nursing facility must report to the state agency any incidents and allegations of neglect immediately, but no later than two hours after the allegation is made if the event that caused the allegation involves abuse or results bodily harm or injury.</p> <p>Review of Resident #1's Incident Report dated [DATE] revealed the following, in part:</p> <p>Date Entered: [DATE] at 3:03 p.m.</p> <p>Date Occurred: [DATE] at 1:05 p.m.</p> <p>Date Discovered: [DATE] at 1:05 p.m.</p> <p>Resident Victim: Resident #1</p> <p>Accused: S8CNA</p> <p>Accused Allegations: Neglect</p> <p>Narrative: On [DATE] at approximately 1:05 p.m., S8CNA transferred Resident #1 by herself with the mechanical lift. Resident #1 fell from the lift. Approximately forty minutes later, S2DON made a round on Resident #1 and found her to be unresponsive. At that time, CPR was started and Resident #1 was taken to local hospital for evaluation and treatment.</p> <p>An interview was conducted on [DATE] at 2:18 p.m. with S2DON. S2DON stated she was made aware of the incident with S8CNA and Resident #1 on [DATE] at 1:21p.m.</p> <p>Review of the facility's video footage revealed S1ADM entered Resident #1's room at 1:38 p.m.</p> <p>Resident #2:</p> <p>Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE].</p> <p>Review of the Resident #2's Incident report dated [DATE] revealed the following, in part:</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dated Entered: [DATE] at 11:32 a.m.</p> <p>Date Discovered: [DATE] at 4:38 p.m.</p> <p>Resident Victim: Resident #2</p> <p>Accused: S10CNA</p> <p>Accused Allegations: Neglect</p> <p>Narrative: Resident #2 had a witnessed fall from bed during care by S10CNA on [DATE] at approximately 7:30 p.m. While rolling the resident onto her side to change bedding, the resident rolled from the bed and struck her knee on the bedside table. S10CNA stated resident was then lowered to the floor. A skin tear was noted by S4LPN and dressed. After the incident, no additional pain was noted through the weekend. On [DATE], resident had bruising to leg and knee and seemed to be in some pain upon assessment. X-rays were ordered which revealed a proximal fracture to the tibia/fibula. The resident was sent out to the hospital for evaluation and treatment on [DATE] at 6:01p.m.</p> <p>An interview was conducted with S1ADM on [DATE] at 12:20 p.m. S1ADM stated he was responsible for reporting all incidents involving neglect to the state. S1ADM stated he was present in the facility at the time of Resident #1's incident and was notified immediately after her fall on [DATE] at approximately 1:05 p.m. He confirmed he reported the incident to the state on [DATE] at 3:03 p.m. He stated he was made aware of Resident #2's witnessed fall on [DATE]. He confirmed he discovered Resident #2 had a tibia/fibula fracture on [DATE]. S1ADM said he reported an allegation of neglect to the state on [DATE] at 11:32 a.m. He further confirmed allegations of neglect with serious bodily injury should be reported to the state survey agency within 2 hours.</p>

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43133</p> <p>Based on record review and interviews, the facility failed to implement a comprehensive person-centered care plan for 1 (#2) of 3 (#1, #2 and #3) residents reviewed in the sample. The facility failed to ensure Resident #2 was transferred properly using the mechanical lift with two person assistance.</p> <p>Findings:</p> <p>Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Dysphagia Following Other Cerebrovascular Incident, Hemiplegia Following Cerebral Infraction Affect Right Dominate Side, Muscle Wasting and Atrophy, Acquired Absence of Left Leg Above Knee, and Contracture Right Wrist.</p> <p>Review of Resident #2's Quarterly MDS with ARD 03/14/2024, revealed she had a BIMS of 01, which indicated she was severely cognitively impaired and required extensive assistance/two person assist with transfers.</p> <p>Review of Resident #2's Care Plan dated 02/27/2023 revealed Resident #2 required two person assist for transfers with mechanical lift.</p> <p>An interview was conducted with S4LPN on 06/20/2024 at 2:38 p.m. S4LPN stated the communication sheet posted on wall next to resident's bed indicated Resident #2 was a two person mechanical lift for transfers. S4LPN stated she was called to Resident #2's room by S9CNA. S4LPN stated Resident #2 was lying on left side of bed on floor when she entered the room. S4LPN stated she and S9CNA physically picked Resident #2 up and transferred her back into her bed. S4LPN stated the mechanical lift was not used to transfer Resident #2 her back in bed.</p> <p>An interview was conducted with S9CNA On 06/24/2024 at 11:55 a.m. S9CNA stated on 06/08/2024 she and S4LPN physically picked up Resident #2 after she had a fall from her bed and placed her back in the bed. S9CNA stated she did not lift Resident #2 with the mechanical lift.</p> <p>An interview was conducted with S10CNA on 06/24/2024 at 1:50 p.m. S10CNA stated Resident #2 was care planned as a shower per shower chair. She stated she gave her a shower on a Saturday, 06/10/2024 after resident injured her right leg. She stated she sat Resident #2 on the side of bed and physically lifted and transferred her to the shower chair. She stated she did not transfer Resident #2 with the mechanical lift.</p> <p>An interview was conducted with S2DON on 06/25/2024 at 9:09 a.m. She stated on 06/08/2024 she received a phone call from S4LPN to inform her Resident #2 had a near fall from her bed and received a skin tear to her right shin. She confirmed Resident #2 was care planned as a two person mechanical lift for transfers. She stated she would expect all mechanical lifts to be completed with two staff members. She confirmed Resident #2 was lifted with the mechanical lift on 06/08/2024 and 06/10/2024 with one person assistance. She further confirmed per Resident #2's care plan and facility's policy Resident #2 should have been transferred with two person assistance mechanical lift and was not.</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48872</p> <p>Based on record reviews and interviews, the facility failed to ensure residents, who required two person assistance with mechanical lift transfers, remained free of accident hazards for 1 (#1) of 8 (#1, #2, #3, R1, R2, R3, R4, and R5) residents reviewed for transfers.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at approximately 1:12 p.m. for Resident #1, a resident requiring mechanical lift with 2 person assistance for transfers, when S8CNA transferred the resident without another staff member's assistance. The transfer resulted in Resident #1 falling from the lift to the floor. Resident #1 was found unresponsive at 1:45 p.m., CPR initiated, and transferred to the hospital via emergency transportation. Resident #1 expired in the hospital at 2:24 p.m. from cardiac arrest.</p> <p>The facility implemented corrective actions, which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.</p> <p>S1ADM was notified of the Past Noncompliance Immediate Jeopardy on [DATE] at 1:30 p.m.</p> <p>Findings:</p> <p>Review of the facility's undated policy Hydraulic Lift revealed the following, in part:</p> <p>Policy:</p> <p>The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair. Require two or three staff members to operate and accomplish the transfer.</p> <p>Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Guillain-Barre Syndrome, Lack of Coordination, Contracture of Right and Left Hand and Muscle Wasting and Atrophy.</p> <p>Review of Resident #1's most recent MDS with an ARD of [DATE] revealed Resident #1 required two-person staff assistance for transfers.</p> <p>Review of Resident #1's current Care Plan revealed:</p> <p>Problem: Self -care ADL deficit: dependent upon staff for transfers related to Bilateral Hand Contractures and limited range of motion due to multiple muscles in bilateral lower extremities and bilateral upper extremities.</p> <p>Intervention: [DATE]- Use mechanical lift for transfers times 2 person</p> <p>Review of Resident #1's current Physician Orders revealed, in part:</p> <p>[DATE] Resident requires 2 person assist with transfers, uses a mechanical lift.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Jefferson Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  9919 Jefferson Hwy. Baton Rouge, LA 70809	
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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>Review of the facility's surveillance video footage on [DATE] at 1:30 p.m. with S1ADM and S2DON revealed the following:</p> <p>Date: [DATE]</p> <p>1:12 p.m., S8CNA transported Resident #1 via geriatric chair into her room.</p> <p>1:16 p.m., S8CNA retrieved a mechanical lift and entered Resident #1's room alone. No other staff member was seen to enter Resident #1's room with S8CNA.</p> <p>1:19 p.m., S9CNA was in the hallway by Resident #1's door and S8CNA stepped into the hallway to talk to S9CNA.</p> <p>1:21 p.m., S3LPN, S9CNA, S2DON and other nursing staff entered Resident #1's room.</p> <p>1:55 p.m., S2DON entered Resident #1's room.</p> <p>Review of the facility's Investigation Report dated [DATE] at 1:05 p.m. revealed:</p> <p>S8CNA transferred Resident #1 by herself with the mechanical lift. Resident #1 fell from the lift and landed with her shoulders/back on the leg of the lift. S8CNA immediately called for assistance, and nurses assessed Resident #1. At that time, the only complaint Resident #1 had was she felt she had cracked some ribs. Resident #1 maintained her normal faculties and was able to appropriately, answer all questions. Approximately forty minutes later, S2DON made a round on Resident #1 and found her to be unresponsive. At that time, CPR was started and Resident #1 was taken to a local hospital for evaluation and treatment.</p> <p>Review of the facility's written staff member statements revealed the following:</p> <p>Staff member: S8CNA.</p> <p>Staff Statement on the fall that occurred on [DATE]:</p> <p>After lunch when I was making my last round I went to get Resident #1 to put her in bed before I went home. When I rolled Resident #1 into the room I went to get the lift from down the hallway and didn't see anyone. When I went back to Resident #1's room, I hooked her up to the lift and lifted her up and that's when the lift bars were tilted, and Resident #1 was leaning sideways on the lift pad. I put her back into her Geri chair and tried to fix the lift pad under her correctly. When I lifted her out of her chair and pulled the lift from under it, Resident #1 said she was falling. That is when Resident #1 slid out of the side of the lift pad on the right and hit her side on the legs of the lift.</p> <p>Review of the [DATE] Nurse's Notes for Resident #1 revealed the following:</p> <p>[DATE] at 1:34 p.m.-1:15 p.m. S3LPN was called to Resident #1's room by S9CNA, and observed Resident #1 lying supine with her head on the feet on the mechanical lift and lower extremities on the floor. Resident #1 complained of pain to the sacrum, back and right flank. S12NP gave an order to send the resident to the local hospital for evaluation.</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>At 1:45 p.m. nursing staff was summoned to Resident #1's room due to Resident #1 becoming unresponsive. Nursing staff and administration begun CPR efforts. At 1:51 p.m., the ambulance arrived on scene and continued CPR. At 1:58 p.m. Resident #1 was intubated, no pulse. At 2:00 p.m. Resident #1 exited facility via ambulance for local hospital. Signed by S3LPN.</p> <p>Review of the hospital's Emergency Department Provider's Notes for Resident #1 dated [DATE] at 2:31 p.m. revealed the following, in part:</p> <p>Resident #1 was a level 1 trauma activation after a fall and cardiac arrest in the field. Per ambulance Resident #1 had a fall at her nursing home and was transported back to her room. Approximately 15 minutes later she was found pulseless. Ambulance arrived and performed ACLS with 3 rounds of Epinephrine and pulseless electrical activity consistently. Resident #1 arrived with supraglottic airway in place and compressions being performed. Total time of ACLS prior to arrival 35 minutes. At that time bedside cardiac ultrasound showed no cardiac activity, patient's pupils were fixed and dilated, no spontaneous breathing noted, no pulses palpable. Time of death called on [DATE] at 2:24 p.m.</p> <p>An interview was conducted on [DATE] at 8:27 a.m. with S8CNA. She stated on [DATE] she transported Resident #1 via geriatric chair to her room. S8CNA stated she then retrieved the mechanical lift and pushed it to Resident #1's room. S8CNA stated during transfer of Resident #1 with the mechanical lift, Resident #1 slipped out of the lift pad and fell on top of the legs of the lift hitting her right flank. She stated she did not ask for help with the mechanical lift transfer and transferred Resident #1 without assistance. S8CNA stated she knew she was supposed to use two person assistance with the lift.</p> <p>An interview was conducted on [DATE] at 11:37 a.m. with S13CNAS. She stated she required the CNA's to use two person assistance with all mechanical lift transfers. She stated S8CNA should have had another staff member to assist her with the mechanical lift transfer with Resident #1.</p> <p>An interview was conducted on [DATE] at 2:18 p.m. with S2DON. S2DON stated she was made aware of the incident with S8CNA and Resident #1 on [DATE]. She stated the facility's policy had always been two person assistance with a mechanical lift transfer. She stated she would expect all mechanical lift transfers to be completed with two staff members. She stated S8CNA was suspended and sent home immediately after the incident with Resident #1. S2DON stated she started the plan of correction immediately after the incident with Resident #1 on [DATE].</p> <p>The facility implemented the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was sent out to local hospital for evaluation and treatment on [DATE].</li> <li>2. A root cause analysis and 5 Whys was completed by the Administrator/DON on [DATE] to help identify the reason for the employee non-compliance.</li> <li>3. Lift and lift pad were both checked by DON on [DATE] after the incident - no issues noted with lift and the lift pad was in good repair.</li> <li>4. S8CNA was immediately pulled from the section on [DATE]. She gave a statement and was sent home pending investigation.</li> </ol> <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>5. A list of Physician Orders were printed to determine lift status for all residents. All residents who require assistance via lifts have the potential to be affected on [DATE].</p> <p>6. All lifts were immediately taken out of service on [DATE] by DON/Maintenance until re-education and lift check-offs of present staff were completed.</p> <p>7. No staff were allowed to use a lift until after education and check-off by DON/nursing administration.</p> <p>8. The lift competency check-off created by Central Management (and a part of orientation) was used to re-educate staff beginning [DATE]. A post-test was created from the check-off, and was utilized to help ensure understanding.</p> <p>9. Throughout the evening of [DATE] and the weekend of [DATE] through [DATE], the Administrative Nursing staff came to the facility to re-educate, test, and check-off all CNA, LPN, and RN prior to using a lift to ensure compliance. Return demonstrations were observed on all above-listed staff. Hours were staggered by the Nursing Administration to ensure supervisor and training on all shifts.</p> <p>10. A new protocol by DON/nursing administration was implemented on [DATE] that all lifts must be completed with at least 3 certified/licensed/registered staff members (and 2 CNAs must have an LPN or RN present to perform a lift transfer) to ensure compliance with protocol.</p> <p>11. Effective [DATE], the hall LPNs were required to sit on the hall to do documentation to help ensure availability and accessibility during transfers if needed.</p> <p>12. All lifts and lift pads were inspected on [DATE] by mechanical lift medical supply company- no issues noted with lift operability or lift pads. One lift did have a part ordered and was taken out of commission until [DATE] to ensure maximum safety.</p> <p>13. All wall care plans were checked by MDS on [DATE] to ensure that transfer status was correct for each resident.</p> <p>14. Monitors were implemented beginning [DATE] by Nursing Administration to help ensure lifts were being done per care plan and safely. Re-educated provided as needed.</p> <p>15. An in-service staff on the reporting of changes of resident condition was begun on [DATE] in regards to a different matter, but was applicable to this plan of correction also.</p> <p>16. A multifaceted monitor on nurse's notes, treatment notes, physician orders, incident/accidents, and verbal notifications was put into place to help ensure the reporting of potential changes of resident status. This was implemented on [DATE].</p> <p>17. A QAPI monitor had been developed to ensure that lift transfers were done correctly and per care plan. This monitor was to be performed twice weekly for 6 weeks on a random sample by the DON or their designee, and then monthly thereafter until compliance was maintained.</p> <p>(continued on next page)</p>		

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