Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195492	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Place	4385 Old Sterlington Road Monroe, LA 71203

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on record reviews, and interviews, the facility failed to ensure notifications of changes in resident conditions were made, as evidenced by the facility failing to ensure the resident's physician was notified of an incident for 1 (#1) of 3 (#1, #2, and #4) residents reviewed for notification of change. Findings: Review of the facility's Change in a Resident's Condition or Status Policy undated revealed: Policy Statement Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc). Review of the medical record for resident #1 revealed an admitted [DATE] with diagnoses including unspecified dementia with other behavioral disturbance, depression, and hypothyroidism. Review of the resident #1's medical record revealed no documentation of an Admit Minimum Data Set Assessment (MDS) due to the resident was transferred to the emergency roiagnom on [DATE]. Resident #1 was discharged from the facility on 10/26/2024 before the Admit MDS assessment could be completed. Review of resident #1's Baseline Care Plan revealed she was confused, nonverbal, and required 1 person assistance with all activities of daily living. Review of the Incident/Accident (IA) Reporting Form dated 10/26/2024 at 10:15 a.m., revealed S4Licensed Practical Nurse (LPN) was summoned to the locked unit by S3Certified Nursing Assistant (CNA). S3CNA reported that resident #1 sat on the floor and when she got up she hit the left side of her head on a chair. S4LPN found the resident sitting on buttocks with legs extended out in front of her. Resident #1 was assessed for injuries and she had a knot on the side of her head (left side per diagram). There was no bleeding or any other visible injuries. Resident #1 was moving her extremities continuously. Further review of the IA report revealed the resident's physician was notified on 10/26/2024 at 10:20 a.m. However, there was no time documented for time the physician responded. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with S3CNA on 12/04/2024 at 12:15 p.m., revealed she witnessed the above incident. She reported the object that resident #1 bumped her head on was the table in the day room in the locked unit. S4LPN documented in the above IA Report that the object was a chair, which was incorrect. A phone interview with S4LPN was conducted on 12/03/2024 at 9:35 a.m. S4LPN revealed she tried to contact the resident's physician regarding the above incident on 10/26/2024 at 10:20 a.m but the physician's phone number in the computer was not up to date. She called the phone number but it had been disconnected. S4LPN revealed she tried to look up the physician's new number on her phone but couldn't find it. S4LPN confirmed she failed to find out the physician's new number at that time and resident #1's physician was not notified of the incident on 10/26/2024 at 10:20 a.m. An interview with S2Interim Director of Nursing on 12/04/2024 at 10:00 a.m. confirmed S4LPN should have notified resident #1's physician regarding the above incident that occurred on 10/26/2024 at 10:15 a.m.