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	10/16/2024

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

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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 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** 18118 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 1) the resident's representative was notified after resident #69 had a fall, and 2) staff notified the nurse when resident #6 was found to have bruises for 2 (#6 and #69) of 2 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). Resident #69 Review of the medical record for resident #69 revealed an admitted [DATE] with diagnoses including pulmonary edema, hypertension, dementia, muscle weakness, and cerebral infarction. Review of the current Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment for daily decision making. Further review of the MDS revealed resident #69 required assistance with activities of daily living. Review of the Incident/Accident Reporting Form dated 10/14/2024 revealed resident #69 was found lying in the supine position on the floor mat. Further review of the report revealed there was no documented evidence that S4Licensed Practical Nurse (LPN) notified the family of the fall. On 10/15/2024 at 1:50 p.m., an interview with S4LPN confirmed she did not inform the family that the resident had a fall on 10/14/2024. On 10/16/2024 at 2:45 p.m., an interview with S2Assistant Director of Nursing (ADON) confirmed S4LPN should have notified the responsible party on 10/14/2024 that #69 had a fall. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32231 Resident #6 Review of the medical record revealed resident #6 was admitted to the facility on [DATE]. Further review revealed her diagnoses included in part, dementia without behavioral disturbance and a history of pressure ulcers. Review of the annual MDS assessment dated [DATE] revealed resident #6 had a BIMS score of 09. A score of 08-12 indicated resident #6 had moderately impaired cognitive skills for daily decision making. On 10/14/2024 at 2:30 p.m., an observation revealed resident #6 in her room and resting in bed. Further observation revealed the resident's feet were both pressed against the footboard of the bed. Further observation revealed resident #6 had purple colored bruising to the top of her left foot between the resident's great toe and the distal interphalangeal joints. There was further bruising observed to the outer, lateral part of the left foot. S9LPN was notified of the bruising. On 10/16/2024 at 12:00 p.m., S2ADON and S8ADON were notified of resident #6 having bruising observed to the top of her left foot. S2ADON and S8ADON performed an inspection of resident #6's skin. Observation revealed two dime sized areas of greenish-yellow bruising to the resident's outer biceps of her right arm. Further observation revealed one small area of bruising to the back of the resident's inner, lateral part of the right knee and a second area that was approximately dime sized to the back of her left leg, below the bend of the knee. During an interview with resident #6, resident #6 revealed she could not recall exactly how the bruising had occurred. Both S2ADON and S8ADON confirmed they were not aware of resident #6's bruises. They further confirmed that staff were to notify them upon discovery of any injury of unknown origin. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator were notified of the above findings.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on observations, record reviews, and interviews, the facility failed to ensure residents were free from physical restraints imposed for the purpose of discipline or convenience for 3 (#25, #52 and #70) of 3 residents reviewed for restraints. The facility failed to have documented evidence of monitoring the release of the lap trays for residents #25, #52 and #70 and failed to have physician orders for the lap trays for residents #25 and #70. Findings: Review of the facility's Use of Restraints policy and procedure, revised December 2007, revealed the following, in part: Policy Interpretation and Implementation 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which staff applied it given that resident's physical condition (i.e., side rails put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. the specific reason for the restraint (as it relates to the resident's medical condition) b. how the restraint will be used to benefit the resident's medical condition; and c. the type of restraint, and period of time for the use of the restraint. 17. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom, but the underlying problems that may be causing the symptom. 18. Care plans shall also include the measures taken to systemically reduce or eliminate the need for restraint use. Review of the facility's undated Informed Consent for Use of Physical Restraint revealed the following, in part: a staff member shall assess restrained residents every 30 minutes, for physical needs and comfort, and release the restraint for 10 minutes at least every 2 hours, changing position, toileting, and performing range of motion exercises to all extremities, as part of the resident's plan of care. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #70 Review of the medical record for resident #70 revealed an admitted [DATE] with diagnoses of edema, depression, muscle weakness, seizures, hypertension and lack of coordination. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #70 had a Brief Interview for Mental Status (BIMS) score of 2 which indicated severe cognitive impairment for daily decision making and the resident required assistance with activities of daily living (ADLs). Review of resident #70's October 2024 physician's orders revealed a physician's order dated 10/05/2024 to use a geri chair when the resident was out of the bed. Further review of the physician's orders revealed no order for the use of a lap tray. Review of the current careplan revealed resident #70 was at high risk for injury due to the resident used a geri chair with a lap tray. On 10/14/2024 at 10:00 a.m. and 2:10 p.m., observations of resident #70 revealed he was sitting in a geri chair with a lap tray. On 10/15/2024 at 9:18 a.m. and 10/16/2024 at 9:00 a.m., observations of resident #70 revealed he was sitting in a geri chair with a lap tray. Review of resident #70's Pre-Restraining assessment dated [DATE] revealed the resident had a geri chair with a lap tray to assist with trunk control. Review of the Informed Consent for Use of Physical Restraint dated 09/01/2024 for resident #70 revealed use of a geri chair with lap tray, physical restraint for trunk control. Review of the record revealed no documentation of monitoring the release of the lap tray at least every 2 hours for resident #70. On 10/16/2024 at 1:55 p.m., an interview with S2Assistant Director of Nursing (ADON) confirmed resident #70 did not have a physician's order for use of a lap tray. S2ADON confirmed resident #70 did not have any documentation of monitoring the release of the lap tray for resident #70. 32231 Resident #52 Review of the medical record revealed resident #52 was admitted to the facility on [DATE] with diagnoses including in part, dementia without behavioral disturbance and a history of falls. Review of the Significant Change in Status MDS assessment dated [DATE] revealed resident #52 had a BIMS score of 99 which indicated the resident had severe cognitive impairment with daily decision making skills. Further review revealed resident #52 was dependent upon staff for all activities of daily living. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #52's Pre-Restraining Evaluation form dated 09/18/2024 revealed an interdisciplinary team evaluation revealed a recommendation for resident #52 to have a geri chair with a lap tray to assist with poor trunk control and forward leaning. Review of the Informed Consent for Use of Physical Restraint dated 09/01/2024 for resident #52 revealed use of a geri chair with lap tray for trunk control. Review of the medical record revealed there was no documented evidence of monitoring for the release of the lap tray at least every two hours for resident #52. On 10/14/2024 at 10:22 a.m., an observation in the dayroom revealed resident #52 sitting up in a geri chair. Further observation revealed a lap tray was intact to the geri chair. Further observation revealed the resident's hand were closed and contracted. On 10/16/2024 at 11:45 a.m., an interview with S2ADON confirmed there was no documented evidence in the medical record to address monitoring for the release of resident #52's lap tray. She further confirmed resident #52 had contractures to both hands and could not remove the lap tray. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator were notified of the above findings. 43405 Resident #25 Review of the medical record for resident #25 revealed an admitted [DATE] with diagnoses including vascular dementia unspecified severity with other behavioral disturbance, cerebrovascular disease, Alzheimer's disease early onset, pseudobulbar affect, anxiety disorder, type 2 diabetes mellitus, hypotension, and major depressive disorder. Review of resident #25's October 2024 Physician's Orders revealed there was no order for the use of a geri chair or a lap tray. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 indicating severe cognitive impairment. Further review of the MDS revealed dependence on staff for all activities of daily living and no physical restraint was marked on the MDS. Observations on 10/14/2024 at 9:25 a.m. and 10/15/2024 at 12:42 p.m. revealed resident #25 was in a geri chair with lap tray in his room. Observation of resident #25 on 10/16/2024 at 11:10 a.m. revealed resident was up in a geri chair with a lap tray in the dayroom. An interview on 10/16/2024 at 8:15 a.m. with S3Certified Nursing Aid (CNA) revealed resident #25 was not able to release the lap tray on his geri chair. Review of resident #25's Pre-Restraining assessment dated [DATE] revealed resident had a geri chair for poor trunk control, but did not identify the use of a lap tray while in the geri chair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Informed Consent for Use of Physical Restraint dated 09/01/2024 for resident #25 revealed use of a geri chair with lap tray, physical restraint, purpose- poor trunk control, to be applied when out of bed. Review of the record revealed no documentation of monitoring the release of the lap tray at least every 2 hours for resident #25. An interview on 10/16/2024 at 1:55 p.m. with S2ADON confirmed resident #25 was not able to release the lap tray on his geri chair. S2ADON confirmed resident #25 did not have a physician's order for the use of a geri chair or a lap tray. S2ADON further confirmed resident #25 did not have any documentation of monitoring the release of the lap tray for resident #25.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 32231 Based on record review and interviews, the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and send a copy of the notice to a representative at the Office of the State Long-Term Care Ombudsman for 1 (#12) of 1 (#12) reviewed for hospitalization s. Findings: Review of the Emergency Transfer Logs for June 2024 and July 2024 revealed resident #12 was discharged to the hospital on the dates of 06/23/2024 and 07/17/2024. Further review revealed there was no documented evidence of the Ombudsman being notified of resident #12 being transferred to the hospital on 06/23/2024 and 07/17/2024. On 10/16/2024 at 5:12 p.m., during a telephone interview with the local Ombudsman assigned to the nursing facility, she confirmed that she had not been notified of resident #12's transfers to the hospital on the dates of 06/23/2024 and 07/17/2024. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator were notified of the above findings.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on record reviews and interview, the facility failed to assess residents using the quarterly review instrument specified by the State and approved by Centers for Medicare and Medicaid Services (CMS) not less frequently than once every 3 months for 2 (#25 and #27) of 2 residents sampled for Minimum Data Set (MDS) Assessments. Findings: Resident #25 Review of resident #25's record revealed an admitted [DATE]. Further review of the record revealed the resident's last Quarterly MDS Assessment with an Assessment Reference Date (ARD) of 06/25/2024 and no documented Quarterly MDS for resident #25. Resident #27 Review of resident #27's record revealed an admitted [DATE]. Further review of the record revealed the resident's last Quarterly MDS Assessment with ARD of 06/04/2024 and no documented Quarterly MDS for resident #27. An interview on 10/16/2024 at 7:45 a.m. with S2Assistant Director of Nursing (ADON) confirmed that the Quarterly MDS Assessments for resident #25 and resident #27 were not completed within 3 months of the previous Quarterly MDS Assessments.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 13974 Based on record review and interviews, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 (#72) of 3 (#72, 73, 74) residents selected for closed record reviews. Findings: Review of the discharge Minimum Data Set (MDS) assessment for resident #72 revealed the resident was discharged to the hospital on 09/30/2024. Review of the nurse's notes revealed resident #72 was discharged to home. On 10/16/2024 at 4:05 p.m., an interview with S2Assistant Director or Nursing confirmed the resident was discharged home. On 10/16/24 at 4:15 p.m., an interview with S6Licensed Practical Nurse confirmed the MDS incorrectly indicated resident #72 was discharged to the hospital rather than to home.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on observations, record reviews, and interviews, the facility failed to implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet the resident's needs by not having documentation of the character of urine every shift for 1 (#18) of 1 residents reviewed for urinary catheters. Findings: Review of the Catheter Care Urinary Policy and Procedure updated 01/12/2024 revealed the following in part: Documentation The following information should be recorded in the resident's medical record: 1. Date and time catheter care was given. 2. The name and title of the individual giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor. Review of resident #18's medical record revealed an admitted [DATE] with diagnoses including urinary retention, fibromyalgia, hypertension, paroxysmal atrial fibrillation, hypothyroidism, and urinary tract infection. Review of resident #18's October 2024 Physician's Orders revealed the following orders: 09/04/2024- Foley catheter care every shift, clean with soap and water every shift 3 times per day and 18 French Foley catheter, change every month on the 4th of the month and as needed for dislodgement, diagnoses urinary retention; and 09/21/2024- enhanced barrier precautions during high contact; resident care activities every shift 2 times per day. Review of resident #18's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 indicating cognitively intact. Further review of the MDS revealed resident #18 required substantial/maximal assistance with activities of daily living and had an indwelling urinary catheter. Observations on 10/14/2024 at 10:30 a.m. and 10/15/2024 at 12:45 p.m. revealed resident #18 had an indwelling urinary catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #18's careplan dated 09/05/2024 revealed urinary catheter: indwelling urine retention chronic urinary tract infection with an intervention to assess color, clarity, and character of the urine and catheter care every shift. Review of resident #18's September and October 2024 Medication Administration Record (MAR) revealed no documented evidence of staff assessing the color, clarity, and character of resident's urine. An interview on 10/15/2024 at 12:58 p.m. with S2Assistant Director of Nursing confirmed the facility failed to implement the careplan for resident #18, by failing to document the color, clarity, and character of the resident's urine every shift.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on observations, record reviews, and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 1 (#52) of 5 (#6, #28, #30, #52, and #67) residents investigated for activities of daily living. The facility failed to ensure resident #52's fingernails were kept trimmed. Findings: Review of the Care of Fingernails/Toenails Policy (Undated), included the following, in part: General Guidelines: 1. Nail care includes daily cleaning and regular trimming. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given 2. The name and title of the individual(s) who administered the nail care 3. The condition of the resident's nails and nail bed, including: a. Redness or irritation of skin of hands and feet 6. If the resident refused the treatment, the reason(s) why and the intervention taken 7. The signature and title of the person recording the data. Review of the medical record revealed resident #52 was admitted to the facility on [DATE] with diagnoses including dementia without behavioral disturbance, schizophrenia, mood affective disorder, anxiety disorder, and pseudobulbar affect. Review of the Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] revealed resident #52 had a documented brief interview for mental status score of 99 which indicated the resident had severe cognitive impairment with daily decision making skills. Further review of the MDS revealed that resident #52 had limitation in range of motion to her upper extremity and impairment on one side and she was dependent upon staff for all activities of daily living including personal hygiene. Review of the medical record revealed a section noted as Tasks: Nails cleaned daily. Further review revealed there was no documented evidence of nail care being provided for resident #52 during the look back period of 30 days. Further review of the tasks revealed there was no documented evidence of nail care that included the trimming of the resident's fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/2024 at 10:22 a.m., an observation revealed resident #52 sitting up in a geri chair, in the dayroom. Further observation revealed the resident had contractures and long and untrimmed fingernails to both hands. On 10/14/2024 at 11:00 a.m., an observation revealed S11Activity Director pushing resident #52 out of the activity room in the resident's geri chair. The resident's fingernails had been trimmed. An interview with S11Activity Director revealed she had trimmed resident #52's fingernails. She was notified of the observation on 10/14/2024 at 10:22 a.m. of the resident's nails being long and untrimmed. S11Activity Director confirmed that the resident's fingernail had needed trimming. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator were notified of the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on observations, record reviews, and interviews, the facility failed to ensure a resident with pressure ulcers recieved the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 2 (#6 and #52) of 5 (#5, #6, #18, #52, and #125) residents investigated for pressure ulcers. The facility failed to ensure that a pressure relieving device was implemented for resident #52, who currently had a new, unidentified pressure to her left heel. Findings: Resident #6 Review of the medical record revealed resident #6 was admitted to the facility on [DATE]. Further review revealed her diagnoses included in part, dementia without behavioral disturbance and a history of pressure ulcers. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #6 had a brief interview for mental status (BIMS) score of 09. A score of 08-12 indicated resident #6 had moderate cognitive impaired with daily decision making skills. On 10/14/2024 at 2:35 p.m., an observation revealed resident #6 lying in bed in her room. Further observation revealed the resident's feet were both pressed against the footboard of the bed. Resident #6 reported that her feet were hurting and that she had requested a pillow to go underneath her ankles and legs to keep her feet from touching the mattress. S12Certified Nursing Assistant (CNA) was notified of the residents' request for a pillow. While S12CNA was positioning the resident's lower extremities, an observation revealed some brownish-yellow colored areas of drainage on the bedsheet located underneath the left heel. A visual skin inspection of the left heel with S12CNA revealed an open area to the ball of resident #6's left heel. Further observation revealed the skin had separated from the heel. S12CNA left the resident's room to notify the nurse of the findings. On 10/14/2024 at approximately 2:40 p.m., S9Licensed Practical Nurse (LPN) arrived to the room. She was notified of the findings regarding the drainage and open area to resident #6's left heel. S9LPN observed the heel and revealed that resident #6 had previously had skin breakdown to her heels approximately one to two months ago, but they had since heeled. S9LPN was further notified of the residents' request for a pillow to be positioned underneath her lower extremities due to her complaints of pain. S9LPN revealed that resident #6 had previously complained of pain in her feet, but she (S9LPN) had not assessed the resident's feet at that time as the resident was already taking medication for pain. S9LPN confirmed there was no type of pressure relieving device underneath resident #6's lower extremities to help keep the resident's feet off of the bed mattress and to aide in the prevention of further skin breakdown. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator were notified of the above findings. Resident #52 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed resident #52 was admitted to the facility on [DATE] with diagnoses including in part, dementia without behavioral disturbance and a history of pressure ulcers. Review of the MDS assessment dated [DATE] revealed resident #52 had a documented BIMS score of 99 which indicated that she had severe cognitive impairment with daily decision making skills. Further review revealed resident #52 was dependent upon staff for all activities of daily living. On 10/14/2024 at 10:22 a.m., an observation revealed resident #52 sitting up in a geri chair, in the dayroom. Further observation revealed there was no type of pressure relieving device in the seat of the geri chair. On 10/16/2024 at approximately 5:30 p.m., resident #52 was observed sitting in her geri chair, in the main dining room. Observation revealed there was not any type of pressure relieving device in the seat of the geri chair. S2Assistant Director of Nursing (ADON) was present during the observation. S2ADON revealed that resident #52 currently had a Stage II facility acquired pressure ulcer to the right hip. S2ADON confirmed there was no type of pressure relieving device in the seat of the geri chair to help prevent further skin breakdown. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator were notified of the above findings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on observations, record reviews, and interviews, the facility failed to ensure that a resident with limited range of motion receives appropriate treament and services to increase range of motion and /or to prevent further decrease in range of motion for 1 (#52) of 1 residents reviewed for Position/Mobility. The facility failed to ensure hand rolls were provided for resident #52's hand contractures. Findings: Review of the medical record revealed resident #52 was admitted to the facility on [DATE] with diagnoses including dementia without behavioral disturbance, schizophrenia, mood affective disorder, anxiety disorder, and pseudobulbar affect. Review of the Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] revealed resident #52 had a documented brief interview for mental status score of 99 which indicated the resident had severe cognitive impairment with daily decision making skills. Further review of the MDS revealed that resident #52 had limitation in range of motion to her upper extremity and impairment on one side and she was dependent upon staff for all activities of daily living including personal hygiene. On 10/14/2024 at 10:22 a.m., an observation revealed resident #52 was sitting up in a geri chair in the dayroom. Further observation revealed the resident's hands were both contracted and closed. Further observation revealed the resident did not have any type of hand roll present to either hand. On 10/14/2024 at 11:00 a.m., S9Licenced Practical Nurse (LPN) was notified of the above findings. She revealed that she was not aware of the resident not having hand rolls in place. S9LPN confirmed that resident #52 was supposed to have a hand roll placed in each hand at all times. Review of the medical record revealed there was no documented evidence in the plan of care to address resident #52's hand contractures. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator were notified of the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 18118 Based on observations, record reviews and interviews, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 2 (#25 and #70) of 9 (#5, #12, #17, #25, #38, #52, #69, #70 and #175) residents reviewed for accident hazards. The facility failed to 1) complete an Incident/Accident report after residents #25 and #70 had an incident, and 2) assess resident #70 to determine if the lap tray was appropriate after he slid under the lap tray. Findings: Resident #70 Review of the medical record for resident #70 revealed an admitted [DATE] with diagnoses of edema, depression, muscle weakness, seizures, hypertension and lack of coordination. Review of the physician's orders dated 10/05/2024 for resident #70 revealed an order to use a geri chair when the resident was out of the bed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #70 had a Brief Interview for Mental Status (BIMS) score of 2 which indicated severe cognitive impairment for daily decision making and he required assistance with activities of daily living (ADLs). Review of the current careplan revealed resident #70 was at high risk for injury due to the resident uses a geri chair with a lap tray. On 10/14/2024 at 10:00 a.m. and 2:10 p.m., observations of resident #70 revealed he was sitting in a geri chair with a lap tray. On 10/15/2024 at 9:18 a.m., and on 10/16/2024 at 9:00 a.m., observations of resident #70 revealed he was sitting in a geri chair with a lap tray. Review of the nurses' notes dated 10/06/2024 at 10:04 p.m. revealed resident #70 had behaviors throughout the entire weekend. Resident #70 was yelling, screaming, cursing at staff, and undressing in the day room and in his room. The resident slides down in the geri chair under the lap tray and gets on the floor, banging on the lap tray with his fist, and bumping his knee on the tray attempting to remove the tray. Review of the record revealed no documented evidence that an Incident/Accident Reporting form was completed on 10/06/2024 when the resident was noted sliding down in the geri chair under the lap tray and getting on the floor. Further review of the record revealed no documented evidence that resident #70 was assessed for the use of a lap tray to ensure the assistive device was appropriate after the incident on 10/06/2024 when he slid under the lap tray. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/2024 at 11:50 a.m., an interview with S2Assistant Director of Nursing (ADON) revealed she was unaware that resident #70 slid under the lap tray on 10/06/2024 as stated in the nurses' notes. . On 10/16/2024 at 1:55 p.m. interview with S2ADON confirmed an Incident/Accident Report Form should have been completed for resident #70 for the incident noted in the nurses' notes dated 10/06/2024 when he slid under the lap tray. S2ADON further confirmed the resident should have been assessed for the need of the lap tray to determine if the lap tray was an appropriate assistive device. 43405 Resident #25 Review of the medical record for resident #25 revealed an admitted [DATE] with diagnoses including vascular dementia unspecified severity with other behavioral disturbance, cerebrovascular disease, Alzheimer's disease early onset, pseudobulbar affect, anxiety disorder, type 2 diabetes mellitus, hypotension, and major depressive disorder. Review of the Quarterly MDS assessment dated [DATE] revealed resident #25 had a BIMS score of 2 indicating severe cognitive impairment. Further review of the MDS revealed he was dependent on staff for all activities of daily living. Observations on 10/14/2024 at 9:25 a.m. and 10/15/2024 at 12:42 p.m. revealed resident #25 was in a geri chair with lap tray, in his room. Observation of resident #25 on 10/16/2024 at 11:10 a.m. revealed resident was up in his geri chair with a lap tray in the dayroom. Review of resident #25's nurses' notes dated 08/11/2024 at 11:28 a.m. revealed nurse was summoned to resident's room per certified nursing aide (CNA) that stated resident broke his lap tray and slid on the floor. Resident was found sitting on buttocks in front of his geri chair with legs drawn toward his chest and resident was unable to say what happened. Treatment to skin tear to left elbow and assisted back to bed. Review of the medical record revealed no incident/accident report was done for this incident on 08/11/2024. Review of resident #25's careplan dated 02/07/2022 revealed resident at risk for fall. Further review revealed the careplan was not updated with a fall on 08/11/2024. An interview on 10/16/2024 at 2:50 p.m. with S2ADON confirmed that an incident/accident report was not completed on 08/11/2024 on resident #25, and should have been completed on 08/11/2024 when resident #25 broke his lap tray and slid onto the floor.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13974 Based on interview and record review, the facility failed to ensure that a resident who required dialysis received services consistent with professional standards of practice by failing to ensure fluid restrictions were followed and implemented as ordered for 1 (#3) of 1 sampled residents who were reviewed for dialysis. Findings: Review of the medical record revealed resident #3 was admitted on [DATE]. Her diagnoses included end stage renal disease, hypertensive heart disease and unspecified psychosis. Review of the October 2024 physician orders revealed the resident received dialysis on Monday, Wednesday and Friday and had a 1000 cc fluid restriction. There was no documentation in the medical record that resident #3's fluid intake was being monitored. On 10/15/2024 at 1:55 p.m., interview with S5Certified Nurse Aid (CNA) revealed she worked in the memory care unit where resident #3 resided. S5CNA reported they did not keep a fluid intake log for resident #3. On 10/25/2024 at 2:15 p.m., interview with S2Assistant Director or Nursing (ADON) confirmed the staff were not documenting resident #3's fluid intake to ensure it stayed within the fluid restriction.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on observations, record reviews and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails prior to the installation of bed rails for 4 (#5, #12, #17, and #38) of 5 (#5, #12, #17, #38 and #52) residents reviewed for bed rails. Findings: Review of the facility's undated Physical Restraints, Side Rails policy revealed: Purpose The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. General Guidelines 3. As assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails, when used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident care plan. Resident #17 Review of the medical record for resident #17 revealed an admitted [DATE] with diagnoses including depression, hypotension, edema, hypokalemia, muscle weakness and anemia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #17's Brief Interview for Mental Status (BIMS) score was 15 which indicated intact cognition for daily decision making. Resident #17 required assistance with activities of daily living. Observations on 10/14/2024 at 11:05 a.m. and 10/15/2024 at 11:00 a.m. of resident #17's room revealed the bed rails were raised on both sides of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/2024 at 8:10 a.m., an observation of the resident revealed she was in the bed with bed rails raised on both sides of the bed. Review of the record revealed no documented evidence of an assessment for the risk of entrapment for the bed rails. On 10/16/2024 at 11:45 a.m., an interview with S2Assistant Director of Nursing (ADON) revealed the facility did not assess for the risk of entrapment for the use of bed rails for resident #17. Resident #38 Review of the medical record for resident #38 revealed an admitted [DATE] with diagnoses including diabetes mellitus, depression, history of falling, vascular dementia, pseudobulbar affect, hemiplegia following cerebral infarction, and osteoarthritis. Review of the quarterly MDS assessment dated [DATE] revealed resident #38 had a BIMS score of 12 which indicated the resident had moderate cognitive impairment for daily decision making. Resident #38 required assistance with activities of daily living. On 10/14/2024 at 2:47 p.m., 10/15/2024 at 1:35 p.m. and 10/16/2024 at 7:30 a.m., observations of resident #38's room revealed bed rails were in the raised position on both sides of the bed. Review of the care plan dated 10/28/2022 revealed resident #38 had impaired mobility related to hemiplegia. Further review of the care plan revealed the interventions were to provide assistive devices as needed for transfers/mobility and to have turning bars to assist with bed mobility. Review of the record revealed no documented evidence of an assessment for the risk of entrapment for the bed rails. On 10/16/2024 at 11:45 a.m., an interview with S2ADON revealed the facility did not assess for the risk of entrapment for the use of bed rails for resident #38. 32231 Resident #12 Review of the medical record revealed resident #12 was readmitted to the facility on [DATE] with diagnoses including in part, generalized muscle weakness, heart failure, intervertebral disc, dementia with behavioral disturbance, and repeated falls. Review of the medical record revealed a pre-restraining evaluation dated 09/01/2024. Review of the evaluation revealed the interdisciplinary team's recommendations was for resident #12 to have a turning bar to assist with turning and repositioning. Further review revealed resident #12 had a documented BIMS score of 09. A score of 08-12 revealed the resident had moderate cognitive impairment with daily decision making skills. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual MDS assessment dated [DATE] revealed resident #12 required partial to moderate assistance with rolling from left to right, sitting to lying, lying to sitting, sitting to standing, and from a chair to the bed. On 10/14/2024 at 11:22 a.m., an observation revealed resident #12 in her room and lying in bed. Further observation revealed there were two bed rails intact, one to each side of the resident's bed. The bed rails were up and in a locked position. On 10/15/2024 at 8:52 a.m., resident #12 was observed in her room and was resting in bed. Further observation revealed the bed rails remained up and in a locked position. Review of the medical record revealed there was no documented evidence of resident #12 being assessed for entrapment regarding the use of the bed rails. On 10/16/2024 at 5:00 p.m., an interview with S2ADON confirmed there was no documented evidence of resident #12 being assessed for the risk of entrapment regarding the use of the bed rails. On 10/16/2024 at approximately 5:45 p.m., S7Corporate Administrator and S1Administrator notified of the above findings. 43405 Resident #5 Review of the medical record for resident #5 revealed an admitted [DATE] with diagnoses of mononeuropathy, hypertension, type 2 diabetes mellitus without complications, pressure ulcer, and hyperlipidemia. Review of resident #5's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 6 indicating severe cognitive impairment. Further review of the MDS revealed resident required substantial/maximal assistance with activities of daily living. Observations of resident #5 on 10/14/2024 at 11:45 a.m. and 10/16/2024 at 8:22 a.m. revealed resident #5 was lying in bed with bilateral bed rails in the up position. Review of resident #5's October 2024 Physician's Orders revealed an order dated 04/12/2023 for siderails (bed rails) up while in bed to assist with bed mobility. Review of the medical record revealed no documented bed rail assessment for the risk of entrapment for resident #5. An interview on 10/16/2024 at 11:50 a.m. with S2ADON confirmed there was no documented assessment for the risk of entrapment with bed rail use for resident #5.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record review and interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to monitor edema for a resident who received a diuretic for 1 (#17) of 5 (#17, #35, #38, #52, and #68) residents reviewed for unnecessary medications. Findings: Review of the medical record for resident #17 revealed an admitted [DATE] with diagnoses including depression, hypotension, edema, hypokalemia, muscle weakness and anemia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #17's Brief Interview for Mental Status (BIMS) score was 15 which indicated intact cognition for daily decision making. Resident #17 required assistance with activities of daily living. Review of the current care plan revealed the resident had the potential for hypertension /hypotension related to medication use. The interventions were to monitor blood pressure, administer medications as ordered and obtain labs and diagnostic tests as ordered. Review of the physician's orders revealed an order dated 10/04/2024 for Lasix (diuretic) 40 milligrams, give one tablet orally every other day related to edema. Review of the record for resident #17 revealed no documented evidence of edema checks being performed. On 10/16/2024 at 11:50 a.m., an interview with S2Assistant Director of Nursing (ADON) confirmed resident #17 received Lasix and there was no documentation of edema checks performed for resident #17.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 43405 Based on observations of medication administration, record review, and interview, the facility failed to ensure that it was free from a medication error rate of 5% or greater. The facility had a 10.71% medication error rate with 3 medication errors out of 28 opportunities. Findings: Resident #43 An observation of the medication administration for resident #43 on 10/15/2024 at 8:33 a.m. with S4Licensed Practical Nurse (LPN) revealed S4LPN administered Furosemide 20 milligrams (mg) 1 tablet by mouth and administered Gabapentin 100 mg 1 capsule by mouth. Review of the October 2024 Physician's orders for resident #43 revealed the following orders: 02/13/2024 Gabapentin 300 mg capsule by mouth 2 times per day (BID) at 9:00 a.m. and 5:00 p.m; and 09/23/2024 Furosemide 40 mg tablet: take 1 tablet by mouth (40 milligrams total dose) at 8:00 a.m. every Tuesday, Thursday, Saturday, and Sunday. An interview on 10/15/2024 at 1:30 p.m. with S2Assistant Director of Nursing (ADON) confirmed that S4LPN should have administered Furosemide 40 mg by mouth and Gabapentin 300 mg by mouth to resident #43 during the morning medication pass on 10/15/2024. Resident #44 An observation of the medication administration for resident #44 on 10/15/2024 at 8:15 a.m. with S4LPN revealed S4LPN administered Fludrocortisone 0.1 mg 1 tablet by mouth. Review of the October 2024 Physician's Orders for resident #44 revealed an order dated 09/10/2024 for Fludrocortisone 0.1 mg tablet: take 2 tablets by mouth (0.2 mg total dose) at 8:00 a.m. every day. An interview on 10/15/2024 at 1:30 p.m. with S2ADON confirmed that S4LPN should have administered Fludrocortisone 0.1mg, 2 tablets by mouth to resident #44 during the morning medication pass on 10/15/2024. S2ADON further confirmed that 3 medication errors occurred on the morning medication pass and the medication error rate was greater than 5%.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on record reviews, observations, and interviews, the facility failed to implement policies and procedures for enhanced barrier precautions (EBP) for 3 (#18, #28, and #35) of 3 (#18, #28, and #35) residents reviewed for enhanced barrier precautions. Findings: Review of the Enhanced Barrier Precautions (EBP) policy and procedure dated 04/01/2024 revealed the following in part: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: -colonization with a Center for Disease Control and Prevention (CDC)- targeted Multidrug-resistant organism (MDRO) when Contact Precautions do not otherwise apply; or -wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. Indwelling medical devices examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Communication to Staff The facility will utilize postings outside the room and Point Click Care to communicate to staff if a resident requires EBP. Resident #18 Review of resident #18's record revealed an admitted [DATE] with diagnoses including urinary retention, fibromyalgia, hypertension, paroxysmal atrial fibrillation, hypothyroidism, and urinary tract infection. Review of resident #18's October 2024 Physician's Orders revealed the following orders: 09/04/2024- Foley catheter care every shift, clean with soap and water every shift 3 times per day and 18 French Foley catheter, change every month on the 4th of the month and as needed for dislodgement, diagnoses urinary retention; and 09/21/2024- enhanced barrier precautions during high contact-resident care activities every shift 2 times per day. (continued on next page)

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	10/16/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #18's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating cognitively intact. Further review of the MDS revealed the resident required substantial/maximal assistance with activities of daily living and has an indwelling urinary catheter. Observations on 10/14/2024 at 10:30 a.m. and 10/15/2024 at 12:45 p.m. revealed resident #18 had an indwelling urinary catheter and did not have an EBP sign posted on her door. An interview on 10/15/2024 at 12:58 p.m. with S2Assistant Director of Nursing (ADON) confirmed that the facility failed to post the EBP sign on resident #18's door and should have EBP due to resident #18 having a urinary catheter. Resident #28 Review of resident #28's record revealed an admitted [DATE] with diagnoses including unqualified visual loss both eyes, benign prostate hypertrophy, glaucoma, chronic kidney failure, hypertension, unspecified dementia, and alcohol abuse. Review of the Quarterly MDS assessment dated [DATE] revealed BIMS score of 14 indicating cognitively intact. Further review of the MDS revealed the resident required substantial/maximal assistance with activities of daily living and has dialysis. Review of resident #28's October 2024 Physician's Orders revealed an order dated 08/02/2024 for dialysis every Tuesday, Thursday, and Saturday. Observation on 10/14/2024 at 9:35 a.m. and 10/15/2024 at 12:58 a.m. revealed resident #28's door did not have an EBP sign posted. Interview on 10/15/2024 at 12:58 p.m. with S2ADON confirmed resident #28's door did not have an EBP sign posted and confirmed resident #28 had a dialysis access to right chest wall and required EBP while he has an indwelling medical device. 18118 Resident #35 Review of the medical record for resident #35 revealed an admitted [DATE] with diagnoses of insomnia, anxiety, dementia, enlarged prostate, hyperlipidemia, and osteoarthritis. Review of the quarterly MDS assessment dated [DATE] revealed resident #35's BIMS score was 14 which indicated intact cognition for daily decision making. Resident #35 required assistance with activities of daily living. Review of the current care plan revealed resident #35 had an indwelling catheter and to use EBP as ordered. Review of the physician's orders dated 10/03/2024 revealed EBP during high contact resident care activities every shift. (continued on next page)

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	10/16/2024

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/2024 at 8:35 a.m., 10:15 a.m., and 11:00 a.m., observations of resident #35 revealed he had an indwelling catheter and observation of the resident's door revealed the door did not have signage indicating that the resident required EBP. On 10/15/2024 at 1:10 p.m., observation of #35's door with S2ADON revealed the resident had an indwelling catheter. S2ADON confirmed the door should have signage that indicated EBP should be taken when providing high contact care to the resident.