

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  St Frances Nsg & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  417 Industrial Drive Oberlin, LA 70655	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 47004</b></p> <p>Based on record review and interview the facility failed to ensure an injury of unknown source was reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency for 1 (#1) of 4 (#1, #2, #3, and #4) sampled residents reviewed for abuse. Findings:</p> <p>Review of the facility's undated policy on 11/04/2024 at 4:00 p.m. titled Abuse Prevention and Investigation read in part . The facility has implemented abuse prevention including 7 key components which are: Employee Screening, Training, Prevention, Identification, Investigations, Protection of residents during investigations, and Response and Reporting of incidents of suspected &amp; actual abuse, according to current federal and state laws and regulations. 16. Reporting: a. All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately, but not later than 2 hours after the allegation is made if the alleged violation involves abuse, or results in serious bodily injury OR within 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury to the administrator of the facility and to other officials including the state survey agency and adult protective services in accordance with state law through established procedures. 22. The appropriate State Agency will be notified per regulations for any abuse, suspected abuse, injury of unknown origin using the State- Mandated Protocol for Reporting.</p> <p>Review of the medical record for Resident #1 revealed she was admitted to the facility on [DATE] with diagnoses that included: Osteoporosis, Magnesium Deficiency, Displaced Fracture of Shaft of Left Clavicle (06/30/2021), Muscle Wasting and Atrophy, Dietary Calcium Deficiency, Generalized Muscle Weakness, Unspecified Dementia, Major Depressive Disorder, Anxiety, and Schizoaffective Disorder.</p> <p>Review of Resident #1's Quarterly MDS with an ARD of 08/14/2024 revealed a BIMS score of 99, which indicated the resident was not able to participate in interview. The MDS revealed Resident #1 was dependent on staff for eating, oral hygiene, toileting, showering/bathing, dressing, and personal hygiene.</p> <p>Review of Resident #1's Departmental Progress Notes revealed in part .</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/23/2024 10:31 a.m. by S3 Treatment Nurse: Informed by S5 CNA that Resident had skin tear to right elbow area measuring 5 cm x 2 cm, with small amount of bleeding noted. Cleansed with normal saline, triple antibiotic ointment applied, and covered. Bruising noted to right upper arm with blue and yellow discoloration. Facial grimaces noted upon assessing. S4 NP made aware, new orders given to x-ray right arm.</p> <p>10/23/2024 2:03 p.m. by S3 Treatment Nurse: Portable x-ray obtained as ordered. Results of x-ray revealed right humerus fracture and osteopenia. S4 NP made aware of results, and ordered to send to orthopedist. Appointment scheduled for tomorrow at 9:30 a.m. RP also made aware of results and of appointment. Informed her that an investigation was on going as to what happened, she verbalized understanding.</p> <p>Interview on 11/04/2024 at 1:00 p.m. with S2 DON revealed on 10/23/2024 she was notified by S3 Treatment Nurse that Resident #1 obtained a skin tear to right upper arm with bruising. S2 DON stated S3 Treatment Nurse notified S4 NP, and S4 NP ordered an x-ray. S2 DON stated the X-ray resulted as a Right Humeral Fracture. S2 DON stated the facility began an investigation immediately due to injury of unknown origin and Resident #1 was not able to state the cause. S2 DON stated the facility ultimately could not determine how the injury occurred.</p> <p>Interview on 11/06/2024 at 3:40 p.m. with S1 Administrator revealed he was responsible for reporting incidents into the Statewide Incident Management System. S1 Administrator confirmed according to policy he should have reported the incident regarding Resident #1's injury of unknown origin, that resulted in a serious bodily injury, within 2 hours of becoming aware, but had 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> 46773</p> <p>Based on observation, interview and record review, the facility failed to ensure Resident #2, who had been assessed to be at high risk for elopement, received adequate supervision to prevent the resident from eloping from the facility, for 1 (#2) of 4 (#1, #2, #3, and #4) residents reviewed for elopement.</p> <p>Findings:</p> <p>This deficient practice resulted in an immediate jeopardy situation on 10/26/2024 at 1:55 a.m., when Resident #2, who was moderately impaired cognitively, had a history of exit seeking behaviors, had been identified as a high elopement risk, and wore a wanderguard bracelet, exited the facility through the front door without staff knowledge. The alarm sounded and S6 LPN walked outside to investigate why the alarm had sounded; however, S6 LPN did not alert facility staff to immediately perform a census check on all residents in the facility when no resident was observed outside the building. Facility staff became knowledgeable of Resident #2's elopement when a family member notified the facility at 2:13 a.m. Resident #2 had walked from the facility and through a residential area to a family members' home, which was 0.3 miles away from the facility. The family member returned Resident #2 to the facility on [DATE] at 2:18 a.m.</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>Findings:</p> <p>Review of the facility policy on 11/06/2024 with a revision date of 10/28/2024, and titled Elopement Risk-Resident, read in part .the Facility will make every attempt to provide adequate supervision to all Residents. However, even when all precautions are taken, a resident who is independently mobile may be able to leave the facility grounds without being observed by the staff.</p> <ol style="list-style-type: none"> <li>Residents are assessed upon admission and at least quarterly for potential elopement risk.</li> <li>If a resident is found to be at risk, the facility will closely monitor the resident's locations and document a visual check at least every 2 hours, in addition the resident may be provided with a security soft bracelet that will identify him or her as a resident of the facility in the event the resident becomes lost.</li> <li>The facility may maintain a locking door system whereby an at-risk resident would wear a safety device that activates a door alarm.</li> <li>At the direction of the Administrator, the facility may post, in an inconspicuous yet known to staff location, a list of residents who need to be watched closely for potential elopement. This watch list would also be available in the nurse's stations.</li> </ol> <p>Attempted Elopement</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>4. If the alarm sounds for a wanderguard system, nursing staff is to immediately check entrance where alarm is sounding. If no resident is seen, census checks are to be done immediately on all residents in the building.</p> <p>Review of the facility undated policy on 11/06/2024, titled Elopement - Missing Residents policy, read in part .</p> <p>As soon as a resident is determined to be missing, the charge nurse will immediately do the following:</p> <ol style="list-style-type: none"> <li>1. Assign all available staff to systematically search the entire premises, both inside and outside, patient rooms, bathrooms, closets, kitchen, lobby, and offices.</li> <li>2. Notify the Administrator and /or Director of Nursing.</li> <li>3. Assign staff to search around the facility a radius of one mile during the first 30 minutes. This should include a search by vehicle and on foot.</li> </ol> <p>Review of Resident #2's medical record revealed an admitted [DATE], with diagnoses that included, in part . Alzheimer's Disease, Unspecified Dementia, and Schizophrenia.</p> <p>Review of Resident #2's Admission MDS with an ARD of 08/22/2024, revealed a BIMS score of 12, indicating moderate cognitive impairment. The MDS revealed Resident #2 required no mobility devices, and was able to independently walk 150 feet.</p> <p>Review of Resident #2's 08/2024 Physician's Orders revealed in part . 08/27/2024 - Left ankle wanderguard worn at all times, with Q1 hour census checks related to elopement risk.</p> <p>Review of Resident #2's Care plan with a start date of 08/14/2024, read in part .Elopement: At risk for elopement due to a history of wandering. Interventions: Q1 hour census checks. Left ankle wanderguard at all times.</p> <p>Review of Resident #2's Risk of Elopement Evaluation dated 08/22/2024, revealed Resident #2 ambulated per self, and had a history of elopement attempts at home. Intervention included: frequent monitoring with Q1 hour visual checks, and left ankle wanderguard.</p> <p>During an interview with Resident #2 on 11/04/2024 at 9:45 a.m., she stated she remembered that she left the facility via the front door on 10/26/2024, and stated that was the first time she ever attempted to leave the facility.</p> <p>Observation of the facility's video footage on 11/06/2024 at 12:30 p.m., revealed on 10/26/2024, S6 LPN was observed sitting at the nurse's station with her head down at 1:54 a.m. At 1:55 a.m., Resident #2 was seen walking past the nurse's station, approached the front door, pushed on the door, it opened and she exited the facility. At 1:55:55 a.m., S6 LPN was seen walking to the front door of the facility after hearing the alarm sound. S6 LPN walked out the front door, looked around, reentered the facility and reset the door code. At 2:13:45 a.m., S6 LPN received a telephone call from Resident #2's family member, stating Resident #2 was at her home. At 2:18 a.m., Resident #2 was returned to the facility by her family member.</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>Interview with S6 LPN on 11/06/2024 a 9:35 a.m., revealed she worked on 10/26/2024, the night Resident #2 eloped from the facility. S6 LPN revealed she heard the alarm sound at the front door; approached the door and did not see anyone. She walked outside and looked around, did not see anyone and walked back into the facility. She reset the alarm and sat back down at the nurse's station. S6 LPN stated she received a phone call from Resident #2's granddaughter around 2:00 a.m., notifying her that Resident #2 had left the facility and walked to her home. S6 LPN stated she notified S7 LPN, S1 Administrator and S2 DON that Resident #2 had eloped from the facility. S6 LPN stated Resident #2's granddaughter returned her to the facility, and staff began a census check on all residents in the building. S6 LPN stated she did not conduct a census check on all residents once she was unable to identify why the alarm system sounded at 1:55 a.m., because she thought it was a staff member, or another resident with the door code that may have set off the alarm.</p> <p>Interview with S7 LPN on 11/06/2024 at 10:00 a.m., revealed she cared for Resident #2 on 10/26/2024 when the elopement occurred. S7 LPN revealed she last saw Resident #2 asleep in bed at 1:30 a.m., then was notified by S6 LPN that Resident #2 had left the building and was found at a family member's home nearby. S7 LPN stated all staff immediately initiated a census checks on all residents after Resident #2 returned to the facility. S7 PLN stated once Resident #2 was returned to the facility, Resident #2 was placed on 1:1 supervision, and a body audit was conducted with no issues.</p> <p>Interview with S1 Administrator on 11/06/2024 at 10:11 a.m. revealed he was notified by the facility of the elopement, and arrived at the facility around 2:30 a.m. on 10/26/2024. S1 Administrator stated he and S8 Maintenance Supervisor checked all doors, alarm systems, and wander guards in the facility. He stated they noticed there was a malfunction with the tension bar on the closure of the front door, and fixed the issues at that time.</p> <p>Interview with S2 DON on 11/06/2024 at 11:22 a.m. revealed she was notified of the elopement after the incident occurred on 10/26/2024, and notified staff to conduct a facility wide census check at that time. S2 DON confirmed that a census check should have been initiated immediately when staff were unable to identify why the alarm sounded on 10/26/2024 at 1:55 a.m., but had not been done. S2 DON revealed she initiated an in-service for all staff on 10/26/2024, that was completed on 10/29/2024 on the elopement policy and to ensure that anytime the alarm sounds with an unidentifiable cause, that a census check must be conducted for all residents.</p> <p>The facility has implemented the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> <li>1. Census check completed for all residents.</li> <li>2. Resident #2 was immediately assessed and placed on a 24 hour, 1:1 supervision after returning to the facility on [DATE] at 2:18 a.m. After the 24 hour 1:1 supervision, Resident #2 was placed on Q15 minute census check that are currently still being provided.</li> <li>3. S1 Administrator fixed the malfunction of the tension bar in the closer of the front door.</li> <li>4. Daily monitoring initiated on all exit doors, alarm systems, and wanderguards on 10/26/2024.</li> <li>5. The elopement policy was reviewed and revised on 10/28/2024. A facility wide in-serviced was initiated on 10/26/2024 and completed on 10/29/2024 for all staff, to ensure that anytime the alarm sounds with an unidentifiable cause, that a census check must be conducted for all residents.</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>6. Elopement Risk evaluation was conducted on all residents with wanderguards in the facility on 10/26/2024, and determined that 5 residents were at risk for elopement.</p> <p>7. Daily monitoring tool for high elopement risk residents was initiated on 10/26/2024.</p> <p>8. The alarm system company serviced the alarm system with no issues found</p> <p>9. QA on elopement was initiated on 10/26/2024, and is reviewed daily with morning QA meeting to discuss any new incidents or new exit seeking behaviors in residents.</p> <p>As of 10/29/2024, and once the above interventions were all implemented, the past noncompliance was considered to be corrected.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46773</p> <p>Based on interview on record review, the facility failed to administer its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for 1 (#2) of 4 (#1, #2, #3, and #4) residents reviewed for elopement. The Administration failed to have an effective system in place to respond when Resident #2, who was assessed to be at risk for elopement, eloped from the facility on 10/26/2024 at 1:55 a.m.</p> <p>The likelihood continued for the remaining 3 residents (#1, #3 and #4), who were assessed as being at risk for elopement.</p> <p>This deficient practice resulted in an immediate jeopardy situation on 10/26/2024 at 1:55 a.m., when Resident #2, who was moderately impaired cognitively, had a history of exit seeking behaviors, had been identified as a high elopement risk, and wore a wanderguard bracelet, exited the facility through the front door without staff knowledge. The alarm sounded and S6 LPN walked outside to investigate why the alarm had sounded; however, S6 LPN did not alert facility staff to immediately perform a census check on all residents in the facility when no resident was seen outside the building, because she stated she was unaware that she should have. Facility staff became knowledgeable of Resident #2's elopement when Resident #2's family member notified the facility at 2:13 a.m., that Resident #2 had walked through a residential area to her home, which was 0.3 miles away from the facility. The family member returned Resident #2 to the facility on [DATE] at 2:18 a.m.</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>Findings:</p> <p>Cross reference F689</p> <p>Review of the facility's Elopement Risk-Resident Policy (no original policy date document), on 11/06/2024, with a revision date of 10/28/2024, read in part .</p> <p>The facility will make every attempt to provide adequate supervision to all Residents. However, even when all precautions are taken, a resident who is independently mobile may be able to leave the facility grounds without being observed by the staff.</p> <ol style="list-style-type: none"> <li>Residents are assessed upon admission and at least quarterly for potential elopement risk.</li> <li>If a resident is found to be at risk, the facility will closely monitor the resident's locations and document a visual check at least every 2 hours, in addition the resident may be provided with a security soft bracelet that will identify him or her as a resident of the facility in the event the resident becomes lost.</li> <li>The facility may maintain a locking door system whereby an at-risk resident would wear a safety device that activates a door alarm.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>4. At the direction of the Administrator, the facility may post, in an inconspicuous yet known to staff location, a list of residents who need to be watched closely for potential elopement. This watch list would also be available in the nurse's stations.</p> <p>Attempted Elopement</p> <p>1. If the alarm sounds for a wanderguard system, nursing staff is to immediately check entrance where alarm is sounding. If no resident is seen, census checks are to be done immediately on all residents in the building.</p> <p>Review of the facility undated policy on 11/06/2024, titled Elopement - Missing Residents policy, read in part .</p> <p>As soon as a resident is determined to be missing, the charge nurse will immediately do the following:</p> <ol style="list-style-type: none"> <li>1. Assign all available staff to systematically search the entire premises, both inside and outside, patient rooms, bathrooms, closets, kitchen, lobby, and offices.</li> <li>2. Notify the Administrator and /or Director of Nursing.</li> <li>3. Assign staff to search around the facility a radius of one mile during the first 30 minutes. This should include a search by vehicle and on foot.</li> </ol> <p>When the resident is located, contact an ambulance if injuries are apparent, or if the resident has been exposed to extreme heat or cold weather. Otherwise, return the resident to the facility where the charge nurse will:</p> <ol style="list-style-type: none"> <li>1. Examine the resident and provide first aide or request medical attention as needed.</li> <li>2. Complete and file an incident report; and</li> <li>3. Document the incident in the resident's medical record.</li> <li>4. Documentation must be concise and reflect the actual facts as they relate to the incident including: <ol style="list-style-type: none"> <li>a. Times</li> <li>b. Persons contacted</li> <li>c. Condition of resident upon return to the facility</li> <li>d. Physician notified</li> <li>e. Physician orders</li> <li>f. Treatment indicated</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>g. Any other pertinent information</p> <p>Observation facility's video footage on 11/06/2024 at 12:30 p.m., revealed on 10/26/2024, S6 LPN was observed sitting at the nurse's station at 1:54 a.m. S6 LPN was observed sitting at the nurse's station with her head down at 1:54 a.m. At 1:55 a.m., Resident #2 was seen walking past the nurse's station, approached the front door, pushed on the door, it opened and she exited the facility. At 1:55:55 a.m., S6 LPN was seen walking to the front door of the facility after hearing the alarm sound. S6 LPN walked out the front door, looked around, reentered the facility and reset the door code. At 2:13:45 a.m., S6 LPN received a telephone call from Resident #2's family member, that Resident #2 was at her home. At 2:18 a.m., Resident #2 was returned to the facility by her family member.</p> <p>Interview with S6 LPN on 11/06/2024 a 9:35 a.m., revealed she worked on 10/26/2024, the night Resident #2 eloped from the facility. S6 LPN revealed she heard the alarm sound at the front door; approached the door and did not see anyone. She walked outside and looked around, did not see anyone and walked back into the facility. She reset the alarm and sat back down at the nurse's station. S6 LPN stated she received a phone call from Resident #2's granddaughter around 2:00 a.m., that Resident #2 left the facility and walked to her home. S6 LPN stated she notified S7 LPN, S1 Administrator and S2 DON that Resident #2 had eloped from the facility. S6 LPN stated Resident #2's granddaughter returned her to the facility, and staff began a census check on all residents in the building. S6 LPN stated she did not conduct a census check on all residents once she was unable to identify why the alarm system sounded at 1:55 a.m., because she thought it was a staff member, or another resident with the door code that may have set off the alarm.</p> <p>Interview with S1 Administrator on 11/06/2024 at 10:11 a.m. revealed he was notified by the facility of the elopement, and arrived at the facility around 2:30 a.m. on 10/26/2024. S1 Administrator stated he and S8 Maintenance Supervisor checked all doors, alarm systems, and wander guards in the facility. He stated they noticed there was a malfunction with the tension bar on the closure of the front door, and fixed the issues at that time.</p> <p>Interview with S2 DON on 11/06/2024 at 11:22 a.m. revealed she was notified of the elopement after the incident occurred on 10/26/2024, and notified staff to conduct a facility wide census check at that time. S2 DON confirmed that a census check should have been initiated immediately when staff were unable to identify why the alarm sounded on 10/26/2024 at 1:55 a.m., but had not been done. S2 DON stated the nurse should have been aware that a census check should have been done. S2 DON revealed she initiated an in-service for all staff on 10/26/2024, that was completed on 10/29/2024, on the elopement policy and to ensure that anytime the alarm sounds with an unidentifiable cause, that a census check must be conducted for all residents.</p> <p>On 11/06/2024 at 1:40 p.m., the Administrator gave the surveyors a copy of their Elopement Risk- Resident Policy (no original policy date), with the following revision: The facility is to initiate a census check on all residents in the building if the alarm sounds, and no resident is seen. The revision date was documented as 10/28/2024.</p> <p>Interview with S6 LPN on 11/06/24 1:45 p.m. revealed she was unaware that she should have done a census check on all residents after the alarms sounded, and she was unable to verify the cause. S6 LPN stated she was in-serviced on this after the incident occurred.</p> <p>The facility has implemented the following actions to correct the deficient practice:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  St Frances Nsg & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  417 Industrial Drive Oberlin, LA 70655	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. Census check completed for all residents.</li> <li>2. Resident #2 was immediately assessed and placed on a 24 hour, 1:1 supervision after returning to the facility on [DATE] at 2:18 a.m. After the 24 hour 1:1 supervision, Resident #2 was placed on Q15 minute census check that are currently still being provided.</li> <li>3. S1 Administrator fixed the malfunction of the tension bar in the closer of the front door.</li> <li>4. Daily monitoring initiated on all exit doors, alarm systems, and wander guards on 10/26/2024.</li> <li>5. The elopement policy was reviewed and revised. A facility wide in-serviced was initiated on 10/26/2024 and completed on 10/29/2024 for all staff, to ensure that anytime the alarm sounds with an unidentifiable cause, that a census check must be conducted for all residents.</li> <li>6. Elopement Risk evaluation was conducted on all residents with wanderguards in the facility on 10/26/2024, and determined that 5 residents were at risk for elopement.</li> <li>7. Daily monitoring tool for high elopement risk residents was initiated on 10/26/2024.</li> <li>8. The alarm system company serviced the alarm system with no issues found.</li> <li>9. QA on elopement was initiated on 10/26/2024, and is reviewed daily with morning QA meeting to discuss any new incidents or new exit seeking behaviors in residents.</li> </ol> <p>As of 10/29/2024 and once the above interventions were all implemented, the past noncompliance was considered to be corrected.</p>