STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195508	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francisville Nursing and Rehab, L.L.C.	15243 LA Hwy 10 Saint Francisville, LA 70775

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965 Based on interviews and record reviews, the facility failed to ensure a cognitively impaired resident received treatment and care in accordance with professional standards of practice for 1 (#2) of 3 (#1, #2, and #3) sampled residents. The facility failed to ensure: 1. S5LPN transcribed new telephone orders for Tylenol and an X-Ray for Resident #2; 2. S5LPN implemented a new telephone order for an X-Ray for Resident #2 after a fall and complaint of pain; and 3. S5LPN communicated Resident #2's change in status, fall, or new orders of Tylenol and an X-Ray to oncoming staff prior to leaving the facility at the end of her shift. This deficient practice resulted in an actual harm for Resident #2, a severely cognitively impaired resident, beginning on 04/01/2024 at 6:30 a.m. when S5LPN left the facility without communicating Resident #2's fall and new X-Ray order to any other staff. On 04/01/2024, between 10:30 a.m. and lunch time, Resident #2's CNA notified S4LPN that Resident #2 had complained of pain and required increased assistance with a transfer. S2NP assessed Resident #2, and she complained of left leg pain and would not allow S2NP to touch her leg. On 04/01/2024 around 1:41 p.m., a local imaging company was notified of S2NP's left leg and hip X-Ray order. On 04/01/2024 at 4:00 p.m., X-Ray revealed Resident #2 had a Displaced Left Femoral Neck Fracture that required surgical intervention. Due to Resident #2's impaired cognition, she did not recall the above events, but it could be determined that a reasonable person would have suffered physical harm as a result of the failed communication and delayed treatment. Findings: Review of the facility's policy with a revision dated of July 2016 and titled, Medication and Treatment Orders revealed the following, in part: Policy Interpretation and Implementation: 3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER St Francisville Nursing and Rehab, L.L.C.		STREET ADDRESS, CITY, STATE, ZIP CODE 15243 LA Hwy 10 Saint Francisville, LA 70775	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	7. Verbal Orders must be recorded immediately in the resident's chart by the person receiving the order . Review of Resident #2's Clinical Record revealed an admitted [DATE] and diagnoses, which included Unspecified Signs and Symptoms Involving Cognitive Functions and Awareness, Cognitive Communication Deficit, History of Falling, Major Depressive Disorder, and Dementia. Further review revealed a new diagnosis of a Displaced Intertrochanteric Fracture of Left Femur on 04/01/2024. Review of Resident #2's MDS with an ARD of 04/12/2024 revealed she had a BIMS summary score of 99, which indicated Resident #2 had severely impaired cognition. Review of Resident #2's Nurses' Notes dated 04/01/2024 revealed the following, in part: 04/01/2024 at 2:29 a.m. Called to Resident #2's room by her roommate. Resident #2 found on the floor in bathroom. Resident #2 complained of pain to Left Knee. Spoke with S3OCNP at about 1:50 a.m. S3OCNP advised giving Tylenol for Knee Pain and X-Ray on 04/01/2024. Signed S5LPN. Review of Resident #2's Telephone Orders dated 03/31/2024 through 04/01/2024 revealed no evidence S5LPN transcribed the orders for Tylenol or X-Ray received from S3OCNP on 04/01/2024. Review of Resident #2's Hallway 24-Hour Report Log dated 03/31/2024 revealed the following, in part: Change of Condition: Resident #2 - unwitnessed fall New orders 6:00 p.m. to 6:00 a.m.: Resident #2 - X-Ray 04/01/2024 Review of Resident #2's Electronic Physician Orders dated April 2024 revealed no evidence Tylenol or an X-Ray was ordered on 04/01/2024. Review of Resident #2's Nurses' Notes dated 04/01/2024 revealed the following, in part: 4/01/2024 at 6:00 p.m. Late entry 04/01/2024 at 2:00 p.m. Resident #2 sitting in lobby in wheelchair. Resident #2 has complaints of pain to leg to staff. S2NP making rounds and assessed resident. S2NP with orders for X-Ray of Left Hip and Left Leg. Resident propelling self in wheelchair. Resident given Tylenol 650 mg for pain. Signed S4LPN. Review of Resident #2's Telephone Orders dated 04/01/2024 revealed the following: (04/01/2024) X-Ray of Left Leg and Left Hip Signed by S4LPN and S2NP. Review of Resident #2's Physician Progress Note dated 04/01/2024 revealed the following, in part: Assessment/Plan: 1. Left Hip Pain (Primary) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Overview: will obtain X-Ray at this time Review of Resident #2's Nurses' Notes dated 04/01/2024 revealed the following, in part: 04/01/2024 at 6:08 p.m. At 4:00 p.m., a local imaging company arrived for X-Rays. Signed S4LPN. Review of Resident #2's Left Hip and Femur X-Ray results dated 04/01/2024 revealed the following, in part: Significant Findings: Displaced Left Femoral Neck Fracture Review of Resident #2's Nurses' Notes dated 04/01/2024 revealed the following, in part: 04/01/2024 at 11:30 p.m. Resident sent to a local emergency room . X-ray results showed Left Femoral Neck Displaced Fracture. An interview was conducted with Resident #2 on 05/06/2024 at 9:10 a.m. Due to Resident #2's impaired cognition, she was unable to recall having a fall, fracture, and/or surgery. A telephone interview was conducted with S5LPN on 05/06/2024 at 11:25 a.m. She confirmed she was assigned to Resident #2 on the early morning of 04/01/2024 when Resident #2 had a fall. S5LPN stated Resident #2's roommate notified her around 1:50 a.m. that Resident #2 was on the floor in the bathroom. She stated Resident #2 complained of left knee pain prior to her getting off the floor. S5LPN stated she notified the on-call nurse practitioner who gave her orders to administer Tylenol and obtain X-Rays in the morning. She stated she did not notify the X-Ray Company of Resident #2's order for an X-Ray. S5LPN stated she documented Resident #2's fall and X-Ray order in the 24-hour report book. She stated she left the facility around 6:30 a.m. that morning, and her relief was not present in the facility to verbally communicate report. S5LPN stated she did not notify any facility oncoming staff of Resident #2's fall, new order for Tylenol, and/or the order for an X-Ray. She stated she administered Tylenol, but did not transcribe the verbal order. She stated she did not transcribe or implement the new order for the X-Ray. An interview was conducted with S6CNA on 05/06/2024 at 1:15 p.m. She confirmed she was assigned to Resident #2 on 04/01/2024 from 6:00 a.m. to 6:00 p.m. She stated she was not aware Resident #2 had a fall on the night shift. She stated she was unable to recall the exact timeline of events, but Resident #2 complained of pain intermittently on 04/01/2024. She stated Resident #2 needed more assistance than normal during a transfer and complained of pain to her leg. She stated she notified S4LPN of Resident #2's change in condition and complaint of pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with S4LPN on 05/06/2024 at 11:49 a.m. She confirmed she was assigned to Resident #2 on 04/01/2024 from 6:00 a.m. to 6:00 p.m. S4LPN stated she arrived late to the facility on [DATE] around 7:00 a.m., and S5LPN had already left. S4LPN stated, between BINGO and lunch time, Resident #2's CNA notified her Resident #2 complained of pain and required increased assistance with a transfer. She stated at that point, she read Resident #2's Nurses' Notes and determined Resident #2 had a fall. S4LPN stated she then notified S2NP of Resident #2's change in condition and complaints of pain. S4LPN reviewed Resident #2's Hallway 24-hour report log dated 03/31/2024 and confirmed under new orders for 6:00 p.m. to 6:00 a.m. shift, Resident #2 had a new order for an X-Ray on 04/01/2024. She confirmed the 24-hour report log revealed Resident #2 had an unwitnessed fall. S4LPN confirmed she should have been aware of Resident #2's fall, complaint of pain, and X-Ray order at the beginning of her shift. She stated if she had been aware of Resident #2's change in condition and X-Ray order at the beginning of her shift, she would have immediately assessed Resident #2 and ordered the X-Ray. She stated S5LPN should have notified the X-Ray company when she received Resident #2's X-Ray order. S4LPN explained the nurse who received the X-Ray order was responsible to notify the X-Ray company of the order. She stated she notified a local imaging company of Resident #2's Left Hip and Leg X-Ray order around 2:00 p.m. on 04/01/2024. S4LPN stated the x-ray was performed around 4:00 p.m. A telephone interview was conducted with S3OCNP on 05/06/2024 at 2:26 p.m. She stated she was unable to recall the specified date, time, and scenario regarding Resident #2. She stated if after Resident #2's fall, she complained of pain to her left knee, she would have told the nurse to administer Tylenol and obtain an X-Ray. She stated the expectation would be for the nursing home to notify the X-Ray company first thing the next morning, which was 7:00 a.m. She stated a 2:00 p.m. notification the next day would not have been incredibly sufficient. An interview was conducted with S2NP on 05/06/2024 at 12:22 p.m. She stated, on 04/01/2024 around lunch time, S4LPN reported to her Resident #2 had a fall and was complaining of pain to her left leg. She stated she assessed Resident #2 at that time. She stated Resident #2 was seated in the dining room in her wheelchair. She stated when she attempted to perform range of motion to Resident #2's left leg, Resident #2 would not allow her to touch the leg, and Resident #2 complained of pain. She stated, at that time, she ordered an x-ray of the left hip and leg. She stated she was unaware the on-call Nurse Practitioner ordered x-rays. She stated if the x-rays were ordered overnight, the x-ray company should have been notified at that time. An interview was conducted with a representative from a local imaging company used by the facility on 05/06/2024 at 3:08 p.m. She stated the facility contacted the imaging company on 04/01/2024 at 1:17 p.m. for an x-ray for Resident #2. She stated the imaging company received X-Ray orders 24/7. (continued on next page)

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	195508	A. Building B. Wing	05/07/2024

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with S1DON on 05/07/2024 at 9:33 a.m. She stated residents' change in condition and any new orders should be communicated from shift to shift. S1DON stated there was a 24-hour communication tool at each nurses' station, and there should be a shift to shift verbal report given at the beginning and end of each shift. She stated, ideally, if the day nurse was running late, she would expect the night nurse to give the keys to another day shift nurse and give report so it could be communicated to the oncoming nurse once they arrived. S1DON stated she expected each nurse to review the 24-hour report communication tool at the beginning of their shift. She confirmed Resident #2's fall and X-Ray order was placed on the 24-hour report communication tool. She stated S5LPN should have notified the X-Ray company of Resident #2's X-Ray order when the order was received. S1DON reviewed Resident #2's Physician Orders and Telephone Orders and confirmed the orders S5LPN received for Tylenol and an X-Ray for Resident #2 from S3OCNP were not transcribed and should have been.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965 Based on interviews and record review, the facility failed to ensure a resident's medical record was maintained accurately and systematically in accordance with accepted professional standards and practices by failing to transcribe and document administration of Tylenol on the MAR for 1 (#2) of 3 (#1, #2, and #3) sampled residents. Findings: Review of Resident #2's Clinical Record revealed an admitted [DATE] and diagnoses, which included Unspecified Signs and Symptoms Involving Cognitive Functions and Awareness, Displaced Intertrochanteric Fracture of Left Femur, Cognitive Communication Deficit, History of Falling, and Dementia. Review of Resident #2's MDS with an ARD of 04/12/2024 revealed she had a BIMS summary score of 99, which indicated the interview was unsuccessful and Resident #2 had severely impaired cognition. Review of Resident #2's Nurses' Notes dated 04/01/2024 revealed the following, in part: 04/01/2024 at 2:29 a.m. Called to Resident #2's room by her roommate. Resident #2 found on the floor in bathroom. Resident #2 complained of pain to Left Knee. Spoke with S3OCNP at about 1:50 a.m. S3OCNP advised giving Tylenol for Knee Pain and X-Ray on 04/01/2024. Signed S5LPN. 04/01/2024 at 6:00 p.m. Late entry 04/01/2024 at 2:00 p.m. Resident #2 sitting in lobby in wheelchair. Resident #2 has complaints of pain to leg to staff. S2NP making rounds and assessed resident. S2NP with orders for X-Ray of Left Hip and Left Leg. Resident propelling self in wheelchair. Resident given Tylenol 650 mg for pain, effective. Signed S4LPN. Review of Resident #2's Physician Orders revealed no evidence an order for Tylenol was transcribed into her Electronic Medical Record. Review of Resident #2's MAR dated April 2024 revealed no evidence Resident #2 received Tylenol on 04/01/2024. A telephone interview was conducted with S5LPN on 05/06/2024 at 11:25 a.m. She confirmed she was assigned to Resident #2 on the early morning of 04/01/2024 when Resident #2 had a fall. S5LPN confirmed she received an order and administered Tylenol to Resident #2 around 2:00 a.m. on 04/01/2024. An interview was conducted with S4LPN on 05/06/2024 at 11:49 a.m. She confirmed she was assigned to Resident #2 on 04/01/2024 from 6:00 a.m. to 6:00 p.m. S4LPN stated, between BINGO and lunch, Resident #2's CNA notified her Resident #2 complained of pain. She stated she administered Tylenol to Resident #2. S4LPN stated she thought she documented the administration of Tylenol on Resident #2's MAR. She stated if the Tylenol administration was not on the MAR, then she did not document it, and should have. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with S1DON on 05/07/2024 at 9:33 a.m. She reviewed Resident #2's Physician Orders and MAR dated April 2024 and confirmed there was no documented evidence Resident #2's order was transcribed into her Electronic Medical Record. S1DON confirmed there was no documented evidence Resident #2 received Tylenol on 04/01/2024. S1DON stated Physician Orders should be transcribed into the resident's electronic record and administration of medications should be documented on the resident's MAR.