

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Claiborne Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  6942 Highway 79 Homer, LA 71040	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30115</p> <p>Based on observations, record reviews, and interviews the facility failed to ensure a resident has a right to be free from any physical restraint not required to treat the resident's medical symptoms for 1 (#37) resident out of 2 (#37 and #90) residents investigated for physical restraints. The facility failed to ensure 1.) A written order was in place 2.) A consent for the use of a lap tray was obtained, 3.) A specific reason for the restraint and 4.) An assessment was completed for the use of a lap tray for Resident #37.</p> <p>Findings:</p> <p>Review of the facility's Use of Restraints policy with a revision date of 01/12/2024 revealed in part:</p> <p>Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.</p> <p>Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Physical Restraints are defined as any manual method of physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.</p> <p>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 the staff applied it given that resident's physical condition (for example, side rails are 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.</p> <p>3. Examples of devices that are/may be considered physical restraints include . geri-chairs, lap cushions and trays that the resident cannot remove.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Prior to placing a resident in restraints, there shall be a Restraint Necessity/Positioning Device Assessment Form and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions.</p> <p>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:</p> <ul style="list-style-type: none"> <li>a. The specific reason for the restraint (as related to the resident's medical symptom);</li> <li>b. How the restraint will be used to benefit the resident's medical symptom; and</li> <li>c. The type of restraint, and period of time for the use of the restraint .</li> </ul> <p>Review of Resident #37's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, unspecified dementia, schizoaffective disorders, restlessness and agitation.</p> <p>Review of Resident #37's Quarterly MDS (Minimum Data Sets) dated 07/05/2024 revealed in part, a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Resident #37 was totally dependent on staff for bed mobility, transfers, eating, and toileting.</p> <p>Review of Resident #37's Comprehensive Care Plan dated 05/03/2024 revealed Resident #37 was at risk for falls characterized by, in part, a history of fall/injury, and multiple risk factors related to impaired balance.</p> <p>Review of Resident #37's physician's orders failed to reveal an order for the use of a lap tray.</p> <p>Review of Resident #37's medical record failed to reveal an assessment had been completed for the use of a lap tray.</p> <p>Review of Resident #37's nurses' notes revealed in part:</p> <p>07/16/2024 at 11:30 a.m. - Staff reported Resident #37 was attempting to get out of the geri-chair. Resident #37 was placed at the nurse's station in view of the staff.</p> <p>08/21/2024 at 12:10 p.m. - Resident #37 was actively attempting to get out of the geri-chair, Resident #37 was resistive to staff.</p> <p>An observation on 09/03/2024 at 1:19 p.m. revealed Resident #37 was up in a geri-chair with a lap tray secured to the chair.</p> <p>An observation on 09/03/2024 at 1:23 p.m. revealed Resident #37 was sitting up in a geri-chair hitting and banging on the lap tray with his fist, grabbing the sides and shaking the lap tray. Resident #37 was not observed to have removed the lap tray.</p> <p>An observation on 09/03/2024 at 2:40 p.m. revealed Resident #37 remained sitting up in a geri-chair with a lap tray secured in place.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 09/03/2024 at 3:31 p.m. revealed Resident #37 sitting up in a geri-chair with lap tray secured in place.</p> <p>During an interview on 09/04/2024 at 3:10 p.m. S3 CNA (Certified Nursing Assistant) reported Resident #37's lap tray was used during meals but sometimes it was left on longer.</p> <p>During an interview on 09/04/2024 at 1:55 p.m. Resident #37's RP (Responsible Party) was in the room and reported she liked the lap tray on the chair when he was sitting up because he has tried to get up. Resident #37's RP further reported Resident #37 would fall if he got up.</p> <p>During an interview on 09/05/2024 at 3:30 p.m. S2 DON (Director of Nursing) acknowledged Resident #37 used a lap tray and there was not an order, a care plan or an assessment for the use of a lap tray. S2 DON, acknowledged if the lap tray was in use and the resident cannot remove it, it was considered a restraint.</p> <p>During an interview on 09/05/2024 at 3:45 p.m. S1 Corporate Nurse confirmed a lap tray was considered a restraint if the resident could not remove it.</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39897</p> <p>Based on record reviews and interviews the facility failed to ensure residents' medical records reflected the resident's advance directive wishes for 1 (#6) of 19 (#1, #6, #7, #9, #10, #17, #18, #24, #27, #28, #29, #32, #36, #37, #38, #39, #90, #92, #240) total sampled residents. The facility failed to ensure the profile page, physician's orders, medication administration records, comprehensive care plan and LaPost (Louisiana Physician Orders for Scope of Treatment) were consistent with the resident's wishes for advance directives.</p> <p>Findings:</p> <p>Review of Resident #6's medical record revealed an admitted [DATE] and Resident #6's profile page indicated Resident #6's code status to be Full Code: May use AED (automated external defibrillator) unless contraindicated.</p> <p>Review of Resident #6's physician orders revealed an order dated [DATE] for Full Code, may use AED unless contraindicated. Further review revealed an order dated [DATE] admit to hospice.</p> <p>Review of Resident #6's August and [DATE] medication administration records revealed Resident #6 was a Full Code.</p> <p>Review of Resident #6's comprehensive care plan dated [DATE] revealed Resident #6's code status was DNR (do not resuscitate) Resident/family choice: Ensure the current code status is in the medical record. If arrest occurs CPR (Cardio Pulmonary Resuscitation) will not be given. Place DNR in resident's record.</p> <p>Review of Resident #6's LaPost signed and dated on [DATE] by Resident #6's brother/Health Care Representative, revealed a status of DNR/Do Not attempt Resuscitation (allow natural death).</p> <p>During an interview on [DATE] at 1:42 p.m. Resident #6's brother/Health Care Representative confirmed Resident #6's DNR status.</p> <p>During an interview on [DATE] at 3:00 p.m. S2 Director of Nursing reviewed Resident #6's medical record and confirmed Resident #6's code status on the profile page, physician's orders, medication administration record, comprehensive care plan and LaPost were not consistent with Resident #6's wishes for advance directives and should have been.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30115</p> <p>45317</p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure the correct use and the maintenance of bed rails by ensuring residents were care planned for the use of bed rails, assessed for the risk of entrapment from bed rails, and a written order was obtained from the physician for bed rails prior to installation for 4 (#7, #27, #90, #240) out of 5 (#6, #7, #27, #90, #240) residents reviewed for accidents.</p> <p>Findings:</p> <p>Resident #7</p> <p>Review of Resident #7's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, chronic obstructive pulmonary disease, dementia with behavioral disturbance, and lack of coordination.</p> <p>Review of Resident #7's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 7 indicating severely impaired cognition and Resident #7 was totally dependent of one staff for bed mobility.</p> <p>Review of Resident #7's medical record failed to reveal a physician's order for bed rails, a risk assessment for entrapment from bed rails, and a care plan for bed rails were in place for Resident #7.</p> <p>An observation on 09/03/2024 at 9:15 a.m. revealed Resident #7 lying in bed. Resident #7's bed had bed rails in place/use bilaterally at the HOB (head of bed) in a raised position.</p> <p>An observation on 09/04/2024 at 8:30 a.m. revealed Resident #7 sitting up in bed eating breakfast. Resident #7's bed had bed rails in place/use bilaterally at the HOB in a raised position.</p> <p>An observation on 09/04/2024 at 2:15 p.m. revealed Resident #7 lying in bed on right side with eyes closed. Resident #7's bed had bed rails in place/use bilaterally at the HOB in a raised position.</p> <p>Resident #27</p> <p>Review of Resident #27's medical record revealed an admitted [DATE] with diagnoses, including but not limited to, other sequelae of cerebral infarction.</p> <p>Review of Resident #27's Annual MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. Resident #27 required the use of a wheelchair and was independent with chair/bed transfers.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #240's medical record revealed an admitted [DATE] and readmitted [DATE] with diagnoses including, but not limited to, pneumonia due to pseudomonas, chronic obstructive pulmonary disease, osteoarthritis, and chronic pain.</p> <p>Review of Resident #240's Discharge MDS dated [DATE] and Quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderately impaired cognition. Resident #240 requires limited assist of one person with bed mobility and transfers.</p> <p>Review of Resident #240's medical record failed to reveal a physician's order for bed rails, a risk assessment for entrapment from bed rails, and a care plan for bed rails were in place for Resident #240.</p> <p>An observation on 09/03/2024 at 3:40 p.m. revealed Resident #240 sitting up in bed. Further observation revealed Resident #240's bed had a bed rail at the HOB in a raised position.</p> <p>An observation on 09/04/2024 at 2:45 p.m. revealed Resident #240 sitting up in bed O2 per NC in place. Further observation revealed Resident #240's bed had a bed rail at the HOB in a raised position.</p> <p>During an interview on 09/05/2024 at 11:25 a.m., S5 RN (Registered Nurse) reported Resident #240 used the bed rail to reposition herself in bed and to help with transfers.</p> <p>During an interview on 09/05/2024 at 2:00 p.m. S2 DON (Director of Nursing), confirmed Resident #7, #27, #90, and #240 did not have an order, a care plan, or an assessment for the use of bed rails.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39897</p> <p>Based on observations, record review and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection. The facility failed to ensure Enhanced Barrier Precautions (EBP) were in place. This deficient practice had the potential to affect any of the facilities 46 residents.</p> <p>Findings:</p> <p>Review of the facility's policy Enhanced Barrier Precautions with an effective date of 04/01/2024 revealed in part:</p> <p>Definition and Scope: Enhanced Barrier Precautions (EBP) are infection control interventions designed to reduce transmission of multidrug-resistant organisms (MDROs).</p> <p>Example of Use: EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices).</p> <p>Enhanced Barrier Precautions (EBP) refer 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.</p> <p>EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies .</p> <p>The facility will ensure PPE (personal protective equipment) and alcohol-based hand rub are readily accessible to staff prior to entry to their room.</p> <p>Resident Activity/Assistance: perform wound care: any skin opening requiring a dressing, changing briefs or assisting with toileting, turn and reposition or assist with bed mobility, bathing/showering, providing hygiene</p> <p>Disposal of PPE: PPE used during resident care, including care of residents placed in Enhanced Barrier Precautions are not regulated medical waste requiring disposal in a biohazard bag, and should be discarded as routine non-infection waste. Facilities should remember to have an appropriate disposal container available in the resident room to allow for removal of PPE inside the room.</p> <p>Communication to Staff: The facility will utilize postings outside the room and employee shift change report (word of mouth) to communicate to staff if a resident requires EBP.</p> <p>Observation on 09/04/2024 at 3:05 p.m. revealed S6 CNA (Certified Nursing Assistant) and S7 CNA performed pericare for Resident #6 with gloves as the only PPE used. Resident #6 has a PEG (percutaneous endoscopic gastrostomy) feeding tube in place.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations throughout this survey on 09/03/2024, 09/04/2024, and until 09/05/2024 at 11:00 a.m. failed to reveal any indication enhanced barrier precautions were in use according to facility policy for residents requiring EBPs.</p> <p>During an interview on 09/05/2024 at 11:30 a.m. S8 Medical Records confirmed residents requiring EBPs had not been identified appropriately with postings outside the residents' rooms to communicate with staff the need for EBP.</p> <p>During an interview on 09/05/2024 at 11:55 a.m. S1 Corporate Nurse reported there should be signage/notifications outside the residents' rooms for the type of precautions in place, red bags or infection control boxes for PPE, and PPE should have been readily available on the hallway for staff use and they was not.</p> <p>During an interview on 09/05/2024 at 12:08 p.m. S4 LPN (Licensed Practical Nurse) reported staff should use PPE when entering a residents' room on EBP and were not.</p> <p>An observation on 09/05/2024 at 1:10 p.m. revealed EBP signage outside of Resident #90's door. Further observation revealed S7 CNA exited Resident #90's room with dirty linens in her gloved hands and no other PPE was in use.</p>		