

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Eunice Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3859 Highway 190 Eunice, LA 70535	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251 Based on record review and interview, the facility failed to notify the State Long Term care Ombudsman of facility-initiated transfer for 1 (Resident #57) out of 2 (#22, #57) residents investigated for hospitalization . The deficient practice has the potential to affect a census of 81. Findings: A request was made for the facility's policy for Ombudsman notifications of hospital transfers to S1ADM (Administrator). No policy was provided by the time of exit. Review of Resident #57's medical record revealed that the resident was admitted to the facility on [DATE] with diagnoses that read in part, Spastic Hemiplegia Affecting Left Nondominant Side, Lobar Pneumonia, Unspecified Organism, Sepsis, Unspecified and Other Seizures. Review of Resident #57's nurses' notes revealed on 08/14/2024 at 12:21 p.m., the resident was transferred to the hospital. Further review of the nurse's notes revealed that on 08/15/2024 at 12:35 p.m., the resident returned from the hospital back to the facility. Review of the Emergency Transfer Log for August 2024 revealed Resident #57's transfer to the hospital on 08/14/2024 was not identified on the list. On 12/04/2024 at 1:19 p.m., an interview and record review was conducted with S3BOM (Business Office Manager). She confirmed she was responsible for the Emergency Transfer Log and to send it to the State Long Term Care Ombudsman. S3BOM reviewed Resident #57's EMR (Electronic Medical Record) and confirmed the resident was transferred to the hospital on 08/14/2024. She then reviewed the Emergency Transfer Log for August 2024 and confirmed the resident was not listed as having been transferred on that date. S3BOM confirmed that Resident #57 should have been listed on the Emergency Transfer Log sent to the State Long Term Care Ombudsman and was not. S1ADM was present during the interview and also confirmed that Resident #57 was not included on the Emergency Transfer Log sent to the State Long Term Care Ombudsman and should have been.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 39319 Based on observation and interview, the facility failed to ensure: 1. the daily nurse staffing information was posted in a prominent place readily accessible to residents and visitors, and 2. the daily nurse staffing information include the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. Findings: On 12/03/2024 at 3:30 p.m., an observation was made of the daily nursing staffing information posted next to the staff time clock near the dining room and nurse's station which are in the central area of the building. The posting did not include the total number and actual hours worked by the staff responsible for resident care. On 12/03/2024 at 3:45 p.m., an observation and interview was conducted with S1ADM (Administrator) and S2RN (Registered Nurse). An observation of the nursing staffing information posted near the staff time clock was conducted with S1ADM and S2RN. They both confirmed that the posting did not include the total number and actual hours worked by the staff responsible for resident care. When asked if the posting was readily accessible for residents and visitors, S2RN did agree not all residents or visitors went to the dining room and may not see the posting. S1ADM voiced that she had always posted the nursing staffing information this way and posted it by the staff time clock. She stated that she was unaware that the nursing staffing information needed to include the total number and actual hours worked by the staff.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47354 Based on observations and interview, the facility failed to maintain a safe, sanitary environment as evidenced by failing to ensure cookware was stored in a sanitary manner. This deficient practice had the potential to affect a total of 80 residents who consumed meals from the kitchen. On 12/02/2024 at 8:45 a.m., an observation was made of one sheet pan on the floor, in-between the fryer and the standing oven. On 12/02/2024 at 09:55 a.m., a second observation was made of a sheet pan on the floor, in-between the fryer and the standing oven. An immediate interview was conducted with S4RD (Registered Dietician), she confirmed the sheet pan was on the floor and it should not have been.		