

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195552	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Tri-Community Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7014 Hwy 71 Palmetto, LA 71358	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20777</p> <p>Based on observations, record review and interviews, the facility failed to supervise and monitor assistive devices to prevent accidents. This occurred in 1 (#35) out of 1 (#35) residents who were investigated for Accidents out of 19 sampled residents.</p> <p>Findings:</p> <p>Record review of the facility policy titled Resident Alarms and dated 12/31/2024 read in part, Alarms are to be utilize in accordance with the resident's needs .to maintain highest .level of well-being .when movement is detected .The use of alarms does not eliminate the need for adequate supervision of the resident .Each resident shall be assessed for fall .and periodically thereafter as part of the comprehensive assessment process .When alarms are used .monitoring shall be provided .to .verify alarms are working properly.</p> <p>Review of Resident #35's record revealed he was admitted to the facility on [DATE]. His diagnoses were in part, Bipolar, Major Depression, Seizures, Paralytic Syndrome, Anoxic brain damage, Cerebral Vascular Disease, and Hemiplegia affect left dominant side. Resident had a BIMS (Brief Interview of Mental Status) score of 13 meaning his cognition was intact.</p> <p>Record review of Resident #35's Fall Risk assessment dated [DATE] revealed a total score 50 meaning he was at a High Risk for falls.</p> <p>Record review of Resident #35's care plan dated 05/03/2024, under problem area, read in part Resident #35 is at risk for falls due to CVA (Cerebrovascular Accident or Stroke) with left side hemiplegia, paralytic syndrome .weakness .unsteadiness . Under approaches read in part, Monitor for falls q (every) 1/2 hours . Bed alarm while in bed .Staff to observe more closely when resident coming back from smoking and assist to bed .Staff to offer resident transfer assist more often.</p> <p>Record review of Resident #35's February 2025 physicians orders read in part, Monitor for falls q 1/2 hours . Bed alarm while in bed.</p> <p>On 02/24/2025 at 11:23 AM, an observation was made of Resident #35 lying in bed with his bed alarm pad located under his torso and attached to the alarm monitor hanging from his bed rails. Resident #35 stood up on one leg and transferred himself into his wheelchair. At this time, the bed alarm was not alarming.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/25/2025 at 2:57 PM, an observation was made of Resident #35 lying in bed. His bed alarm pad was not observed under his torso. The alarm monitor was hanging from the bed rails. There was no light on to indicate that the alarm was working.</p> <p>On 02/25/2025 at 3:02 PM, an observation was made with S4CNA (Certified Nursing Assistant) who confirmed Resident #35 was lying in bed with the alarm pad by his feet. She stated the nurses and CNA were to ensure the alarm pad was located under the resident's torso and the monitor was working. She stated the bed alarm monitor for Resident #35 was not working at this time.</p> <p>On 02/25/2025 at 3:08 PM, S5LPN (Licensed Practical Nurse) stated the batteries in Resident #35's bed alarm monitor was dead. She stated the alarm pad was not under the resident and if the monitor was working it would alarm.</p> <p>On 02/25/2025 at 3:10 PM, S6LPN entered the room and stated she was Resident #35's nurse. She stated the staff were to ensure Resident #35's alarm pad was located under his body and were to ensure that the alarm monitor was working.</p> <p>On 02/26/2025 at 10:01 AM, an observation was made of Resident #35 lying in his bed and his alarm monitor was hanging from the side rails. The alarm pad was under the resident's bed sheet at the foot of the bed. The monitor was not alarming.</p> <p>On 02/26/2025 at 10:03 AM, S7CNA confirmed Resident #35's bed alarm pad was not under his body. At this time, S7CNA placed the pad under Resident #35's body and turned on the monitor. She then had the resident stand up and the alarm sounded. She stated it was the nurses and the CNA's responsibility to ensure the pad was under the resident's body and that the alarm monitor was working properly.</p> <p>On 02/26/2025 at 12:30 PM, S8MDS (Minimum Data Set) Coordinator confirmed the nurses should be monitoring the resident and the nurses and CNA should be ensuring the Resident's bed alarm pad was correctly placed under the resident as well as ensuring the alarm monitor was working every shift.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251</p> <p>Based on record review, observations and interview, the facility failed to provide appropriate and sufficient services, treatment and care according to standards of professional practice for 1 (#48) of 4 (#16, #17, #32 and #48) residents that were reviewed for urinary catheter or UTI (urinary tract infection). The facility failed to ensure Resident #48's urinary catheter drainage bag was secured properly off of the floor.</p> <p>Findings:</p> <p>On 02/26/2025 a review of the facility's policy with a review date of 12/31/2024 titled Catheter Care read in part, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.</p> <p>Resident #48 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, anxiety disorder and retention of urine.</p> <p>Review of Resident #48's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 01/21/2025 revealed in Section H - Bladder and Bowel she was coded for an indwelling catheter.</p> <p>On 02/24/2025 at 9:30 AM, an observation was made of Resident #48's indwelling urinary drainage bag lying on the floor beneath her bed.</p> <p>On 02/24/2025 at 11:24 AM, a second observation was made of Resident #48's indwelling urinary drainage bag in the same position lying on the floor beneath her bed.</p> <p>On 02/24/2025 at 11:46 AM, an observation and interview was conducted with S2CNA (Certified Nursing Assistant). She confirmed that Resident #48's indwelling urinary drainage [NAME] was lying on the floor beneath the bed. She stated that the drainage bag should have been clipped to the bed below the resident's bladder and not on the floor.</p> <p>On 02/26/2025 at 9:30 AM, an interview was conducted with S3LPN/IP (Licensed Practical Nurse/Infection Preventionist). She stated appropriate catheter care for indwelling urinary drainage bags were that they should be hung on the resident's bed or wheelchair with a privacy covering and should not be on the floor.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>47123</p> <p>Based on record review and interview, the facility failed to electronically submit accurate payroll information for direct care staffing as required. This deficient practice had the potential to affect any of the 51 residents residing in the facility.</p> <p>Findings:</p> <p>Review of the PBJ (Payroll Based Journal) Staffing Data Report for Fiscal Year 2024, Quarter 1 (October 1-December 31) revealed the following:</p> <ul style="list-style-type: none"> -One star staffing rating, triggered. -Excessively low weekend staffing, this metric is suppressed for this facility and quarter. -Failed to have licensed nursing coverage 24 hours/day, triggered. <p>On 02/26/2025 at 9:22 AM, an interview was conducted with S1ADM (Administrator). She stated she reviewed her entries to PBJ for Quarter 1, and realized she had two licensed practical nurses coded as a regular staff member versus a licensed practical nurse that was providing direct care to the residents. S1ADM confirmed she did not submit accurate payroll information to PBJ.</p>