STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on record review, observations, and interviews, the facility failed to ensure a dementia resident received the appropriate treatment and services to attain or maintain his highest practicable level of well-being for 1 (Resident #1) out of 3 sampled residents by failing to: 1. Revise the comprehensive care plan to include interventions that addressed Resident #1's continued wandering; 2. Staff failing to report continued incidents of wandering into other resident rooms for Resident #1, and 3. Failing to provide adequate supervision of Resident #1 after complaints that he continued to wander in other resident rooms. Findings: Review of the facility's policy on 05/08/2024 titled Care Plans, Comprehensive Person - Centered read in part: A comprehensive, person-centered care plan that includes measureable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .8. The comprehensive, person-centered care plan will .m. aid in preventing or reducing decline the resident's functional status and/or functional levels. Review of Resident #1's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses including, but were not limited to, Unspecified Dementia, Aphasia following Cerebral Infarction, and Mixed Receptive - Expressive Language Disorder. Review of Resident #1's plan of care revealed the following: Mental Distress- Resident gets in roommate's bed and tries to take w/c (wheelchair) and pull sheets off of roommate's bed at times. Redirect resident PRN (as needed) Resident may possibly go into other resident's room and get into other resident's bed. Staff to redirect resident to correct room if occurrence. Sign of truck placed on wall next to door to help remind resident of room location. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an in-service conducted by S1DON (Director of Nursing) with nurses and CNAs (Certified Nursing Assistants) dated 02/09/2024, revealed in part: 5. Everyone should know who to report things to, follow the chain of command. 6. We need to all work together to redirect residents that go into other residents' rooms and wander around the facility. On 05/08/2024 at 7:32 a.m., an interview was conducted with S2LPN (Licensed Practical Nurse). She stated that Resident #1 could propel himself in the wheelchair and get to the bed on his own when he wanted to. S2LPN further stated the resident did not try to wander outside of the facility, but did enter other residents' rooms. She stated that on 05/07/2024, she had to re-direct him from another resident's room, and he had gone into different residents' rooms on several occasions. S2LPN said that the staff simply re-directed the resident each time he wandered into another resident's room. On 05/08/2024 at 10:30 a.m., an interview was conducted with S1DON (Director of Nursing). S1DON stated that the facility was first made aware of Resident #1 wandering into Resident #2's room by Resident #2's daughter in December 2023, and the intervention was to put him in his bed after lunch and increase his time in activities. Resident #1 then wandered into Resident #2's room again in February, and Resident #2's daughter reported that Resident #1 was in her bed. The new intervention was to place a picture of a truck outside of Resident #1's room door to remind him that was his room. S1DON stated that she was unaware that Resident #1 was wandering into other residents' rooms because it was not reported to her by her staff, and they should have reported the incidents to her. On 05/08/2024 at 1:38 p.m., a second interview and record review was conducted with S1DON. S1DON was asked about the facility's response to the concerns voiced by Resident #2's daughter in an email sent to the Administrator in Training on December 18, 2023. S1DON confirmed that Resident #2's daughter had notified the facility that Resident #1 had not only wandered into Resident #2's room, but into two other residents' rooms as well in her email. She stated that there were no interventions to increase supervision of Resident #1 after the first or second report of Resident #1 wandering into other residents' rooms. S1DON also stated that she did not follow up with the other residents named in the email sent by Resident #2's daughter. A review of Resident #1's plan of care was then conducted with S1DON. S1DON confirmed that the interventions to put the resident in bed after lunch and to increase his time in activities were not included in the resident's care plan.