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	08/27/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46149 Based on observations and interviews, the facility failed to maintain a clean, comfortable, and homelike environment by failing to ensure the walls were clean in resident rooms for 2 (#3 ,#R2) out of 5 (#1, #2, #3, #R1, #R2) sampled residents. Findings: Review of the facility's policy titled Homelike Environment, with a last updated date of 03/12/2024, read in part: . The facility, staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary, and orderly environment. On 08/27/2024 at 10:43 a.m., an observation was made of Resident #3 and #R2's shared room. Upon entering the residents' room, the lower portion of the wall to the left of the residents' bathroom door was observed with tan stains that were in a drip-like pattern. Further observation of the room revealed the wall to the left of Resident #3's bed had light browns stains, in a drip-like pattern, that spanned from the top to the bottom of the wall, as well as dark brown and rust colored scattered stains on the lower portion of the wall. Additionally, the front wall of the residents' room had multiple scattered light brown stains that spanned from the middle to the lower portion of the wall. On 08/27/2024 at 1:10 p.m., an observation of the Resident #3 and #R2's room was conducted with S4HSKSUP (Housekeeping Supervisor). The lower portion of the wall to the left of the residents' bathroom door, the wall to the left of Resident #3's bed, and the front wall of the residents' room was observed with the S4HSKSUP. She acknowledged that the walls should have been cleaned, and this was a housekeeping responsibility.

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: 195565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Cornerstone at the Ranch		STREET ADDRESS, CITY, STATE, ZIP CODE 103 West Martial Ave Lafayette, LA 70506	

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on observations and interview, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident by failing to promptly respond to a resident's call for assistance for 1 (#R1) out of 5 (#1, #2, #3, #R1, #R2) sampled residents. Findings: On 08/27/2024, a review of the facility's policy titled Answering the Call Light with a last reviewed date of 07/29/2023 read in part: 8. Answer the call light as soon as possible. Review of Resident #R1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses including, but not limited to, Other Acute Osteomyelitis, Cellulitis of Right Lower Limb, and Other Chronic Pain. Review of Resident #R1's baseline care plan revealed she required 1 person assist for transfers, walking, grooming, and hygiene. On 08/27/2024 at 8:42 a.m., an observation was made on D Hall. Resident #R1 activated her call light. 3 loud beeps, a pause, and 3 additional loud beeps were heard. An electronic sign at the end of the hall was observed that displayed the resident's room number, and the time 8:42 a.m. in red. At 8:50 a.m., S5LPN (Licensed Practical Nurse) was observed as she entered the nurse's station. At this time, an overhead announcement was made over the intercom stating the resident needed assistance. At 8:54 a.m., a second observation was made of S5LPN sitting in the nurse's station. An electronic board that displayed when a resident's room number when the call light was activated could be observed with the resident's room number in the nurse's station. The electronic sign on the hall remained with Resident #R1's room number and time of 8:42 a.m. At 8:57 a.m., 3 loud beeps, followed by a pause, and 3 additional beeps were heard. At 9:00 a.m., a second overhead announcement was made, stating that the resident needed assistance. At this time, an interview was conducted with Resident #R1 who stated she needed medication and needed to get up. At 9:03 a.m., the nurse practitioner was observed exiting another resident's room, went to the nurse's station and asked S5LPN for assistance. At 9:09 a.m., an interview was conducted with S5LPN in the nurse's station. She stated that there was a board in the nurse's station that displayed when a resident's call light was activated. She proceeded to show the surveyor the board, and Resident #R1's room number was on the electronic board. S5LPN stated that when she came onto the hall at 8:50 a.m., she noticed that the resident's call light was activated on the sign on the hallway and on the electronic board in the nurse's station, so she paged so that an announcement would be made over the overhead intercom that the resident needed assistance. She then stated that she made a second page at 9:00 a.m., before exiting the nurse's station to assist with another resident. S5LPN stated that when a resident calls, she waits 5 minutes to see if the light is answered, makes an overhead page for the CNA (Certified Nursing Assistant), then waits another 5 minutes and makes another overhead page for the CNA. She stated she saw the resident was calling for assistance when she came onto the hall at 8:50 a.m., and acknowledged that the resident's call light had been activated since 8:42 a.m. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/2024 at 9:13 a.m., an interview was conducted with S2DONIP (Director of Nursing/ Infection Preventionist) who stated that if a resident activated their call light for assistance, the nurse should go to assist that resident if they are available. She also stated that it is not the facility's protocol for an overhead announcement to be made and then wait 5 minutes to see if another staff member responds to the call for assistance.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on interviews and record reviews, the facility failed to ensure the nursing staff demonstrated specific competencies and skill sets necessary to provide care to meet the residents' needs safely to attain or maintain the highest practicable physical well-being for 1 (#3) out of 5 (#1, #2, #3, #R1, #R2) sampled residents as evidenced by failure to: 1. ensure weekly skin assessments were completed; 2. accurately document the staging of a resident's wound; 3. update the resident's clinical record with an accurate wound status; 4. obtain physician orders to continue or discontinue wound care orders; and 5. notify the physician or Nurse Practitioner (NP) of a deteriorating wound. Findings: On 08/27/2024, a review of the facility's policy titled, Skin and Body Audit, with a last reviewed date of 01/12/2024, read in part .Policy: .2. Residents are considered high risk for skin injury if the Braden assessment score is less than 19. 3. Body audit will be performed weekly for all residents at risk for skin injury by a licensed nurse. 4. Any findings will be addressed to the resident or responsible party, and the resident's physician. The licensed nurse will document all findings in the medical chart. On 08/27/2024, a review of the facility's policy titled, Pressure Ulcer/Injury Risk Assessment, with a last reviewed date of 07/30/2024, read in part .General Guidelines .7. Perform weekly skin audits on residents who are at high risk for skin/pressure injuries .Steps in the Procedure: .b. The effects of the interventions must be evaluated .Documentation .4. Any changes in the resident's condition, if identified .12. Documentation in medical record addressing MD (Medical Doctor) notification if new skin alteration noted with change of plan of care, if indicated .Reporting .2. Report other information in accordance with facility policy and professional standards of practice .3. Notify attending MD if new skin alteration noted. Review of Resident #3's electronic health record (EHR) revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Hemiplegia, Dysphagia, Aphasia, and Lack of Coordination. Review of Resident #3's August 2024 physician's orders revealed the following: order dated 08/10/2024: DTI (Deep Tissue Injury) to Left Ischium-Cleanse with Wx (wound cleanser), apply Zinc Oxide to Periwound, apply Calcium Alginate, and cover with foam border dressing every day. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's care plan read in part: I have the potential for .Pressure Ulcers, Pressure Injuries . 05/03/2024: DTI to left ischium .(d/c'd (discontinued) 08/10/2024) 05/03/2024: DTI to Left Ischium cleanse with Wx cleanser, apply Zinc Oxide, Cover with foam border dressing .08/10/2024: DTI to left ischium cleanse with Wx cleanser, apply Zinc oxide to periwound, apply Calcium Alginate, and cover with foam border dressing .Notify MD as needed. Review of Resident #3's EHR (Electronic Health Record) revealed the following wound assessments: 05/29/2024 that read in part .Wound Type: Pressure Ulcer .Wound Location: Left buttock, left ischium . Wound Status: Unchanged .Date wound identified: 05/03/2024 .Assessment occasion: Weekly update . Stage: 2 .Measurements: Length 0.80 cm, Width 0.90 cm. 06/05/2024 that read in part .Wound Type: Pressure Ulcer .Wound location: Left buttock, left ischium .Wound status: Improved .Date wound identified: 05/03/2024 .Assessment occasion: Weekly update .Stage: 2 . Measurements: None. Further review of Resident #3's EHR failed to reveal an initial assessment of the resident's wound when it was identified on 05/03/2024. There were also no wound assessments or weekly skin inspections completed until 08/10/2024. On 08/27/2024 at 8:40 a.m., an interview was conducted with S3TN who stated she was responsible for completing skin assessments, wound assessments, and wound care. S3TN stated weekly skin assessments were only completed on high risk residents, based on their Braden Assessment scores. When asked what made residents high risk, S3TN stated she was unsure. S3TN stated she completed the skin assessments on paper, and would provide the surveyor with the assessments. S3TN further stated if a wound was deteriorating or if she was unsure about a wound, she notified the MD (Medical Director) or NP (Nurse Practitioner). A review of the documents provided by S3TN revealed the following: A skin assessment dated [DATE], which read in part .Weekly Skin Assessment .6. Any open ulcers (indicate even if being treated) Comments: Moderate 1.5cm x1.0cm unstageable . A wound evaluation dated 08/10/2024, which read in part .Wound Location: Left ischium .Type of Wound: Pressure .Pressure: Stage 2 .General Comments: Stage 2 . A wound evaluation dated 08/22/2024, which read in part .Wound Location: Left ischium .Type of Wound: Pressure .Pressure: Stage 3 . A review of Resident #3's nursing progress notes revealed an entry dated 08/27/2024 at 7:54 a.m. by S3TN that read: Stage three pressure injury noted to left ischium. S6NP (Nurse Practitioner) notified. New orders noted and carried out. Refer to Wound Care. Further review of the resident's nursing progress notes revealed no evidence that S3TN had notified the MD, NP, or wound care specialists that the resident's wound had deteriorated upon assessment on 08/22/2024. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/2024 at 11:52 a.m., an interview and review of Resident #3's EHR and wound documents was conducted with S2DONIP (Director of Nursing, Infection Preventionist) and S3TN. S3TN stated she measured the wounds weekly, and S2DONIP stated she staged the wounds weekly. S2DONIP confirmed the DTI to the resident's left ischium was first identified on 05/03/2024 and no initial wound assessment was completed. S2DONIP also confirmed a wound assessment was not completed until 05/29/2024. She stated the initial wound assessment should have been completed on 05/03/2024, and the resident should have had weekly wound and skin assessments thereafter because he was high risk. S3TN confirmed that she inaccurately documented that the resident had an open, unstageable pressure ulcer with moderate drainage on 06/22/2024 after S2DONIP staged it as a stage 2. S3TN further stated Resident #3's wound was healed the following week, but she did not notify the MD or NP, complete an assessment, or update the resident's EHR with the resident's updated wound status. She confirmed that she did not call the physician to discontinue or get new orders after the resident's wound healed and should have. Regarding the resident's newly identified wound on 08/10/2024, S3TN confirmed the physician's order read: DTI to left ischium, cleanse with Wx cleanser, apply zinc oxide to periwound, apply calcium alginate, and cover with foam border dressing. S3TN stated she believed the resident's stage 2 pressure injury was a DTI. She confirmed the physician's orders and careplan did not accurately reflect that Resident #3 had a Stage 2 pressure injury. S2DONIP confirmed she had staged the pressure area on 08/10/2024 as a Stage 2. S3TN further stated Resident #3 returned from an inpatient hospital stay on 08/21/2024, and she completed a follow up wound assessment on 08/22/2024. She stated the wound had deteriorated during his hospital stay and progressed to a Stage 3. When asked why the NP was notified on 08/27/2024 that the resident's wound had deteriorated, instead of on 08/22/2024 upon his return assessment, S3TN stated she did not know, and should have notified the NP on 08/22/2024 and did not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on observations, record review and interview, the facility failed to provide a safe and sanitary, environment to help prevent the development and transmission of communicable diseases and infections by failing to remove contaminated gloves and perform hand hygiene during wound care for 1 (#3) resident out of 5 (#1, #2, #3, #R1, #R2) sampled residents. Findings: On 08/27/2024, a review of the facility's policy titled, Handwashing/Hand Hygiene, with a last review date of 01/12/2024, read in part .7. Use an alcohol-based hand rub containing at least 62% alcohol or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . g. Before handling clean or soiled dressings, gauze pads, etc.i. After contact with a resident's intact skin .m. After removing gloves. Review of Resident #3's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Hemiplegia, Dysphagia, Aphasia, and Lack of Coordination. Review of Resident #3's August 2024 physician's orders revealed the following order dated 08/10/2024: DTI (Deep Tissue Injury) to Left Ischium-Cleanse with Wx (wound cleanser), apply Zinc Oxide to Periwound, apply Calcium Alginate, and cover with foam border dressing every day. On 08/27/2023 at 11:37 a.m., an observation was conducted of S3TN (Treatment Nurse) as she provided Resident #3's wound care treatment to his left ischium. S3TN put on a pair of gloves and removed the old dressing. She removed her gloves then put on a clean pair of gloves without performing hand hygiene and cleaned the resident's wound. S3TN removed her gloves, then put on a clean pair of gloves without performing hand hygiene, retrieved Zinc, applied it to the resident's wound, then retrieved Calcium Alginate and applied it to the resident's wound. She then realized she had forgotten the dressing. S3TN removed her gloves then put on a clean pair of gloves without performing hand hygiene, retrieved Zinc, reapplied to resident's wound, then covered the wound with a clean dressing wearing the same gloves used to apply the Zinc. S3TN did not sanitize hands after changing gloves during wound care and did not change gloves or sanitize hands after applying Zinc prior to applying the clean dressing. On 08/27/2024 at 11:43 p.m., an interview was conducted with S3TN, she confirmed she should have sanitized her hands after changing gloves during Resident #3's wound care and should have changed her gloves and sanitized her hands prior to applying the clean dressing and did not. On 08/27/2024 at 4:38 p.m., an interview was conducted with S2DONIP (Director of Nursing/Infection Preventionist), she confirmed S3TN should have properly changed gloves and sanitized her hands while providing Resident #3's wound care.