STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195575	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Haven Rehabilitation and Healthcare Center	1515 Highway 107 Center Point, LA 71323

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44315 Based on interview and record review, the facility failed to ensure the comprehensive plan of care was reviewed and revised to ensure staff provided extensive assistance with 2 person physical assistance for turning, repositioning and bed mobility, when providing ADL care (bed bath), for 1 (#1) of 2 (#1 and #2) residents reviewed for falls. Findings: Review of the facility's policy and procedure dated 09/01/2024, and titled Fall Prevention Program read in part . Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 9. When any resident experiences a fall, the facility will: e. Review the resident's care plan and update as indicated. Review of Resident #1's medical record revealed an admitted [DATE], with diagnoses that included in part . Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Unspecified Dementia. Review of Resident #1's Quarterly MDS with an ARD 10/30/2024, revealed a BIMS score of 00 (severely impaired cognitively). The MDS revealed in part . Resident #1 was coded for functional limitations in ROM with impairment on one side for upper and lower extremities. Resident #1 required substantial/ maximal assistance for shower/ bathing, toileting, dressing, and rolling left and right. Review of Resident #1's Care Plan with a target date of 12/02/2024, revealed the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. High risk for falls r/t limited mobility, r/t previous CVA affecting right side; right side hemiplegia. I scoot myself around in bed at times, with a goal to be free of falls. Interventions included in part . I am a fall risk. Follow facility fall protocol - Initiated 07/03/2019. 09/15/2024 - Fall without injury. Ensure resident is in middle of bed upon rounds. 11/07/2024 - Fall with major injury. Leave resident's door open for frequent rounding and increased visualization. 2. ADL self-care performance deficit r/t CVA with right sided hemiplegia and dementia, with a goal to maintain current level of ADL function. Initiated on 07/03/2019. Interventions included in part . Assist me with dressing, bed mobility, personal hygiene, toileting, eating and transfers - revision on 06/14/2024; Assist me with bathing as needed; and honor my choice for type of bath I prefer - revision on 01/09/2024. Interview on 12/04/2024 at 2:30 p.m. with S2 ADON, and review with S2 ADON of the Care Plan Item Task Listing Report, revealed an intervention initiated on 01/08/2024 for 2 person extensive assistance for bed mobility, turning and repositioning in bed for Resident #1, should have been listed on the report form, and was not listed. S2 ADON stated the report lists all residents that required extensive 2 person assistance for bed mobility, and the report was generated from the residents' care plans. S2 ADON stated Resident #1 was not listed on the report, because the information was not on her comprehensive plan of care, and should have been. S2 ADON stated she would update Resident #1's care plan interventions today (12/04/2024), to include Resident #1 required extensive assistance by 2 staff to turn and reposition in bed. S2 ADON confirmed Resident #1 should have been care planned for 2 person extensive assistance for ADL care and bed mobility, and was not.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44315 Based on observation, interview and record review, the facility failed to provide adequate supervision, and use extensive, 2 person physical assistance for turning, repositioning and bed mobility for 1 (#1) of 2 (#1 and #2) residents reviewed for falls. This failed practice resulted in an actual harm situation on 11/07/2024 at 9:35 a.m., when Resident #1, who was severely impaired cognitively; had diagnoses that included Hemiplegia, and Hemiparesis following Cerebral Infarction affecting the Right Dominant Side; Unspecified Dementia; and required substantial/ maximal assistance for shower/ bathing and rolling left and right; rolled out of bed while receiving a bed bath by S4 CNA. Resident #1 fell on to the floor, and sustained a Closed Right Hip Fracture. Findings: Review of the facility's policy and procedure with revision date of March 2018, and titled Activities of Daily Living (ADLs), Supporting read in part . Policy Interpretation and Implementation 5. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the ARD and the following MDS definitions in part . d. Extensive Assistance - While resident performed part of activity over the last 7 days, staff provided weight-bearing support. 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The resident's response to interventions will be monitored, evaluated and revised as appropriate. Review of Resident #1's medical record revealed an admitted [DATE], with diagnoses that included in part . Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Unspecified Dementia. Review of Resident #1's Quarterly MDS with an ARD 10/30/2024, revealed a BIMS score of 00 (severely impaired cognitively). The MDS revealed in part . Resident #1 was coded for functional limitations in ROM with impairment on one side for upper and lower extremities. Resident #1 required substantial/ maximal assistance for shower/ bathing, toileting, dressing, and rolling left and right. Review of Resident #1's Care Plan with a target date of 12/02/2024, revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. High risk for falls r/t limited mobility, r/t previous CVA affecting right side; right side hemiplegia. I scoot myself around in bed at times, with a goal to be free of falls. Interventions included in part . I am a fall risk. Follow facility fall protocol - Initiated 07/03/2019. 09/15/2024 - Fall without injury. Ensure resident is in middle of bed upon rounds. 11/07/2024 - Fall with major injury. Leave resident's door open for frequent rounding and increased visualization. 2. ADL self-care performance deficit r/t CVA with right sided hemiplegia and dementia, with a goal to maintain current level of ADL function. Initiated on 07/03/2019. Interventions included in part . Assist me with dressing, bed mobility, personal hygiene, toileting, eating and transfers - revision on 06/14/2024; Assist me with bathing as needed; and honor my choice for type of bath I prefer - revision on 01/09/2024. Observation on 12/02/2024 at 11:00 a.m., and 12/03/2024 at 10:00 a.m., revealed Resident #1 lying in bed with call light within reach. Resident #1 was not interviewable. Resident #1's bed was in low position, with mattress with bolsters on each side of Resident #1, and a fall mat was observed on the window side of the bed. Signage was noted over the HOB that revealed a fall leaf, a picture of a bed with the number 2 (2 person assist), a red heart (DNR), a blue triangle (color of the lift pad), fall mat, a red circle (use lift for transfers), a coffee cup (to prevent scalding when drinking), nectar thick liquids, no ice, no straws, turn schedule, pillow under right arm, and elevate right wrist. Interview with S6 CNA Supervisor on 12/04/2024 at 9:35 a.m. revealed that a binder was located at each nurses' station for the HOB signage with pictures and meanings of each picture. S4 CNA was in-serviced on the overhead bed signage and its meanings when she was hired and throughout orientation, and S4 CNA was aware that the book was located at the nurses' station. S6 CNA Supervisor stated that the HOB signage on 11/07/2024, revealed Resident #1 was required to have 2 person extensive assistance with ADLs, bed mobility and transfers, and should have had 2 persons assisting with her bathing and turning while in bed. Interview on 12/04/2024 at 10:15 a.m. with S7 FNP revealed that prior to fall with injury of hip fracture, Resident #1 was bed bound. S7 NP stated the nurse called her and she came shortly, assessed Resident #1 and initially c/o her right arm and waiting for mobile x-ray. S7 FNP revealed Resident #1 continued to complain with facial grimacing, and sent her out to the hospital for further evaluation and x-rays. Telephone interview on 12/04/2024 at 12:30 p.m. with S4 CNA, revealed Resident #1 was on her list of residents to receive a bed bath that day; however, she stated she didn't remember looking at the over-head bed signage before providing Resident #1's care to see what assistance with care was needed. She stated she knew she could check the kiosk, but didn't look at the kiosk either, prior to caring for Resident #1, and should have. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/04/2024 at 2:30 p.m. with S2 ADON, revealed the information that was included on each resident's HOB signage and in the Kiosk, was generated directly from the current MDS assessment, and that Resident #1's intervention for 2 person extensive assistance for bed mobility, turning and repositioning in bed was initiated on 01/08/2024. Interview on 12/05/2024 at 1:55 p.m. with S4 CNA, revealed she provided care to Resident #1 3-4 months ago, prior to the incident. During that time the resident was bathed by bath aides. S4 CNA stated she worked with Resident #1 on 11/07/2024, and Resident #1 was scheduled to have her bed bath right after breakfast. S4 CNA stated she was giving Resident #1 a bed bath on 11/07/2024 by herself, and rolled Resident #1 onto her left side, on the opposite side of the bed she (S4 CNA) was on. S4 CNA stated she had her arm on Resident #1 when she (Resident #1) started scooting closer to the edge of her bed, and rolled out of the bed, and onto the floor. S4 CNA stated she called for help and pressed the call light for assistance, and the nurse and 2 CNAs came into room to assist. S4 CNA stated she had been trained on the over bed signage and use of the kiosk for resident care, but didn't remember looking at Resident #1's HOB signage prior to providing her bed bath. Interview on 12/05/2024 at 2:50 p.m. with S3 LPN revealed that she cared for Resident #1 on 11/07/2024, and was summoned to her room after she fell out of her bed. She stated Resident #1 was found lying on the floor on her side. S3 LPN reported according to Resident #1's overhead bed signage and ADL Documentation on 11/07/2024, Resident #1 was required to have 2 person extensive assistance with ADLs, bed mobility and transfers, and should have had 2 persons assisting with her bathing and turning while in bed. Review of Resident #1's Radiology results dated 11/07/2024 at 3:01 p.m. read in part .History/ Reason for X-Ray: Fall, Right shoulder, elbow pain; fall, Right hip pain. Procedure: Pelvis AP 1 view/ Right Hip AP and Lateral. Impression: Right Trans-Cervical Femoral Neck Fracture. Review of Nursing Progress Notes dated 11/07/2024 at 9;35 a.m., revealed in part .S3 LPN stated she was summoned to Resident #1's room and noted the resident lying flat on her back. Resident #1 assisted up times 3 person assist. Neuro-checks in progress. S7 FNP notifed with new orders for x-ray of bilateral upper arms, and bilateral hip and legs. Interview on 12/05/2024 at 3:50 p.m. with S1 DON, and review of the ADL documentation located in the Kiosk, revealed Resident #1 required extensive assistance with 2 person assistance. The ADL documentation revealed in part . 3,3, which indicated Resident #1 required extensive assistance with 2 person assistance for bed mobility and transfers. S1 DON revealed the X-rays showed Resident #1 had a fracture to her Right Femur. S1 DON confirmed S4 CNA should not have attempted to provide ADLs and turn Resident #1 in her bed by herself.