

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/19/2024
NAME OF PROVIDER OR SUPPLIER  Allen Oaks Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  909 East 6th Avenue Oakdale, LA 71463	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45213</p> <p>Based on record review and interview, the facility failed to ensure a resident was treated with respect and dignity and cared for in a manner which promotes enhancement of his or her own quality of life for 1 (Resident #1) of 12 (Resident #1, Resident #2, Resident #3, #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, and #R9) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's policy titled Quality of Life - Dignity dated 08/2009 read in part .Each resident will be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents will be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 8. Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed .</p> <p>Review of Resident #1's medical record revealed an admitted on 03/24/2021 with diagnoses which included: Altered Mental Status, Dementia, Pseudobulbar Affect, Muscle Weakness, Difficulty in Walking, Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of Resident #1's Significant Change MDS with an ARD of 05/01/2024 revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #1's MDS revealed she had the ability to express her ideas and wants which could be understood. Resident #1's MDS stated she required moderate assistance with upper body dressing, lower body dressing and personal hygiene; maximal assistance with bathing; and she was dependent on staff for toileting hygiene.</p> <p>Review of Resident #1's Care Plan with a Target Date of 08/30/2024 revealed in part .Communication problem related to dementia. Interventions: Anticipate and meet needs. Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, ask yes/no questions if appropriate, use simple brief consistent words/cues, use alternative communication tools as needed. Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed. ADL self-care performance. Interventions: Camera in room provided per family. Extensive assistance to total care with ADL's and mobility. Encourage the resident to participate to the fullest extent possible with each interaction. Praise all efforts at self-care.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review on 08/09/2024 of video camera footage of Resident #1's room dated 07/23/2024 at 11:07 p.m. revealed S3 CNA providing care to Resident #1. While adjusting Resident #1's gown, S3 CNA roughly turned her, let go of her, and let fall back on the mattress.</p> <p>Review on 08/09/2024 of video camera footage of Resident #1's room dated 07/19/2024 at 1:43 a.m. through 1:54 a.m. revealed S3 CNA in the room providing care to Resident #1. Christian music could be heard playing on Resident #1's radio in the room. S3 CNA was on her cellphone throughout the video talking to a female on speaker phone. Resident #1 tried to speak to S3 CNA while she was providing care. S3 CNA did not acknowledge Resident #1 when Resident #1 spoke to her and she continued with her cell phone conversation.</p> <p>Interview on 08/12/2024 at 9:13 a.m. with S17 CNA Supervisor revealed there was video footage of S3 CNA on her cell phone while providing care to Resident #1. S17 CNA stated she should not have been on the phone while providing care to Resident #1.</p> <p>Telephone interview on 08/15/2024 at 10:52 a.m. with S3 CNA confirmed she used her cell phone on speaker while providing care to Resident #1, but should not have.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>45213</p> <p>Based on interview and record review, the facility failed to ensure a resident's right to be free from verbal and mental abuse by staff for 1 (Resident #1) of 12 (Resident #1, Resident #2, Resident #3, #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, and #R9) sampled residents.</p> <p>This failed practice resulted in an actual harm situation for Resident #1 on 07/23/2024 on the 6:00 p.m. to 6:00 a.m. shift when Resident #1, who was severely impaired cognitively, and had diagnoses of Dementia and Major Depressive Disorder, was verbally and mentally abused by S3 CNA. Review of Resident #1's video camera footage revealed on 07/23/2024 at 7:54 p.m., S3 CNA while in Resident #1's room stated to Resident #1 You old meanie. At 11:00 p.m., while S3 CNA and S4 CNA were providing ADL assistance to Resident #1, S3 CNA stated to Resident #1 Why you gotta be like that man? Resident #1 replied I love Jesus. S3 CNA stated If you loved Jesus, you wouldn't be ugly every time someone came in here. That's not loving Jesus, that's loving the Devil. At 11:07 p.m., S3 CNA and S4 CNA were in Resident #1's room. S3 CNA stated to Resident #1, You act a F***** animal.</p> <p>A reasonable person in Resident #1's situation would have experienced severe psychosocial harm and humiliation as a result of this verbal and mental abuse.</p> <p>Findings:</p> <p>Review of the facility's policy titled Abuse and Neglect - Clinical Protocol dated 07/2017, read in part .1. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse .</p> <p>Review of Resident #1's medical record revealed an admitted on 03/24/2021, with diagnoses that included: Altered Mental Status, Dementia, Pseudobulbar Affect, Muscle Weakness, Difficulty in Walking, Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of Resident #1's Significant Change MDS with an ARD of 05/01/2024, revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #1's MDS revealed she had the ability to express her ideas and wants which could be understood. Resident #1's MDS stated she required moderate assistance with upper body dressing, lower body dressing and personal hygiene; maximal assistance with bathing; and she was dependent on staff for toileting hygiene.</p> <p>Review of Resident #1's Care Plan with a Target Date of 08/30/2024 revealed in part .Communication problem related to dementia. Interventions: Anticipate and meet needs. Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, ask yes/no questions if appropriate, use simple brief consistent words/cues, use alternative communication tools as needed. Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed. ADL self-care performance. Interventions: Camera in room provided per family. Encourage the resident to participate to the fullest extent possible with each interaction. Praise all efforts at self-care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of video camera footage of Resident #1's room dated 07/23/2024 at approximately 7:54 p.m., revealed Resident #1 lying in bed with S3 CNA standing near the head of the bed. S3 CNA stated You old meanie to Resident #1, while adjusting the foot of the electric bed.</p> <p>Review on 08/12/2024 of video camera footage of Resident #1's room, dated 07/23/2024 at approximately 11:00 p.m., revealed Resident #1 in bed, and S3 CNA and S4 CNA changing her gown. As S3 CNA was removing her gown, she stated Why you gotta be like that man? Resident #1 responded I love Jesus. S3 CNA then stated If you loved Jesus you wouldn't be ugly every time someone came in here. That's not loving Jesus, that's loving the Devil.</p> <p>Review on 08/12/2024 of video camera footage of Resident #1's room, dated 07/23/2024 at approximately 11:07 p.m., revealed S3 CNA near Resident #1's bed, and S4 CNA present in the room. As S3 CNA was adjusting Resident #1's gown, she stated to her You act a F***** animal.</p> <p>The video camera footage of Resident #1's room, dated 07/23/2024 at 7:54 p.m., 11:00 p.m., and 11:07 p.m. was reviewed with S1 ADM and S2 DON on 08/15/2024 at 2:15 p.m. S1 ADM confirmed the above statements were made to Resident #1 by S3 CNA. S1 ADM confirmed verbal and mental abuse of Resident #1 by S3 CNA was evident in the camera footage.</p> <p>Review of S4 CNA's, undated, written statement provided by S1 ADM on 08/15/2024 read in part .To my knowledge, S3 CNA and I went into Resident #1's room .While in there providing care, S3 CNA did make some comments that were not appropriate to Resident #1 and mishandled her. I was in shock .All I could do was be quiet and try the best to give her care. After all of this, I did inform the nurse about what took place that night.</p> <p>Telephone interview on 08/16/2024 at 11:50 a.m. with S4 CNA revealed she worked with S3 CNA on 07/23/2024. S4 CNA reported when they provided care to Resident #1 together, S3 CNA was going off. S4 CNA revealed S3 CNA was not speaking to Resident #1 the way she should. S4 CNA reported Resident #1 was scared because of the way S3 CNA was talking to her. S4 CNA reported she could recall S3 CNA saying something along the lines of If you hit me, I don't know what my reflexes might do, but could not recall everything else she said. S4 CNA stated she was unsure of the number times S3 CNA acted like that throughout that night.</p> <p>Telephone interview on 08/16/2024 at 2:26 p.m. with Resident #1's daughter revealed Resident #1 had always listened to Christian music. She revealed she was Pentecostal, and raised her and her sisters Pentecostal. She reported prior to being in the nursing home, Resident #1 went to church services faithfully on Wednesdays and Sundays. She reported Resident #1, prior to having dementia, would have been mad and upset by the way S3 CNA cursed at her, and called her names. She reported Resident #1 would have responded in a Christian manner even if she was mad and upset. Resident #1's daughter stated it would have hurt Resident #1's feelings, upset her, and she would have felt extremely disrespected.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47004</p> <p>Based on interview and record review the facility failed to review and revise the care plan for 1 Resident (#R7), of 12 sampled residents (#1, #2, #3, #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, and #R9). The facility failed to revise the comprehensive person centered care plan to include new interventions following two elopements. Findings:</p> <p>Review of Resident #R7's medical record revealed she was admitted to the facility on [DATE]. Resident #R7 had diagnoses that included in part . Alzheimer's Disease, Schizoaffective Disorder, Generalized Muscle Weakness, Major Depressive Disorder, Unspecified Behavioral and Emotional Disorders, Anxiety Disorder, and Bipolar Disorder.</p> <p>Review of Resident #R7's Quarterly Wandering Risk Scale dated 05/23/2024, completed by S13LPN, revealed a score of 13, which indicated she was at high risk to wander.</p> <p>Review of Resident #R7's Quarterly MDS with an ARD of 05/23/2024, revealed a BIMS score of 3, which indicated severely impaired cognition. Review of the MDS revealed Resident #R7 used a wander/elopement alarm daily.</p> <p>Review of Resident #R7's current comprehensive plan of care with a target date of 08/21/2024, revealed Resident #R7 was at risk for elopement; initiated on 04/17/2023. Interventions included in part .04/19/2023 - Coded locks on doors and gates to prevent elopement of residents, gates are kept closed; 04/19/2023 - Monitor every 1 hour to prevent elopement; and 04/19/2023 - Signs are posted for visitors to not let residents out without staff approval, and keep gates closed after entry, and 06/25/2024 - Went outside behind a visitor, wander guard in place, resident seen, and brought back inside by staff. Further review revealed no new interventions were put into place after the 06/25/2024 or 08/03/2024 elopements.</p> <p>Interview on 08/16/2024 at 2:15 p.m. with S2 DON revealed Resident #R7 went out the X Hall front door, unsupervised by staff on 06/25/2024 and 08/03/2024.</p> <p>Interview on 08/16/2024 at 2:25 p.m. with S2 DON revealed the facility had not implemented any further interventions to Resident #R7's plan of care following elopements on 06/25/2024 and 08/03/2024.</p> <p>Interview on 08/16/2024 at 6:50 p.m. with S1 ADM revealed she was aware of Resident #R7's elopements that occurred on 06/25/2024 and 08/03/2024. S1 ADM confirmed the facility had not updated Resident #R7's plan of care with further interventions following elopements to prevent the likelihood of elopement, but should have.</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45213</p> <p>Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 1 (Resident #1) of 12 (Resident #1, Resident #2, Resident #3, #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, and #R9) sampled residents. The facility failed to create and sustain an environment which humanized Resident #1's quality of life when:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was abruptly transferred to her geri-chair.</li> <li>2. Resident #1 was pulled up in bed with S3 CNA standing on her bed.</li> </ol> <p>Findings:</p> <p>Review of Resident #1's medical record revealed an admitted on 03/24/2021 with diagnoses which included: Altered Mental Status, Dementia, Pseudobulbar Affect, Muscle Weakness, Difficulty in Walking, Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of Resident #1's Significant Change/OSA MDS with an ARD of 05/01/2024 revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #1's MDS revealed she had the ability to express her ideas and wants which could be understood. Resident #1's MDS stated she required moderate assistance with upper body dressing, lower body dressing and personal hygiene; maximal assistance with bathing; and she was dependent on staff for toileting hygiene. Resident #1's MDS revealed she required extensive 2+ person physical assistance with bed mobility and transfer was coded as did not occur.</p> <p>Review of Resident #1's Care Plan with a Target Date of 08/30/2024 revealed in part .Communication problem related to dementia. Interventions: Anticipate and meet needs. Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, ask yes/no questions if appropriate, use simple brief consistent words/cues, use alternative communication tools as needed. Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed . ADL self-care performance. Interventions: Camera in room provided per family. Geri-chair as tolerated. Mattress at bedside, may place two mattresses if needed. Extensive to total care with ADLs and mobility. Encourage the resident to participate to the fullest extent possible with each interaction. Praise all efforts at self-care.</p> <ol style="list-style-type: none"> <li>1. Review of a facility incident investigation for Resident #1 documented by S1 ADM dated 06/11/2024 revealed in part .</li> </ol> <p>On the morning of 06/11/2024, DON of local hospice stated that one of her nurses was visiting Resident #1. When she was visiting, Resident #1's daughter was visiting her mother.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The hospice nurse stated Resident #1's daughter had a video of two facility CNAs putting Resident #1 in a geri-chair in a rough manner. She stated that there were 2 CNAs as per protocol but that it seemed that they just plopped her mother into the geri-chair instead of placing her gently. Hospice DON also stated that the family has the incident on video and that the family showed the video to the hospice nurse.</p> <p>The CNAs should have removed one of the mattresses and moved the geri-chair closer to Resident #1 when getting her up. The mattresses on the floor make the CNAs footing very unsteady and they often hurriedly place the resident in the chair or bed without taking extra time .this is an improper transfer.</p> <p>Review of S5 CNA's written statement signed and dated 07/11/2024 at 12:30 p.m. read in part .me and my coworker found Resident #1 on the mattresses they have laid out on the floor. We picked her up and transferred her to her chair.</p> <p>Review of S6 CNA's written statement signed and dated 06/11/2024 at 1:00 p.m. read in part . me and my coworker found Resident #1 on the floor. We both picked her up under her arms and transferred her to her chair.</p> <p>Interview on 08/12/2024 at 10:45 a.m. with S1 ADM and S2 DON revealed they had received video footage of Resident #1's room on 06/11/2024. S1 ADM reported S5 CNA and S6 CNA transferred Resident #1 from the mattress in between her bed and the other mattress on the floor to a geri-chair that was on the other side of the end mattress. S1 ADM and S2 DON revealed S5 CNA and S6 CNA could have done a proper transfer. S1 ADM confirmed they should have moved the mattress and placed the geri-chair closer to the mattress that Resident #1 was on to prepare for a safe, proper transfer.</p> <p>Review on 08/12/2024 at 3:17 p.m. of undated video camera footage of Resident #1's room which was provided to S1 ADM on 06/11/2024 revealed Resident #1 sitting on the mattress that was in between her bed and the other mattress on the floor. There was a geri-chair on the side of the mattress farthest from the bed. S5 CNA and S6 CNA go to lift Resident #1 off the mattress and one CNA can be heard stating to Resident #1 You can lock up all you want. S5 CNA and S6 CNA lift Resident #1 from under both of her arms and drag her backwards across the other mattress making a dragging sound with her heels. The geri-chair was unlocked as it was seen moving around as S5 CNA and S6 CNA abruptly sit Resident #1 in her geri-chair. As Resident #1 was seated, a 'ding' sound can be heard and the foot rest of the chair kicks up approximately a foot.</p> <p>Telephone interview on 08/13/2024 at 2:26 p.m. with S5 CNA revealed she worked 6:00 p.m. to 6:00 a.m. and remembers she transferred Resident #1 with S6 CNA but could not recall the exact date. S5 CNA reported they picked Resident #1 up from under hers arms and moved her across the second mattress to put her in the geri-chair. S5 CNA stated Why would you move the mattresses? I don't know why they have them there anyway. I just don't understand that.</p> <p>Telephone interview on 08/13/2024 at 2:40 p.m. with S6 CNA revealed she recalled a video of a transfer she did with another CNA for Resident #1 but could not recall the date or the name of the other CNA. S6 CNA reported Resident #1 was on the mattress next to her bed and she and the other CNA lifted her from under her arms and transferred her to the geri-chair. S6 CNA revealed she did not move the other mattress because they were trying to get her up quickly but could not remember why they had to do it quickly.</p> <p>(continued on next page)</p>		

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(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 - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004</b></p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure a cognitively impaired resident who had a history of wandering, was adequately supervised and not allowed to exit the building without staff knowledge, for 1 Resident (#R7) of 12 sampled residents (#1, #2, #3, #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, and #R9).</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 06/25/2024 at 3:59 p.m., when Resident #R7, a severely cognitively impaired resident who had a history of wandering, followed visitors out of the building via the front entrance door, and walked into the parking lot unsupervised on 06/25/2024 and 08/03/2024.</p> <p>S1 ADM was notified of the Immediate Jeopardy on 08/16/2024 at 6:50 p.m.</p> <p>The Immediate Jeopardy was removed on 08/19/2024 at 5:13 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Elopements, dated 12/2007, revealed in part . Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.</p> <p>Review of Resident #R7's medical record revealed she was admitted to the facility on [DATE]. Resident #R7 had diagnoses that included in part . Alzheimer's Disease, Schizoaffective Disorder, Generalized Muscle Weakness, Major Depressive Disorder, Unspecified Behavioral and Emotional Disorders, Anxiety Disorder, and Bipolar Disorder.</p> <p>Review of Resident #R7's Quarterly Wandering Risk Scale dated 05/23/2024, completed by S13LPN, revealed a score of 13, which indicated she was at high risk to wander.</p> <p>Review of Resident #R7's Quarterly MDS with an ARD of 05/23/2024, revealed a BIMS score of 3, which indicated severely impaired cognition. Review of the MDS revealed Resident #R7 used a wander/elopement alarm daily.</p> <p>Review of Resident #R7's current comprehensive plan of care with a target date of 08/21/2024, revealed Resident #R7 was at risk for elopement; initiated on 04/17/2023. Interventions included in part .04/19/2023 - Coded locks on doors and gates to prevent elopement of residents, gates are kept closed; 04/19/2023 - Monitor every 1 hour to prevent elopement; and 04/19/2023 - Signs are posted for visitors to not let residents out without staff approval, and keep gates closed after entry, and 06/25/2024 - Went outside behind a visitor, wander guard in place, resident seen, and brought back inside by staff. Further review revealed no new interventions were put into place after the 06/25/2024 or 08/03/2024 elopements.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/19/2024
NAME OF PROVIDER OR SUPPLIER  Allen Oaks Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  909 East 6th Avenue Oakdale, LA 71463	

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #R7's Elopement Risk Evaluation dated 06/26/2024, and completed by S11ADON, revealed the following:</p> <p>Elopement Score: 4.0 (At Risk)</p> <p>BIMS Score: 3</p> <p>History of elopement while at home: Yes.</p> <p>History of attempting to leave the facility without informing staff: Yes.</p> <p>Verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door: Yes.</p> <p>Wanders: No.</p> <p>Wandering behavior a pattern or goal-directed: Yes.</p> <p>Review of Resident #R7's current 08/2024 physician orders revealed in part .</p> <p>07/31/2024: Wanderguard to ankle for elopement risk every shift.</p> <p>07/31/2024: Monitor every hour due to elopement attempts.</p> <p>Review of Resident #R7's record revealed no evidence of hourly monitoring.</p> <p>Review of Resident #R7's Departmental Progress Notes revealed the following in part .</p> <p>06/16/2024 11:13 a.m., documented by S10LPN, read in part . Behavior issues noted this shift. Resident pacing in hallways, attempting to get out of doors when someone enters or exit.</p> <p>6/20/2024 3:16 p.m., documented by S10LPN, read in part . Attempting to exit facility, went to north reception screaming and cursing pushing on front door.</p> <p>08/04/2024 17:34 p.m., documented by S8LPN, read in part . Resident walks in hallways independently, Resident often asking when she can go home, re direction difficult at times. Active exit seeker. Safety maintained.</p> <p>Review of Departmental Progress Notes dated 05/2024 - 08/2024 revealed no documentation of Resident #R7's elopements on 06/25/2024 and 08/03/2024.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Telephone interview on 08/16/2024 at 9:07 a.m., with S8LPN revealed she was assigned care of Resident #R7 on 08/03/2024. S8LPN revealed she was seated at the nurse's station charting when she heard a wanderguard alarm go off at the X Hall front door. S8LPN revealed Resident #R7 went out the front door without staff, and ambulated a few feet, before a CNA was able to get to Resident #R7. S8LPN revealed #R7 was outside for about 1 minute, and was located in the facility's driveway when staff responded. S8LPN revealed staff immediately brought Resident #R7 back into the facility. S8LPN revealed Resident #R7 was able to get out the X Hall front door, unsupervised by staff, due to a visitor entering the facility and allowing #R7 outside. S8LPN confirmed #R7 had active exit seeking behaviors, wore a wanderguard, and staff were to monitor Resident #R7 every 1 hour. S8LPN was unable to recall the last time she had visually seen Resident #R7 prior to the elopement. S8LPN revealed Resident #R7 had another elopement on 06/25/2024, but she was unable to recall details of that incident.</p> <p>Observation on 08/16/2024 at 12:40 p.m., revealed there was no signage posted at the front entrance of X Hall side of facility, that instructed that visitors were not to let residents out without staff approval, as noted in Resident #R7's care plan.</p> <p>Observation on 08/16/2024 at 1:56 p.m., revealed there was no signage posted at the front entrance of Z Hall side of facility, that instructed that visitors were not to let residents out without staff approval, as noted in Resident #R7's care plan.</p> <p>Observation on 08/16/2024 at 1:59 p.m. revealed Resident #R7 was ambulating on X Hall, and had a wanderguard device located on her left ankle.</p> <p>Interview on 08/16/2024 at 2:04 p.m. with Resident #R7 revealed she stated I want to go home so bad, I can taste it! Resident #R7 stated Can you do something for me? Can you call my son? I want to see my kids so bad, I got to go! If you have kids you understand what I'm saying.</p> <p>Interview on 08/16/2024 at 2:15 p.m. with S2DON, revealed Resident #R7 went out the X Hall front door, unsupervised by staff on 06/25/2024 and 08/03/2024.</p> <p>Review of the facility's video camera footage on 08/16/2024, revealed on 06/25/2024 at 3:59:36 p.m., a group of visitors entered the access code to unlock the X Hall front door. Before the door closed, Resident #R7 was seen ambulating briskly behind the group of visitors, unsupervised by staff, and quickly ambulated down the sidewalk towards a high traffic road adjacent to the front side of facility. Observation revealed there was no staff present in the X Hall lobby at the time Resident #R7 exited the facility. S14CNA was observed running to respond to the wanderguard alarm, and on 06/25/2024 at 4:00:36 p.m., S14CNA brought Resident #R7 back into the facility.</p> <p>Review of the facility's video camera footage on 08/16/2024, revealed on 08/03/2024 at 1:39:17 p.m., Resident #R7 was observed ambulating from X Hall, and continued to walk towards the X Hall front door. Observation revealed there was no staff present in the X Hall lobby at the time Resident #R7 was in the lobby. At that time, a visitor was seen entering the access code to unlock the front door. As the visitor walked in, Resident #R7 walked out of the facility door unsupervised, and briskly ambulated into the parking lot walking towards a high traffic road adjacent to the front side of facility. S15CNA was observed running out X Hall front door at 1:39:39 p.m. to respond to the wanderguard alarm. S15CNA, S16CNA, and S8LPN were observed speaking to Resident #R7 in the facility's parking lot, and was able to get Resident #R7 back into the facility at 1:40:07p.m.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 08/16/2024 at 2:25 p.m. with S2DON, following review of video camera footage, revealed he was unsure of the last time staff had visually monitored Resident #R7 before she exited the facility unsupervised, as every 1 hour monitoring had not been documented by staff. S2DON revealed Resident #R7 was able to ambulate very quickly. S2DON revealed the facility had not implemented any further interventions to #R7's plan of care following elopements on 06/25/2024 and 08/03/2024. S2DON reported no new in-services related to elopement were done as a result of Resident #R7's elopements. S2DON reported he did not consider these incidents as elopements because Resident #R7 did not leave the facility grounds, and that was why the facility had not implemented further interventions or investigate.</p> <p>Interview on 08/16/2024 at 6:50 p.m. with S1ADM, revealed she was aware of Resident #R7's elopements that occurred on 06/25/2024 and 08/03/2024, and the facility did not feel the incidents were elopements. S1ADM revealed Resident #R7 was able to ambulate very quickly, and stated She's fast! S1ADM revealed the facility did not have 1 hour monitoring documentation for Resident #R7 as ordered and care planned. S1ADM confirmed the facility had not updated Resident #R7's plan of care with further interventions following Resident #R7's elopements, to prevent the likelihood of further elopements by Resident #R7, but should have.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>47004</p> <p>Based on record review and interview, the facility failed to administer its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for 1 Resident (#R7), of 12 sampled residents (#1, #2, #3, #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, and #R9).</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> <li>1. Have an effective system in place to ensure Resident #R7 was adequately supervised to prevent her from exiting the building unsupervised on 06/25/2024 and 08/03/2024;</li> <li>2. Complete an incident report and/or thoroughly investigate Resident #R7's elopements on 06/25/2024 and 08/03/2024; and</li> <li>3. Update Resident #R7's care plan to include new interventions to prevent the resident from exiting the building unsupervised after two previous elopements.</li> </ol> <p>This deficient practice resulted in an Immediate Jeopardy situation on 06/25/2024 at 3:59 p.m. when Resident #R7, a severely cognitively impaired resident who had a history of wandering, followed visitors out of the building via the front entrance door, and walked into the parking lot unsupervised on 06/25/2024 and 08/03/2024.</p> <p>S1 ADM was notified of the Immediate Jeopardy on 08/16/2024 at 6:50 p.m.</p> <p>The Immediate Jeopardy was removed on 08/19/2024 at 5:13 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.</p> <p>Findings:</p> <p>Cross Reference to F689</p> <p>Review of the facility's policy titled, Elopements dated 12/2007 revealed in part . Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse of Director of Nursing.</p> <p>Review of the facility's policy titled, Accidents and Incidents-Investigating and Reporting dated 07/2017 revealed in part . All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.</p> <p>Interview on 08/16/2024 at 2:15 p.m. with S2 DON revealed Resident #R7 went out the X Hall front door, unsupervised by staff on 06/25/2024 and 08/03/2024. S2 DON confirmed the facility did not complete an incident report on 06/25/2024. S2 DON revealed the facility had not investigated Resident #R7's elopement incidents as there was no incident to investigate.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 08/16/2024 at 2:25 p.m. with S2 DON revealed the facility had not implemented any further interventions to Resident #R7's plan of care following elopements on 06/25/2024 and 08/03/2024. S2 DON revealed no new in-services related to elopement were done as a result of Resident #R7's elopements. S2 DON revealed he did not consider these incidents an elopement because Resident #R7 did not leave the facility grounds.</p> <p>Interview on 08/16/2024 at 3:19 p.m. with S2 DON revealed the facility did not have a policy related to training staff on risk for elopement, how to respond after an elopement, or a policy specific to Elopement/Wandering Assessments.</p> <p>Interview on 08/16/2024 at 6:50 p.m. with S1 ADM revealed she was aware of Resident #R7's elopements that occurred on 06/25/2024 and 08/03/2024, and the facility did not complete incident reports or in-servicing because the facility did not feel the incidents were elopements. S1 ADM confirmed the facility had not updated Resident #R7's plan of care with further interventions following elopements to prevent the likelihood of elopement, but should have.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45213</p> <p>Based on interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help to prevent the development of communicable diseases and infections for 1 (Resident #1) of 12 (Resident #1, Resident #2, Resident #3, #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, and #R9) sampled residents. The facility failed to ensure the following:</p> <ol style="list-style-type: none"> <li>1. Staff provided proper perineal care for Resident #1.</li> <li>2. Staff did not stand on Resident #1's mattresses to provide care.</li> <li>3. Proper disposal of soiled linens and briefs in Resident #1's room.</li> </ol> <p>Findings:</p> <p>Review of the facility's policy titled Perineal Care dated 02/2018 read in part .The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritations, and to observe the resident's skin condition. b. Wash perineal area, wiping from front to back. e. Wash the rectal area thoroughly, wiping from the base of the labia towards extending over the buttocks. 9. Discard disposable items into designated containers.</p> <p>Review of Resident #1's medical record revealed an admitted on 03/24/2021 with diagnoses which included: Altered Mental Status, Dementia, Pseudobulbar Affect, Muscle Weakness, Difficulty in Walking, Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of Resident #1's Significant Change MDS with an ARD of 05/01/2024 revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #1's MDS revealed she had the ability to express her ideas and wants which could be understood. Resident #1's MDS stated she required moderate assistance with upper body dressing, lower body dressing and personal hygiene; maximal assistance with bathing; and she was dependent on staff for toileting hygiene.</p> <p>Review of Resident #1's Care Plan with a Target Date of 08/30/2024 revealed in part . ADL self-care performance. Interventions: Camera in room provided per family. Encourage the resident to participate to the fullest extent possible with each interaction. Praise all efforts at self-care.</p> <p>Review on 08/12/2024 of video camera footage of Resident #1's room dated 07/19/2024 at 1:47 a.m. revealed S3 CNA providing perineal care to Resident #1 while standing on the mattress that is on the floor by the side of Resident #1's bed. S3 CNA turned Resident #1, removed the disposable incontinent brief from under her, and put it on the mattress on the side of Resident #1's bed.</p> <p>Review on 08/12/2024 of video camera footage of Resident #1's room dated 07/23/2024 at 7:52 p.m. revealed S3 CNA standing on the mattress on the floor next to Resident #1's bed. The mattress has areas that were wet where S3 CNA is standing. S3 CNA then climbed into Resident #1's bed and stood on the mattress at the head of the bed to pull her up. S3 CNA then walked on the mattress to get off of the bed.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review on 08/12/2024 of video camera footage of Resident #1's room dated 07/23/2024 at 11:02 p.m. revealed S3 CNA and S4 CNA were providing perineal care to Resident #1. S3 CNA and S4 CNA rolled Resident #1 on her left side and S3 CNA cleansed from her buttocks downward to her labia. S4 CNA grabbed the disposable incontinent brief from under Resident #1 and tossed it on the floor.</p> <p>Interview on 08/12/2024 at 10:45 a.m. with S1 ADM revealed she reviewed video video footage on 07/29/2024 where S3 CNA got on Resident #1's bed to pull her up in bed. S1 ADM confirmed S3 CNA should have never stood on Resident #1's bed. S1 ADM revealed S3 CNA reported she did not want to have to pick up the floor mattress and raise the bed to pull her up.</p> <p>Telephone interview on 08/15/2024 at 10:52 a.m. with S3 CNA revealed she would have had to move the mattress next to Resident #1's bed and lower the bed but she was in a rush. S3 CNA confirmed she should not have stood on Resident #1's bed to pull her up.</p>