STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195603	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayou Vista Nursing and Rehab Center	323 Evergreen Hwy Bunkie, LA 71322

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 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** 38894 Based on observation, interview and record review the facility failed to ensure each resident's call light, fall mat and bed alarm were in place and/or functioning properly to prevent accidents for 1 (Resident #1) of 3 (Resident #1, Resident #2 and Resident #3) sampled residents at risk for falls. The deficient practice resulted in an actual harm for Resident #1 on 07/14/2024 at 2:25 p.m., when Resident #1 was found on the floor in his room by his bed. At the time of the fall, Resident #1's fall mat was not in place, his call light was not in reach, and his bed alarm was not functioning properly. Resident #1 was hospitalized from 07/14/2024 to 07/17/2024 with a Subdural Hematoma, Left Eye Laceration and Skin Tears to Left Arm and Hand. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the facility's 2023 Policy titled Resident Alarms revealed in part . Policy Explanation and Compliance Guidelines 6. b. ii. Verifying alarms are working properly. Review of Resident #1's Electronic Health Record revealed an admitted [DATE], with the following diagnoses in part . Hemiplegia and Hemiparesis following other Non-Traumatic Intracranial Hemorrhage Affecting Right Dominant side; Dementia; Anxiety Disorder; and Major Depressive Disorder. The EHR revealed Resident #1 was admitted to Hospice on 05/06/2024. Review of Resident #1's Care Plan with target date of 08/14/2024, revealed the following problem: high risk for falls, with a goal of I will be free of major injury through the review date. Interventions included: Staff to make sure bed locked at all times; Bed alarm assess every shift for placement & proper working order; Staff to monitor call light position on rounds while in bed; Nurse to monitor placement of wedges and fall matt in place as ordered. I will have my call light within reach. I will be encouraged to use my call light for assistance as needed; Keep bed low locked; and Leaf to make staff aware high risk for falls. Review of Resident #1's 07/2024 MD Orders included the following: (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	07/19/2024 - Monitor placement of bed alarm and working order. Review of Resident #1's 07/14/2024 Electronic Medication Administration Record (e-MAR) revealed that his bed alarm and fall mat were signed off by S3 LPN as being in place at 1:00 p.m. Review of Resident #1's 07/14/2024 - 07/17/2024 Nurse Notes revealed on 07/14/2024 at 2:25 p.m., the nurse was called to Resident #1's room per CNA. Resident found on floor laying on left side with a puddle of blood. Resident rolled over to back for assessment. Findings include laceration on top of left eye, AAO x 1. Resident complained of back pain, left shoulder and hip pain. Skin tear noted to left arm/hand. Resident sent to hospital for evaluation. S8 NP; S2 DON; RP; and RN at Hospice agency notified. Interview on 07/30/2024 at 1:16 p.m. with S6 Housekeeper revealed that on 07/14/2024 (she was unable to remember the time), she entered Resident #1's room to clean. S6 Housekeeper stated Resident #1's fall mat was leaning against the air conditioner in his room. S6 Housekeeper stated she ask S5 CNA to help her move the mat so she could finish cleaning the room, and the mat was placed in front of Resident #1's closet. S6 Housekeeper stated when she finished cleaning the room she left. S6 Housekeeper stated she thought S5 CNA would replace the fall mat beside Resident #1's bed when she left. Telephone interview on 07/30/2024 at 1:29 p.m. with S3 LPN, revealed she worked at the facility on 07/14/2024 and was the nurse for Resident #1. S3 LPN stated Resident #1, who was normally up in his Geri-Chair, remained in bed on 07/14/2024, because he was not feeling well. S3 LPN stated she was called to Resident #1's room by a CNA, and found Resident #1 lying on the floor on his left side, bleeding. S3 LPN stated she rolled Resident #1 over to his back, and he had a laceration to the top of his left eye. S3 LPN stated Resident #1's fall mat was not in place beside his bed; his call light was not within reach; and she did not hear the bed alarm because the battery was weak and the alarm was very quiet. S3 LPN stated the ambulance was called, and Resident #1 was transferred to the emergency room . Telephone interview on 07/31/2024 at 2:28 p.m. with S3 LPN revealed she checked the bed alarm, call light placement and the fall mat status at around 11:00 a.m. on 07/14/2024, instead of 1:00 p.m. as indicated on the e-MAR. S3 LPN stated that all were in place and the bed alarm was functioning properly. Interview on 07/30/2024 at 2:26 p.m. with S1Administrator revealed Resident #1's Hospice and the facility staff were responsible for checking the battery in the bed alarms. The facility has implemented the following actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Termination Report dated 07/17/2024: S5 CNA was dismissed due to violation of policy - Failure to place protective fall equipment, resulting in a resident fall with injury. Staff In-services dated 07/14/2024 - 07/28/2024: 1. Room monitoring Audit on Fall Prevention Equipment B/C Hall which included Bed Bolsters, fall mats. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Protective equipment for fall prevention - do not document on this until you first ensure equipment is in place. This includes bed bolsters, wedges, as well as fall mats. Audits have been put in place to ensure compliance, to be completed by the QA team, as well as staff nurses. 3. Resident #1 - Each shift while resident is in bed, observe for bed alarm in place and working. Extra battery at B/C nurses station 9 volt, wedge in place, fall pad on floor next to bed, bed low and locked position, call bell within reach. Paper audit to be completed by LPN on duty. 4. Housekeeping - When cleaning resident's rooms, place fall mat back in place after sweeping and mopping. If a fall mat is in the room, yet not in proper place, check with staff nurse on duty regarding need for fall mat, and place it on floor next to appropriate resident's bed. Please also check to ensure call light in reach. 5. Resident #1 - a monitoring tool dated 07/17/2024 - 07/30/2024: Resident #1's Bed Alarm was applied and working. Extra battery on hall; Face plate in reach; wedge and floor pad in place. To be completed every 8 hours by LPN on duty on B/C hall. If up in Geri-Chair please document this. 6. In-service 07/17/2024 - Battery Log - Staff in-serviced on battery change and monitoring proper function of bed alarms. Check each time a resident is gotten out of bed, and periodically in between. An audit tool was initiated on 07/14/2024 by the facility QA team to be used by the QA team as well as nurses on duty to determine that fall prevention measures were in place, and were being utilized. The audit consisted of monitoring every 8 hours x 1 week, then BID x 4 weeks, then BID for 2 days a week x 4 weeks, then weekly until compliance was met. This audit should span a period of time of 2 months and 2 weeks at a minimum, depending on when weekly compliance was met. Completion date: 07/28/2024 Review of the facility's 07/17/2024 - 07/30/2024 Monitoring Sheets revealed CNAs and Nurses had monitored Resident #1' fall prevention devices as instructed. Interview on 07/30/2024 at 2:32 p.m. with S4 LPN revealed that the bed alarms are checked each time a resident was gotten out of bed and periodically in between. She stated she had changed the battery on Resident #1's bed alarm last week. Observation on 07/30/2024 at 1:04 p.m. revealed the resident asleep in his bed. His bed was in low position and he had a fall mat on the floor beside his bed. His bed alarm was in place with the alarm placed on top of his bed covers next to him. His call light was within reach. Interview on 07/30/2024 at 2:37 p.m. with S1 DON revealed the battery log was started on 07/17/2024 after Resident #1 returned from the hospital. She stated all staff were in-serviced on battery change and monitoring proper function of bed alarms. She stated Resident #1's bed alarm, call light and fall mat placement were to be monitored each shift. She stated there was nothing in place prior to Resident #1's fall concerning battery checks on alarms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 07/31/2024 at 8:14 a.m. revealed Resident #1 sitting asleep in his Geri-chair in his room. He had the bed alarm in his lap. His call light was within reach. Interview on 07/31/2024 at 11:31 a.m. with S1 DON revealed that S5 CNA was terminated due to openly admitting that she did not put Resident #1's fall mats in place. Interview on 07/31/2024 at 2:17 p.m. with S7 CNA revealed she used the Point Click Care Task to see what each resident required. She stated & demonstrated the use of the device for Resident #1. Resident #1 was to have q 2 hour checks on fall mat placement, bed alarm, and call light. Review of S5 CNA Personnel Record revealed a hire date of 05/20/2024 and a separation date of 07/17/2024. S5 CNA last worked on 07/14/2024. S5 CNA was terminated/fired due to violation of policy. On 07/14/2024 the CNA clocked in at 6:04 a.m. and clocked out at 1:51 p.m.