

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Courtyard Manor Nurse Care Center & Assisted LIV		STREET ADDRESS, CITY, STATE, ZIP CODE 306 Sydney Martin Road Lafayette, LA 70507	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on record reviews, observations and interviews, the facility failed to ensure reasonable accommodation of resident's needs for 1 (#12) out of 29 sampled residents as evidenced by Resident #12's easy touch call light device outside of her reach. Findings: On 10/30/2024, a review of the facility's policy titled Call System, Residents with no revision date, read in part residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Review of Resident #12's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Hemiplegia and Hemiparesis, Non-traumatic Intracranial Hemorrhage Affecting Left Non-dominant Side, Contracture Left and Right hand, and Right Mastectomy. Review of Resident #12's October 2024 physician's orders revealed an order dated 11/15/2023 which read in part .ensure flat soft touch call bell is within reach at all times, every shift. Review of Resident #12's comprehensive care plan, dated 11/15/2023, revealed in part, resident bilateral hand contractures. I had a flat soft touch call bell that I was able to use accurately. Intervention - ensure the flat soft touch call bell is within my reach at all time. On 10/28/2024 at 9:49 a.m., an observation was made of Resident #12's call bell position The soft touch call bell was located on the right side of the resident near her hip. When the resident was asked if she was able to reach her call bell, she stated she did not know where it was. The surveyor pointed to the call bell and the resident stated she was unable to reach it. On 10/29/2024 at 7:45 a.m., a second observation was made of Resident #12's call bell position. The resident's soft touch call bell was hanging on the bed rail, and not within the resident's reach. On 10/29/2024 at 7:48 a.m., an observation and interview was conducted with S1ADM (Administrator) who stated the call bell should have been clamped to the resident's sheet to ensure the resident was able to reach and use the call bell. She stated staff should have ensured the resident was able to reach and press the call bell prior to leaving the room.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 195606	Facility ID: 195606 If continuation sheet Page 1 of 12

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on record review and interviews, the facility failed to notify a resident's representative when a resident had a significant change in condition for 1 (#18) resident out of 29 sampled residents. Findings: A review of the facility's policy titled, Change in a Resident's Condition or Status with a last reviewed date of 03/15/2024, read in part, . Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status; 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. there is a significant change in the resident's physical, mental, or psychosocial status. Review of Resident #18's record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, Cerebral Infarction, Aphasia, and Alzheimer's disease. Review of Resident #18's progress notes revealed a note dated 10/11/2024 by S15LPN (Licensed Practical Nurse) that read in part, Resident started throwing up a lot in his bed. No morning medications administered. Review of Resident #18's progress notes revealed a note dated 10/17/2024 by S15LPN that read in part, Resident vomited twice on yesterday so medications were held. Review of Resident #18's progress notes revealed a note dated 10/22/2024 by S15LPN that read in part, Resident throwing up again this morning. Holding medications. Review of Resident #18's progress notes revealed a note dated 10/23/2024 by S15LPN that read in part, Resident has thrown up three times this week. He has been unable to keep his food and medications down. He was weak afterwards and didn't put up a fight . On 10/30/2024 at 10:27 a.m., a phone interview was conducted with S15LPN. S15LPN stated she did not recall notifying Resident #18's responsible party of his episodes of vomiting during the month of October 2024. S15LPN confirmed that she should have notified the responsible party of Resident #18's change in condition. On 10/30/2024 at 2:27 p.m., an interview was conducted with S2DON (Director of Nursing). S2DON stated that Resident #18's episodes of vomiting that occurred on 10/11/2024, 10/17/2024, 10/22/2024 and 10/23/2024 were considered a change in condition. She confirmed that the S15LPN had not notified the responsible party after each episode of vomiting and should have done so.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on observations, record reviews and interviews, the facility failed to ensure that services were provided as outlined in the comprehensive plan of care for 1 (#12) of 29 sampled residents as evidenced by staff failing to turn Resident #12 every two hours. Findings: Review of the resident's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Unspecified Site of Female Breast, Aphasia, Contracture of Muscle, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Contracture Left and Right Hand, and Alzheimer's Disease. Review of the resident's current physician's orders revealed an order dated 04/29/2023 which read, Turn every two hours every shift. Review of the resident's MAR (Medication Administration Record) for October 2024 read in part .turn every two hours every shift. Review of the resident's care plan dated 03/07/2024 read in part .at risk for impaired skin integrity related to incontinence, and immobility. Intervention - encourage/assist with turning and reposition every two hours. On 10/28/2024 at 9:00 a.m., an observation was made of Resident #12 in her room. The resident was lying on her back with a pillow under her head, and her bilateral above the knee amputation stumps were elevated on a cushion. On 10/28/2024 at 12:00 p.m., a follow up observation was made of Resident #12's room, which revealed the resident was lying on her back with one pillow under her head, and both stumps elevated on a cushion. Further observation revealed no other positional cushions or pillows on the resident's side of the room. On 10/29/2024 at 7:37 a.m., another observation was made of Resident #12 in her room which revealed the resident was lying on her back, with one pillow under her head, and bilateral stumps elevated on a cushion. Further observations were conducted at 8:20 a.m., 11:32 a.m., 1:29 p.m., and 4:00 p.m. The resident was in the same position for all observations. On 10/30/2024 at 8:25 a.m., an interview was conducted with S9CNA (Certified Nursing Assistant), S11TX (Treatment Nurse), S3ADON (Assistant Director of Nursing). S11TX stated that Resident #12 was on a turn schedule, and was supposed to be turned every two hours. S3ADON confirmed that staff should have had positioning cushions or extra pillows to assist with the repositioning of the resident and did not. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 11:05 a.m., an interview was conducted with S6LPN (Licensed Practical Nurse) who confirmed that staff had not been repositioning Resident #12 every two hours as per physician orders and comprehensive care plan.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on record review, observation, and interview, the facility failed to ensure a resident who was unable to carry out Activities of Daily Living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 1 (#57) of 3 (#12, #47 and #57) residents reviewed for ADLs. Findings: Review of Resident #57's clinical record revealed he was admitted to the facility on [DATE] with the following diagnoses, in part, Hemiplegia and Hemiparesis following other non traumatic intracranial hemorrhage affecting left non-dominant side, Contracture to left and right hand, and Contracture to left and right leg. Review of the Minimum Data Set (MDS) dated [DATE] read in part .Brief Interview for Mental Status (BIMS) score was 9, which indicated he had moderate cognitive impairment. Review of the resident's care plan dated 08/27/2024 read in part At risk for bowel and bladder incontinence related to immobility, Benign Prostatic Hyperplasia (BPH), Overactive bladder. I am incontinent of bowel and bladder, and I require total assistance with perineal care. Incontinent checks every two hours with perineal care. I require assistance with activities of daily living for a history related to Cerebrovascular accident with left hemiparesis, immobility, bowel and bladder incontinence, and bilateral upper and lower extremity contractures. Perineal care provided per staff every two hours and as needed. On 10/28/2024 at 9:09 a.m., an observation and interview was conducted with Resident #57. He stated staff got him up this morning at 5 a.m. and they had not performed perineal care on him since 5 a.m. Resident #57 stated that when the staff gets him up in the mornings, no one comes back put him in bed until after lunch and that is when they usually perform perineal care again. On 10/28/2024 at 11:05 a.m., an observation and follow-up interview was conducted with the resident. He stated that staff had not perform perineal care on him since put him in his geri (geriatric) chair. Resident #57 was observed with a strong urine and feces odor. On 10/28/2024 at 12:26 p.m., Resident #57 was observed in the dining room being assisted with his meal by S10CNA (Certified Nursing Assistant). During the lunch meal, the resident still had a strong urine and feces odor. On 10/28/2024 at 12:56 p.m., S10CNA and S11TX (Treatment Nurse) was observed assisting Resident #57 back to bed. Further observation revealed the resident was soiled with a large amount of urine and feces. S10CNA confirmed she had not performed perineal care prior to the resident going to the dining room. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 1:08 p.m., Resident #57 stated, in the presence of S10CNA, this was the second time he received perineal care since he was put in his geri chair at 5 a.m. S10CNA confirmed that the night shift put the resident in his geri chair around 5 a.m., or 6 a.m. S10CNA also confirmed that the resident should have received perineal care prior to bringing him to the dining room and every two hours, as needed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on observations, interviews, and record reviews, the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 residents (#46) investigated for respiratory care out of a finalized sample of 29 residents by failing to label and properly store Resident #46's CPAP (continuous positive airway pressure) mask. Findings: Resident #46 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Cerebral Infarction, Congestive Heart Failure, Acute and Chronic Respiratory Failure with Hypercapnia, Sleep Apnea and Morbid (Severe) Obesity. Review of Resident #46's physician orders revealed an order initiated on 01/26/2024 that read Change CPAP humidifier chamber and full mask with head gear every 6 months and prn (as needed.) Review of Resident #46's care plan revealed in part . I am at risk for respiratory complications r/t (related to) chronic respiratory failure, sleep apnea and obesity. I require O2 (oxygen) therapy and I use a CPAP during sleep to assist with breathing. Interventions: CPAP as ordered; follow directions to keep it clean. On 10/28/2024 at 12:26 p.m., an observation and interview was conducted with S3ADON (Assistant Director of Nursing) of Resident #46's CPAP mask. Resident #46's CPAP mask was observed to be unlabeled and stored in an unlabeled plastic bag. S3ADON confirmed that the mask or storage bag should have been labeled with the date it was changed and was not.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41419 Based on observations, interviews and record reviews, the facility failed to ensure that nursing staff possessed competencies and skill sets necessary to provide nursing services to meet the residents' needs safely, and attain or maintain the highest practicable physical well-being for 1(#12) of 00 sampled residents as evidenced by nursing staff failing to properly maintain and record output from a Jackson Pratt (JP) drain for Resident #12. Findings: On 10/30/2024, a review of the facility's assessment with no revision date, read in part Before any new diagnoses is accepted into the facility the facility ensures the staff is competent of taking care of the resident. If a new diagnosis occurs then the facility would seek education and resources to ensure that the facility is able to care for the resident and new diagnoses, through this process. Further review revealed a review of clinical competencies within the clinical department is done on hire, annually and as needed based on need to ensure new protocols and procedures are performed adequately. Review of Resident #12's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Unspecified Site of Female Breast, Aphasia, Contracture of Muscle, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Contracture Left and Right Hand, and Alzheimer's Disease. Review of Resident #12's Treatment Administration Record (TAR) dated October 2024 read in part monitor JP drain to right breast surgical incision site, for placement, color and drainage amount in milliliters. Review of Resident #12's discharge summary from a local hospital titled Drain Instructions and dated 10/17/2024, read in part instructions for emptying the drain- squeeze the container making it flat and close it. Keeping the container flat, helps to remove drainage from under the skin. Record the date, time, and the amount of drainage on the bottom of the sheet. Empty the container three times a day-morning, noon, and night. On 10/28/2021 at 2:21 p.m., a Review of Resident #12's physician's orders dated October 2024 prior to the facility staff changing the order read in part record JP drain output and record. Review of Resident #12's care plan dated 10/17/2024, read in part .right breast mastectomy due to breast cancer - follow post-operative orders as ordered by physician, monitor and record drainage from JP drain as ordered, monitor incision site of s/s (signs/symptoms)of infection, and bring to follow up appointment. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/2024 at 2:21p.m., an observation of Resident #12's JP drain revealed an uncompressed bulb with light red colored fluid in the drain. An immediate observation and interview was conducted with S3ADON (Assistant Director of Nursing) who stated that S5LPN (Licensed Practical Nurse) should have emptied the drain. S3ADON confirmed that the drain bulb should have been compressed. S3ADON emptied the JP drain and discarded 75 ml (Milliliters) of drainage which compressed the bulb. Further observation revealed an additional 65 ml was emptied from the JP drain immediately. S3ADON confirmed that S5LPN should have been monitoring the JP drainage every shift and as needed. On 10/28/2024 at 2:30 p.m., S2DON (Director of Nursing) entered the resident's room and presented the recorded output for the JP drain since its insertion on 10/17/2024. A review of the document revealed on 10/19/2024, 10/20/2024, 10/21/2024, and 10/25/2024, staff had failed to record output on the 6 a.m. to 6 p. m. shift. 10/29/2024 at 1:29 p.m., an interview was conducted with S7LPN who stated when the resident returned to the facility on [DATE] she had two forms for recording output in her discharge packet. One was to complete and return to physician office at the time of follow up. The other form was for care of the JP drain, and to empty 3 times daily and record amount and color. S7LPN stated drainage was recorded every shift and not three times daily. On 10/29/2024 at 4:00 p.m., an interview was conducted with S7LPN who stated that S12LPN worked with Resident #12 on 10/19/2024 and 10/20/2024 and S5LPN worked with the resident on 10/21/2024. S13LPN worked with her on 10/25/2024. Review of the staff skills checklist with S7LPN, revealed no evidence staff were trained or had knowledge of the care and maintenance of a JP drain. On 10/30/2024 at 8:28 a.m., an interview was conducted with S7LPN who stated the S2DON should have completed an in-service training on the care of the JP drain. On 10/30/24 at 11:00 a.m., an interview was conducted with S2DON who confirmed she did not complete an in-service on the care and maintenance of the JP drain with staff. On 10/30/2024 at 4:05 p.m., a follow up observation of Resident #12's JP drain was conducted. The JP drain was observed not compressed. An observation and interview was immediately conducted with S7LPN confirmed the bulb was not compressed. S6LPN was called into the resident's room by S7LPN, and when asked if she had compressed the bulb of the drain after emptying the drain, S6LPN did not have a response. S7LPN confirmed that the JP bulb was to remain compressed.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 47251 Based on observations and interview, the facility failed to ensure staffing information posted daily was accurate and current. The facility's census was 83. Findings: On 10/29/2024 at 10:15 a.m., an observation of the daily posted staffing information revealed a date of 10/28/2024. On 10/29/2024 at 10:16 a.m., an observation of the daily posted staffing information and an interview was conducted with S14WC (Ward Clerk). She stated that she was responsible for posting the staffing information on a daily basis. S14WC confirmed the date of 10/28/2024 on the posting and stated that they have always posted the staffing information for the previous day. On 10/29/2024 at 10:50 a.m., an interview was conducted with S1ADM (Administrator). She confirmed that the staffing information posted was from the previous day (10/28/2024). She stated the information had always been posted with the prior, and not the current date.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on observations, interviews, and record review, the facility failed to honor and accommodate food preferences for 2 (#17 and #23) out of 6 (#17, #23, #26, #49, #72, and #379) residents reviewed for dining. This deficient practice had the potential to affect 78 residents who consumed meals from the kitchen. Resident #17 Review of Resident #17's medical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Type 2 Diabetes Mellitus and Muscle Wasting and Atrophy. Review of Resident #17's most recent Annual Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 8, indicating his cognition was moderately impaired. Review of Resident #17's meal ticket, read in part, . meal note: No [NAME] Leafy foods. On 10/29/2024 at 12:40 p.m. and observation and interview was conducted with Resident #17. Resident #17 was observed to have iceberg lettuce on his meal tray. Resident #17 stated that he did not like lettuce and he had removed the lettuce from his hamburger. On 10/29/2024 at 12:40 p.m., an observation of Resident #17's meal tray was conducted with S4DM (Dietary Manager). S4DM confirmed that iceberg lettuce was served on Resident #17's meal tray. On 10/30/2024 at 10:39 a.m., an observation and interview was conducted with S4DM (Dietary Manager). S4DM confirmed that Resident #17's meal ticket stated that the resident's preference included no green leafy foods. S4DM confirmed that iceberg lettuce should not have been served on Resident #17's meal tray on 10/29/2024. 47540 Resident #23 Review of Resident #23's record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Type II Diabetes Mellitus, Hyperlipidemia, and Age-Related Osteoporosis. Review of Resident #23's most recent State Annual Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 4, indicating her cognition was severely impaired. Section G: Functional Status read in part, Eating was coded as 1 (supervision-oversight, encouragement or cueing). (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's comprehensive plan of care, read in part, I am at risk for complications/injury r/t (related to) Osteoporosis with interventions . dated 08/14/2023; encourage intake of dairy products . enriched with calcium and vitamin D . Review of Resident #23's meal ticket, read in part, . meal note: milk with lunch meal. On 10/28/2024 at 12:13 p.m., Resident #23 was observed consuming her lunch meal. Her meal tray did not have milk on it. The resident stated, I would like some milk with my lunch, but they never bring any milk with lunch. On 10/28/2024 at 12:16 p.m., an observation and interview was conducted with S8LPN (Licensed Practical Nurse). S8LPN confirmed that Resident #23's meal ticket stated that the resident's preference was to receive milk with all lunch meals and she had not. On 10/30/2024 at 10:31 a.m., an interview and a review of Resident #23's meal ticket was conducted with S4DM (Dietary Manager) who confirmed that Resident #23 should receive milk with all lunch meals.		