STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195618	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record review and interviews, the facility failed to ensure all allegations of injuries of unknown source that resulted in serious bodily injury was reported immediately, or within 2 hours of the allegation to the state survey agency for 1 (#1) out of 2 (#1 and #2) residents sampled with incidents. Findings: On 11/25/2024, a review of the facility's policy titled, Abuse Investigation and Reporting with a last revision date of 01/15/2024, read in part, Reporting: 1. All alleged violations involving abuse, neglect exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; The policy also indicated that the following information 2. An alleged violation of abuse, neflect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Muscle Wasting and Atrophy, Osteoporosis, Osteoarthritis, and Alzheimer's disease. Review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 00 indicating her cognition was severely impaired. Review of Resident #1's progress notes documented by S3LPN (Licensed Practical Nurse) revealed the following in part: 10/23/2024 at 7:25 PM, Call to res (Resident #1) room per S4CNA (Certified Nursing Assistant). She stated that I needed to come take a look at res right lower leg that it look abnormal. When entering Res room res lying in bed on back. Res right lower leg swollen blue and pink pigment noted to extremity. Right foot appears to be misaligned. Unable to move or flex foot Res in severe pain . Review of Resident #1's Tibia Fibula RT (right) AP LAT (two standard X-RAY views) results revealed the following in part: examination date 10/23/2024 at 9:42 PM; . Impression: 1. Comminuted displaced fractures of the distal diaphysis of the tibia and fibula . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195618	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review Resident #1's Facility's Grievance/Complaint completed on 10/23/2024 by S2DON (Director of Nursing), read in part: . Per resident's family, resident is noted to have a fracture of her lower leg . signed by S1ADM (Administrator). On 11/25/2024 at 12:35 PM, an interview was conducted with S2DON. She stated she received a call in the evening on 10/23/2024 notifying her of Resident #1's deformity to her right leg by S3LPN. She stated this was an injury of unknown origin and she did not have access to report incidents to the state survey agency. S2DON confirmed she notified S1ADM of the incident right away on 10/23/2024. On 11/25/2024 at 1:00 PM, an interview was conducted with S1ADM. She stated she was notified about the incident on 10/23/2024 by the S2DON. S1ADM confirmed the resident was sent to the hospital for an injury of unknown origin. She confirmed she did not report this incident to the state survey agency, but should have.

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	195618	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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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 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** 49784 Based on observation, record reviews and interviews, the facility failed to develop and implement a person centered care plan for 1(Resident #2) out of 3 (Resident#1, Resident #2, and Resident #3) sampled residents by failing to ensure that the use of side rails was included in the Plan of Care for Resident #2. Findings: A review of the facility's policy Physical Restraints, Side Rails, with a last review date of 01/15/2024, revealed in part: Purpose: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. General Guidelines: 4.The use of side rails as an assistive device will be addressed in the resident care plan. Review of Resident #2's medical record revealed an admitted [DATE] with diagnosis including, but were not limited to, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Bipolar Disorder, and Major Depressive Disorder. Review of Resident #2's Plan of Care contained no documentation regarding the use of side rails. On 11/21/2024 at 2:23 p.m., an observation was made of Resident #2 in bed. Resident #2's bed was observed to have the left upper side rail in the upward position and the right upper side rail was in the downward position, with the bed's right side positioned against the wall. On 11/21/2024 at 3:09 p.m., an interview was conducted with S6CNA (Certified Nursing Assistant). She stated that Resident #2 has had side rails used in the upward position since she started working at the facility approximately a month ago. On 11/21/2024 at 3:26 p.m., a record review and interview was conducted with S2DON (Director of Nursing). S2DON confirmed that the use of side rails for Resident #2 was not documented in the Plan of Care. .

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	195618	A. Building B. Wing	11/25/2024

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Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on record reviews, observations, and interviews, the facility failed to ensure: 1. Resident #2 and Resident #3 were assessed for the risk of entrapment from side rails. 2. Informed consent was obtained from the resident or resident's representative prior to installation of side rails for Resident #2 and Resident #3. 3. Ongoing monitoring and supervision were provided for Resident #2's use of side rails. This deficient practice occurred for 2 (Resident #2, and Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: Review of the facility's policy, Physical Restraints, Side Rails, with a last review date of 01/15/2024, revealed in part: Purpose: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. General Guidelines: 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. 11. The resident will be checked periodically for safety relative to side rail use. Resident #2 Review of Resident #2's medical record revealed an admitted [DATE] with diagnosis including, which were not limited to, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Bipolar Disorder, and Major Depressive Disorder. Review of Resident #2's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 9, which indicated the resident's cognition was moderately impaired. Resident #2 was independent with rolling left to right. He required supervison or touching assistance with sit to lying; lying to sitting on side of bed; sit to stand; and chair/bed-to-chair transfer. Review of Resident #2's medical record revealed no evidence of assessment for the risk of entrapment from side rails, consent from the resident or resident's responsible party for the use of side rails, nor evidence of ongoing monitoring and supervision of side rails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of S5LPN (Licensed Practical Nurse) nurse's notes dated 09/09/2024 at 5:56 a.m., revealed in part Summoned to room per S7CNA (Certified Nursing Assistant). Resident #2 had his left leg stuck between the side railing and the mattress causing an indention in his leg. Cleaned wound with wound cleanser and applied (antibiotic) ointment and a dressing. Voices no complaints of pain or discomfort. On 11/21/2024 at 2:23 p.m., an observation and interview was conducted with Resident #2 in bed. The left upper side rail was in the up position, while the right upper side rail was in the down position with the bed's right side against the wall. The resident reported that he had no memory of becoming entrapped in the side rails on his bed. Resident #2 reported that he was able to reposition himself in the bed independently without difficulty using the left upper side rail. He demonstrated sitting up independently in the bed with his feet on the floor without difficulty. On 11/21/2024 at 3:09 p.m., an interview was conducted with S6CNA. She stated that Resident #2 has had side rails in use since she started working at the facility about a month ago. She stated that Resident #2 often transferred out of his bed independently with the side rails were in the up position. On 11/25/2024 at 11:09 a.m., a phone interview was conducted with S7CNA. She stated that on 09/09/2024, she observed Resident #2 with his left leg entrapped between the left, upper side rail and the mattress of his bed. She stated that his left leg was red and had a small skin tear as a result of the incident. On 11/25/2024 at 11:22 a.m., a phone interview was conducted with S5LPN. S5LPN stated that he observed Resident #2 with his left leg entrapped between the left, upper side rail and the mattress of his bed on 09/09/2024. He confirmed that the left upper side rail was in the upward position at the time of the incident. He stated that Resident #2 had a small skin tear on his left leg as a result of the incident. On 11/21/2024 at 3:26 p.m., a record review and interview was conducted with S2DON (Director of Nursing). S2DON confirmed Resident #2 had not been assessed for the risk of entrapment prior to the use of side rails; an informed consent had not been obtained from Resident #2 nor his responsible party prior to the use of side rails; and Resident #2 side rails remained in use despite the entrapment incident involving the left upper side rail and mattress on 09/09/2024. On 11/25/2024 at 12:25 p.m., an additional interview was conducted with S2DON. S2DON confirmed that ongoing monitoring or supervision of Resident #2's side rails had not been conducted and should have been. Resident #3 Review of Resident #3's medical record revealed an admitted [DATE] with diagnosis including, which were not limited to, Vascular Dementia, and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Review of Resident #3's Physicians Orders, in part, revealed an order dated 09/29/2023 for 1/2 (one-half) Side Rails for Bed Mobility and Repositioning. (continued on next page)

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Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed that a BIMS (Brief Interview of Mental Status) was unable to be completed due to Resident #3's inability to participate in an interview. Resident #3 was dependent on staff for all mobility areas. Review of Resident #3's care plan revealed the following: Care plan description: I require assistance with ADL's (Activities of Daily Living) r/t (related to) Cerebral Infraction, R (right) Hemiplegia/hemiparesis, Aphasia, Contractures, Foot Drop, Vascular Dementia, Impaired cognitive status. Interventions: 1/2 side rails for bed mobility/repositioning. On 11/21/2024 at 2:16 p.m., Resident #3 was observed in bed with both upper half side rails (left and right) in the upward position. On 11/21/2024 at 3:26 p.m., a record review and interview was conducted with S2DON (Director of Nursing). S2DON confirmed Resident #2 had not been assessed for the risk of entrapment prior to the use of side rails; an informed consent had not been obtained from Resident #2 nor his responsible party prior to the use of side rails; and Resident #2 side rails remained in use despite the entrapment incident involving the left upper side rail and mattress on 09/09/2024. On 11/21/2024 at 4:02 p.m., an interview and record review was conducted with S2DON. S2DON confirmed that Resident #3 had not been assessed for the risk of entrapment prior to the use of side rails, and an informed consent was not obtained from Resident #3's responsible party nor the resident prior to use of side rails.

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Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record reviews and interviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices for 1 (#1) out of 3 (#1, #2, and #3) sampled residents by failing to ensure the EMAR (Electronic Medication Administration Record) was complete and/or accurately documented for Resident #1. On 11/25/2024, a review of the facility's policy titled, Charting and Documentation with a last revision date of 01/15/2024, read in part, Policy Statement: All services provided to the resident, progress toward the care plan goals, or any change in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The policy also indicated that the following information is to be documented in the resident medical record: Medication administered, treatments or services performed, events, incidents or accidents involving the resident and progress toward or changed in the care plan goals and objectives. Review of Resident #1's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Muscle Wasting and Atrophy, Osteoporosis, Osteoarthritis, and Chronic Pain Syndrome. Review of Resident #1's physician orders revealed in part, start date: 09/01/2024 Tylenol Oral Tablet 325 MG (milligram) (Acetaminophen) Give 2 tablets by mouth every 4 hours as needed for pain. Review of Resident #1's progress notes documented by S3LPN (Licensed Practical Nurse) indicated on 10/23/2024 at 7:25 PM, S4CNA notified S3LPN to come take a look at Resident #1. S3LPN assessed the resident and observed the resident was unable to move or flex right foot and was in pain . Review of Resident #1's October 2024 EMAR reviewed and failed to reveal documentation that Tylenol Oral Tablet 325 MG was administered on 10/23/2024 at 7:25 PM by S3LPN. On 11/25/2024 at 12:35 PM an interview was conducted with S2DON (Director of Nursing). A review of S3LPN's progress note from 10/23/2024 at 7:25 PM and October 2024 EMAR was conducted with S2DON. S2DON stated nurses were supposed to document all medications that are were administered in the EMAR. S2DON confirmed there was no documentation on Resident #1's October 2024 EMAR of S3LPN administering Tylenol and it should have been documented in the EMAR.