

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Pointe Coupee Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 False River Road New Roads, LA 70760	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121</p> <p>Based on observations, interviews, and record review, the facility failed to ensure each resident was treated with dignity and respect for 1 (#1) of 3 (#1, #2, and #3) sampled residents reviewed.</p> <p>Findings:</p> <p>Review of an undated facility document titled Resident Rights revealed the following, in part:</p> <p>Every resident in the facility has the right to:</p> <p>12. Be treated courteously, fairly and with the fullest measure of dignity.</p> <p>An observation of video footage provided by Resident #1's family revealed the following, in part:</p> <p>On 09/03/2024 at 6:54 a.m., S3CNA was observed to enter the Resident #1's room and pull her covers back. S3CNA was heard yelling holy, my God what in the Hell. S3CNA was observed to remove a brown soiled sheet from the resident's bed.</p> <p>09/03/2024 6:59 a.m. - 7:01 a.m., S3CNA was observed bathing Resident #1 with a towel and a bottle of water. S3CNA was heard loudly telling Resident #1, I done told you about your attitude, cut it off! and stretch your legs out of the poo. S3CNA stated, s***, every d*** where and if I had left someone like this they would have been ready to take pictures. Resident #1 stated she was sorry and S3CNA stated, you wasn't sorry when you was hollering at me. S3CNA then appear to have someone speaking to her from outside of camera visibility and asked you heard me over here fussing. S3CNA was observed to walk from visibility of the camera towards the hallway and was heard hollering loudly and they took the f***** pictures. This woman is full of s***.</p> <p>09/03/2024 7:02 a.m., S3CNA was observed giving Resident #1 a bed bath and pouring a substance on the resident from a plastic bottle, wiped off, she was stating just be quite, calm. S3CNA stated, this is insane to come into work with this .gonna talk with supervisor as soon as I get out. Resident #1 was heard saying I am sorry and S3CNA was heard stating, don't worry about it, don't worry about it at all. S3CNA stated, honestly, I am not putting her back to bed today she can stay up that is just how p***** off I done got.</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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(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>09/03/2024 at 7:04 a.m., S3CNA was observed cleaning Resident #1 and stated I mean full of poop, what's the purpose of having a camera in here, they don't watch it to see nothing. S3CNA was heard speaking loudly stating, for the last time would you stop folding your legs up. S3CNA stated, Stop Resident #1 stop, I am trying to put your clothes on and you steady folding your legs up. S3CNA retrieved the wheelchair, sat the resident on the side of the bed, grabbed the resident under the arms, lifted and pivoted her, and swiftly and abruptly sat Resident #1 in the wheelchair. Resident #1 was stating, it is hurting. S3CNA responded I ain't got anything to do with that. Resident #1 stated, I am sorry and I don't know what to do or say and thank you ma'am. Resident #1 said are you mad at me? S3CNA responded nope I am just ready to get out of here.</p> <p>Review of Resident #1's Clinical Record revealed the resident was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Unspecified Dementia and Unspecified Severity with Other Behavioral Disturbances.</p> <p>Review of Resident #1's Significant Change MDS with an ARD of 09/22/2024 revealed a BIMS of 4 which indicated severely impaired cognition.</p> <p>On 10/01/2024 at 8:53 a.m., an interview was conducted with S3CNA. S3CNA stated on 09/03/2024, she found Resident #1 soiled in feces and was upset about it. S3CNA stated she fussed about it, was hasty with Resident #1, and had a horrible attitude while providing care to Resident #1. S3CNA stated she was unprofessional.</p> <p>On 10/01/2024 at 1:48 p.m., an interview was conducted with S2DON. S2DON stated on 09/15/2024 Resident #1's family notified her and S1ADM about S3CNA being agitated, cursing and yelling at Resident #1. S2DON confirmed Resident #1's daughter showed them the video footage of S3CNA giving a bed bath to Resident #1. S2DON confirmed S3CNA acted in that manner was undignified towards Resident #1.</p> <p>On 10/01/2024 at 2:16 p.m., an interview was conducted with S1ADM. S1ADM stated Resident #1's family showed 2-3 scenes of video from 09/03/2024 of S3CNA providing a bath, peri-care and transferring Resident #1 to a wheelchair. S1ADM confirmed S3CNA's transfer was rushed and rough. S1ADM stated S3CNA was cursing to staff in the hall regarding Resident #1's brief being full of feces. S1ADM confirmed S3CNA hollering outside the room regarding Resident #1's full brief was undignified and unprofessional. S1ADM confirmed S3CNA did not treat Resident #1 with dignity.</p>		