| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 195620 | A. Building<br>B. Wing | 12/06/2024 |

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| Pointe Coupee Healthcare | 1820 False River Road<br>New Roads, LA 70760 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868<br><br>44590<br><br>Based on observations, interviews and record reviews, the facility failed to promote and facilitate resident self-determination through support of a resident's choice to participate in activities for 1 (#61) of 2 (#22 and #61) residents reviewed for self-determination.<br><br>This deficient practice had the potential to affect any of the 92 residents currently residing in the facility.<br><br>Findings:<br><br>Review of the facility's Resident's Rights, undated, revealed, in part, the following:<br><br>20. Take part in various activities of the nursing facility.<br><br>Review of Resident #61's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses including Paraplegia; History of Falling; Lack of Coordination; Muscle Wasting and Atrophy; Generalized Muscle Weakness; and Difficulty in Walking.<br><br>Review of Resident #61's most recent Minimum Data Set, with an Assessment Reference Date of 10/09/2024, indicated resident had a Brief Interview of Mental Status of 15, which indicated resident was cognitively intact.<br><br>Review of Resident #61's Quarterly Activities Participation Review, performed on 10/09/2024, revealed, in part, the following:<br><br>Attendance and Participation Summary:<br><br>1. Describe the resident's attendance preferences and participation level with activities: Resident participates in all daily group activities.<br><br>2. Describe resident's favorite activities, special accomplishments, and/or new interests: Resident enjoys arts and crafts, bingo, pokeno, parties, movies, music, and being social.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident # 61's Care Plan, reviewed on 12/03/2024 at 11:15 a.m., revealed, in part, the following:<br><br>Problem: The resident would like to attend activities of choice.<br><br>Goals: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date.<br><br>Interventions: The resident needs assistance and escort to activity functions.<br><br>An observation and interview was conducted on 12/02/2024 at 9:02 a.m. with Resident #61. Resident #61 was observed seated in her wheelchair inside of her room with a shirt and brief on, without pants. Resident #61 stated she had difficulty with balance and was unable to safely put pants on without the assistance from staff. Resident #61 stated as soon as she finished breakfast, over an hour ago, she made a request for the CNA to assist her with putting pants on so she would not miss the morning activities. Resident #61 stated morning activities begin daily around 9:30 a.m. but she preferred to be there by 9:00 a.m. so she could converse with her friends before the activities begin. Resident #61 confirmed she really disliked not being there for 9:00 a.m. or having to miss an activity all together due to waiting on staff to assist her with getting dressed. Resident #61 confirmed she participated in the facility's activities daily and it was the highlight of her day.<br><br>An observation was conducted on 12/02/2024 at 9:08 a.m. of Resident #61 pressing the call light to request assistance with her pants.<br><br>An observation was conducted on 12/02/2024 at 9:43 a.m. of Resident #61 exiting her room, fully dressed, and headed to the activities room.<br><br>An interview was conducted on 12/04/2024 at 8:35 a.m. with S7NP. S7NP confirmed Resident #61 enjoyed participating in the facility's daily activities.<br><br>An interview was conducted on 12/05/2024 at 12:45 p.m. with S21AD. S21AD confirmed Resident #61 really enjoyed participating in all of the activities at the facility. S21AD confirmed sometimes Resident #61 was not in the activities room when they started because she was not ready in time.<br><br>An interview was conducted on 12/05/2024 at 2:15 p.m. with S2DON. S2DON confirmed if a resident requested to be up and dressed at a certain time; she would expect staff members to accommodate the resident's preference. S2DON confirmed if a resident wanted to attend an activity, she would expect staff to assist them timely so they would be able to attend. |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868<br><br>Based on record reviews and interviews, the facility failed to ensure a resident's physician was notified of significant changes that required treatment to be altered for 1(#76) of 3 (#54, #76, and #77) residents reviewed for Orthopedic braces. The facility failed to ensure:<br><br>1. The treating physician was notified when Resident #76 constantly removed an ordered LUE immobilizer brace due to a Left Distal Humerus Fracture; and<br><br>2. The physician was notified when Resident #76 showed signs of pain when receiving ADL care.<br><br>This deficient practice resulted in an Immediate Jeopardy situation on 09/13/2024 for Resident #76, a severely cognitively impaired resident, removed an immobilizing splint ordered for treatment of a Left Humerus Fracture and the nursing staff did not reapply it from 09/13/2024 through present. CNA's observed Resident #76 exhibited signs of pain when the left arm was manipulated without the immobilizer. The treating physician was not notified Resident #76 removed the left immobilizing splint and showed nonverbal signs of pain during ADL care. Failure of nursing staff to notify the physicians created a likelihood that Resident #76 could suffer from further bone displacement, improper healing, and additional pain.<br><br>S1ADM was notified of the Immediate Jeopardy Situation on 12/05/2024 at 3:07 p.m.<br><br>The Immediate Jeopardy was removed on 12/05/2024 at 6:30 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit.<br><br>This deficient practice continued at a potential for more than minimal harm for the other 92 residents residing in the facility.<br><br>Cross Reference: F656, F697<br><br>Findings:<br><br>Review of the American Academy of Orthopedic Surgeons' Guidance for Elbow Dislocation revealed, in part, the following:<br><br>Symptoms:<br><br>Elbow dislocation is extremely painful. Signs may include pain when moving the elbow.<br><br>Treatment:<br><br>The goal of immediate treatment of a dislocated elbow is to return the elbow to its normal alignment. The long-term goal is to restore function to the arm.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | After the elbow has been restored to the correct position (reduced), an immobilizing splint is applied to keep the elbow still. This protects the elbow to avoid further injury. The splint should not be removed until you follow up with a physician.<br><br>Simple elbow dislocations are treated by keeping the elbow in an immobilizing splint for 1 to 3 weeks.<br><br>X-rays may be taken periodically while the elbow recovers to ensure that the bones of the elbow joint remain well aligned.<br><br>Surgical Treatment:<br><br>If the elbow joint does not remain well-aligned, surgery may be required.<br><br>Review of [NAME] State University - [NAME] Medicine's Guidance for Elbow Dislocation - Diagnosis and Treatment revealed, in part, the following:<br><br>Elbow dislocation occurs when the humerus, ulna and radius (the elbow bones) move out of place where they meet at the elbow joint.<br><br>Treatment Options for a Dislocated Elbow:<br><br>In many elbow dislocation cases, the bones in the elbow can be realigned and put back into place without surgery. Your doctor will recommend nonsurgical techniques to treat symptoms such as pain and swelling.<br><br>Noninvasive therapy to treat elbow dislocation includes:<br><br>-Activity Modification and Immobilization with a Splint.<br><br>-Icing or applying heat to the elbow joint.<br><br>-Pain or anti-inflammatory medication.<br><br>1.<br><br>Review of the facility Policy Titled, Change in Condition Policy and Procedure, dated 08/27/2018, revealed the following:<br><br>Procedure: 1. Resident change in condition is reported promptly to the nurse by the staff person who first notices the change. 2. The licensed nurse will assess the resident and note any signs and symptoms The licensed nurse will document assessment findings in the electric medical record. 3. The resident's primary physician or designated alternate will be contacted promptly of a significant change in the resident's status. 5. The Director of Nursing or other designated staff member will assist in determining significant change in condition for purposes of reassessment when questions arise.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Review of Resident #76's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Cognitive Communication Deficit, History of Falling, and Contusion of Left Elbow. Further review revealed Resident #76 sustained a Left Humerus Fracture after a fall on 08/18/2024.<br><br>Review of Resident #76's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/11/2024 revealed the provider assessed the resident as having a Brief Interview for Mental Status (BIMS) of 03, which indicated severe cognitive impairment.<br><br>Review of CT results, dated 09/03/2024 revealed Minimally Displaced Supracondylar Humeral Fracture.<br><br>Review of Resident #76's September 2024 Physician Orders revealed the following:<br><br>09/04/2024 Left elbow immobilizing brace with sling<br><br>Review of Resident #76's Orthopedic Physician's Progress Note, dated 09/17/2024, revealed the following:<br><br>Resident #76 to wear immobilizing splint to LUE, ok to remove for bathing.<br><br>Review of Resident #76's Nurse's Notes from September 2024 revealed the following:<br><br>09/10/2024- Resident #76 received an immobilizing splint to left arm today.<br><br>09/13/2024- Resident #76 constantly removed splint to left arm. Splint reapplied multiple times but resident continued to remove it.<br><br>Review of Resident #76's Orthopedic Physician's Progress Progress Note, dated 10/01/2024, revealed the following:<br><br>Diagnosis: Left Distal Humerus Fracture<br><br>Plan: Immobilizing splint to LUE at all times, ok to remove for bathing, return to clinic in 1 month.<br><br>Review of Resident #76's October 2024 through December 2024 Physician Orders revealed the following:<br><br>10/02/2024 Left elbow immobilizing splint, may be removed for cleaning<br><br>Review of Resident #76's Nurse's Notes from October 2024 to December 2024 revealed the following:<br><br>10/02/2024- Resident #76 constantly removed splint to left arm as ordered. Educated the resident on the importance of wearing the splint. Resident voiced understanding but continued to remove the splint from her arm after it is replaced by staff.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Further review of the nursing notes revealed no documentation S2DON or the treating physician was notified Resident #76 constantly removed the immobilizing splint after placement by staff or Resident #76's continued with nonverbal signs of pain.<br><br>Review of Resident #76's Current Care Plan revealed the facility included the following problems and approaches in part:<br><br>Problem: Resident required staff assistance for ADL care related to Left Elbow Contusion.<br><br>09/04/2024 Resident has new order to encourage and ensure resident wears immobilizing splint as directed<br><br>10/02/2024 Resident constantly removing splint from left arm as ordered<br><br>Intervention: Continue to educate resident on importance of wearing the immobilizing splint, continue to encourage resident to wear the immobilizing splint as directed.<br><br>Further review revealed no new updates or interventions added after 10/02/2024.<br><br>Problem: Resident is at risk for pain related to history of falls<br><br>09/03/2024 Resident has a new order to send to ER for evaluation due to left arm pain<br><br>09/11/2024 Resident complained of mild generalized pain.<br><br>Interventions: Monitor/record/report to nurse any signs and symptoms of nonverbal pain; vocalizations (moaning, grunting); mood6/behavior (more irritable, squirmy, constant motion), notify the physician if interventions are unsuccessful.<br><br>Further review revealed no new updates or interventions added related to pain after 09/11/2024.<br><br>On 12/02/2024 at 2:47 p.m., an observation was conducted of Resident #76 without the LUE immobilizing splint.<br><br>On 12/03/2024 at 8:14 a.m., an observation was conducted of Resident #76 without the LUE immobilizing splint.<br><br>On 12/03/2024 at 9:46 a.m., an observation was conducted of Resident #76 without the LUE immobilizing splint.<br><br>On 12/03/2024 at 1:10 p.m., an observation was conducted of staff returning Resident #76 to her room. Resident #76 was noted without the LUE immobilizing splint and staff did not attempt to apply the splint at this time.<br><br>On 12/04/2024 at 9:18 a.m., an interview was conducted with S14CNA. She stated she had been assigned to care for Resident #76 for the past month. S14CNA stated she did not know the resident needed an immobilizing splint. She confirmed she had never seen the resident wear one and never attempted to put it on the resident.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/04/2024 at 9:21 a.m., an interview was conducted with S15CNA. She stated Resident #76 did not wear the splint and always removed the immobilizing splint after it was applied. She stated she provided care to Resident #76 from 08/14/2024 to current. S15CNA stated during ADL care Resident #76 moaned and told the staff, don't touch my arm, that's my broken arm. She stated Resident #76 continued to guard her left arm during ADL care. She stated when she dressed the resident, Resident #76 would guard her left arm while she slowly and very gently fed her arm through the shirt. She stated she did not tell the nurse because they already knew about the fracture. She stated she never reported the following; removing the splint, guarding her left arm or moaning during ADL care, to the nurse because she assumed the nurses knew.<br><br>On 12/04/2024 at 10:29 a.m., an interview was conducted with S16CNA. She stated Resident #76 always removed the immobilizing splint after it was applied. S16CNA stated Resident #76 guarded her left arm and grimaced when they turned her from side to side during ADL care. She stated she never reported the following; removing the splint, guarding her left arm or grimacing during ADL care, to the nurse because she assumed the nurses knew.<br><br>On 12/04/2024 at 10:56 a.m., a telephone interview was conducted with Resident #76's family member. She stated when they visited the facility in November, Resident #76 did not have the immobilizing splint on and she was not moving/using her left arm.<br><br>On 12/04/2024 at 11:58 a.m., a telephone interview was conducted with S12LPN. She stated Resident #76 was ordered to wear the immobilizing splint when she first saw the specialist in September 2024 for her left arm fracture. S12LPN stated Resident #76 was confused and continued to remove the immobilizing splint, despite education. She stated she did not know if Resident #76 still needed to wear the splint. She stated she was assigned to care for Resident #76 on 11/27/2024, 11/28/2024, 12/02/2024 and 12/03/2024. S12LPN confirmed she did not attempt to apply the splint during those shifts and Resident #76 did not have the splint in place on 12/02/2024 and 12/03/2024. She further confirmed she did not review the resident's current orders on 12/02/2024 and 12/03/2024 as to whether the resident still needed to wear the splint.<br><br>On 12/05/2024 at 12:52 p.m., an interview was conducted with S20PT. She stated Resident #76 had a history of being non-compliant due to her cognitive impairment.<br><br>On 12/04/2024 at 2:21 p.m., an interview was conducted with S13LPN. S13LPN confirmed she was Resident #76's regularly assigned nurse. S13LPN stated Resident #76 had a fall in August 2024 resulting in a diagnosis of a left elbow fracture. S13LPN stated she did recall Resident #76's orthopedic specialist ordered an immobilizing splint on 10/01/2024 to be worn at all times, but the resident learned how to take it off. S13LPN confirmed she did not notify the orthopedic specialist of Resident #76 constantly removing the immobilizing splint because she thought S7NP would do so.<br><br>On 12/05/2024 at 2:04 p.m., an interview was conducted with S2DON. S2DON confirmed Resident #76 had a current order to wear the immobilizing splint to the LUE at all times. S2DON stated she would expect the nurse to attempt to apply the splint daily and to notify her if the resident continued to remove it. S2DON stated she was not made aware Resident #76 was not wearing the immobilizing splint and therefore had not notified the Orthopedic Specialist. S2DON stated if she would have been made aware Resident #76 continued to remove the splint, they would have discussed next steps in the morning meeting with administrative staff.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/05/2024 at 5:00 p.m., an interview was conducted with S7NP. She stated she was the NP for the facility, was aware Resident #76 had a left arm fracture but was not the treating physician. S7NP stated staff notified her Resident #76 constantly removed the immobilizing splint and she encouraged staff to attempt to reapply the splint. S7NP stated she would expect staff to attempt to apply the splint at least once a shift. S7NP stated Resident #76 had difficulty understanding and was noncompliant at times due to her severe cognitive impairment. S7NP stated she did not notify the orthopedic surgeon. S7NP stated she was not aware if staff notified the treating physician of Resident #76 removing the splint.<br><br>2.<br><br>On 12/04/2024 at 9:21 a.m., an interview was conducted with S15CNA. She confirmed she was Resident #76's regularly assigned CNA. She stated she had provided ADL care to Resident #76 on 12/02/2024, 12/03/2024 and 12/04/2024 and observed Resident #76 moan, grimace her face and said don't touch my arm, that's my broken arm. She confirmed she had never reported Resident #76's signs and symptoms of pain to her nurse. She stated it was not reported because the nurses were already aware her left arm fracture.<br><br>On 12/04/2024 at 10:29 a.m., an interview was conducted with S16CNA. She confirmed she was Resident #76's regularly assigned CNA. S16CNA stated Resident #76 frequently removed her immobilizing splint. S16CNA confirmed she did not notify anyone of Resident #76 removing the splint because they could see it was not on her. S16CNA confirmed she provided ADL care to Resident #76 on 12/01/2024 and 12/04/2024. She stated during ADL care, Resident #76 always guarded her left arm and grimaced her face as they turned, repositioned or dressed her when they moved her LUE. She confirmed she had never reported Resident #76's signs and symptoms of pain to her nurse. She stated it was not reported because the nurses were already aware her left arm fracture.<br><br>On 12/04/2024 at 2:21 p.m., an interview was conducted with S13LPN. S13LPN confirmed Resident #76's CNAs had not reported any signs or symptoms of pain observed while performing her care. S13LPN stated if a CNA observed Resident #76 demonstrate nonverbal signs and symptoms of pain, she would have expected them to notify her immediately so she could treat her pain. S13LPN stated if she would have been made aware Resident #76 showed unresolved signs and symptoms of pain, she would have notified S7NP to obtain orders for treatment.<br><br>On 12/05/2024 at 5:00 p.m., an interview was conducted with S7NP. She stated she was the NP for the facility, was aware Resident #76 had a left arm fracture but was not the treating physician. S7NP stated staff notified her Resident #76 constantly removed the immobilizing splint and she encouraged staff to attempt to reapply the splint. S7NP stated she would expect staff to attempt to apply the splint at least once a shift. S7NP stated Resident #76 had difficulty understanding and was noncompliant at times due to her severe cognitive impairment. S7NP stated she did not notify the orthopedic surgeon. S7NP stated she was not aware if staff notified the treating physician of Resident #76 removing the splint. S7NP stated she was not made aware Resident #76 continued to show signs and symptoms of pain during ADL care. S7NP stated she was not made aware Resident #76 had not been receiving her PRN pain medications as ordered. S7NP stated she should have been notified immediately of Resident #76's continued signs and symptoms of pain, especially if currently ordered interventions were not working. S7NP stated if she had known of Resident #76's continued nonverbal signs and symptoms of pain, she would have ordered a scheduled pain medication.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/05/2024 at 2:04 p.m., an interview was conducted with S2DON. S2DON confirmed Resident #76 received Tramadol for pain 09/04/2024 through 09/07/2024 and the order was discontinued on 09/07/2024 with no new order for pain medication obtained. S2DON confirmed Resident #76 had a standing order for PRN Tylenol with the last dose of the PRN pain medication administered on 09/16/2024. S2DON stated she was not made aware Resident #76 continued to show signs and symptoms of nonverbal pain while receiving ADL care. S2DON further stated if Resident #76 continued to show signs and symptoms of nonverbal pain during care, the CNA should have immediately informed their nurse and the nurse should have notified herself and the physician. S2DON stated if Resident #76 continued to demonstrate unresolved nonverbal signs and symptoms of pain during care and did not received any of the ordered interventions to treat the pain, the facility had not appropriately managed her pain and they should have.<br><br>On 12/04/2024 at 10:43 a.m., an interview was conducted with a representative of Resident #76's treating Orthopedic Specialist. She confirmed Resident #76 was last seen by the MD on 10/01/2024 and was ordered to wear the immobilizer splint at all times, except when bathing. She stated the MD should have been contacted immediately if Resident #76 would not wear the immobilizing splint and/or had unresolved pain and he was not notified of either. She stated because of the type of fracture Resident #76's had, not wearing the splint could cause further pain, a displacement of the bone and/or the bone to not heal properly.<br><br>The surveyors confirmed the following had been initiated and/or implemented prior to exit:<br><br>1. Residents identified to have the potential to be affected as a result of the alleged noncompliance any resident having a change in condition that may require an alteration in treatment.<br><br>2. The orthopedic physician has been notified for Resident #76 that she is refusing/constantly removing her immobilizer brace on 12/5/2024 at 3:50pm. The orthopedic physician stated they will see her in office on 12/10/2024 and reevaluate the need for the brace at that time.<br><br>3. The primary physician will be notified of Resident #76's pain status immediately following her pain assessment.<br><br>4. Resident #76 had an x-ray of the fracture site today showing negative for a fracture; results were sent to primary physician and orthopedic physician.<br><br>5. Nursing staff will be in serviced by DON on 12/5/2024 to apply braces and/or splints as ordered and to notify physician of any non-compliance and policy on notification of MD for any change in condition requiring and alteration in treatment. Nursing staff present in facility on 12/5/2024 will be in-serviced and other nursing staff will be trained prior to starting their shift until 100% of nursing staff are trained.<br><br>6. For Resident #76, resident will have LPN floor nurse hourly rounds starting 5:00 p.m. to assure brace in place. If brace is not in place, nurse will redirect resident and reapply brace if allowed. MD will be notified of any refusals to reapply brace. Hourly rounds to continue until orthopedic appointment 12/10/2024.<br><br>7. The residents with recent/healing fractures requiring braces/devices will have nurse rounds every two hours starting 5:00 p.m. to assure braces are in place. If brace is not in place, nurse will redirect resident and reapply brace if allowed. MD will be notified of any refusals to reapply brace.<br><br>(continued on next page) |

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|---|---|---|---|
| | 195620 | A. Building<br>B. Wing | 12/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pointe Coupee Healthcare | 1820 False River Road<br>New Roads, LA 70760 |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 8. The DON will monitor compliance with physician notification related to change in condition twice weekly for 3 weeks ending on 12/27/2024 via chart review, interview and observation, gathering data from daily morning meeting to include but not limited to, incidents, wounds, behaviors, devices, and changes in medical condition, to ensure MD was notified of said change appropriately. Any issues found will be addressed immediately with staff education and progressive disciplinary action as applicable.<br><br>As of 12/5/2024, the provider asserts the likelihood for serious harm to any recipient no longer exists. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965<br><br>Based on observation, interviews, and record review, the facility failed to maintain a resident's mattress in a sanitary manner for 1 (#4) of 2 (#4 and #36) residents reviewed for environment in the final sample.<br><br>Review of the facility's Maintenance Log dated October 2024 through December 2024 revealed no entries for Resident #4's mattress.<br><br>Review of Resident #4's Clinical Record revealed an admitted [DATE].<br><br>Review of Resident #4's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/20/2024 revealed she was always incontinent of bladder.<br><br>An observation was made of Resident #4's room on 12/02/2024 at 1:40 p.m. There was a mattress on the bed frame with a cloth covering, which contained multiple brown rings. There was a strong urine odor in the room.<br><br>An interview was conducted with S4CNA on 12/02/2024 at 12:05 p.m. S4CNA stated Resident #4's mattress was replaced today. She stated the room has had a strong urine odor for months. She confirmed the mattress had multiple dried urine rings on it and it smelled like urine. She stated the mattress had been soiled with urine for months. She stated there was a Maintenance Log at the nurses' station to document maintenance concerns. She confirmed she never entered Resident #4's soiled mattress on the Maintenance Log.<br><br>An interview was conducted with S6MS on 12/02/2024 at 3:21 p.m. He stated if the CNAs identified Resident #4's mattress was soiled with urine and needed to be replaced, they should have notified maintenance or placed it on the Maintenance Log. He confirmed he was not notified, and it was not on the log. He confirmed when he removed the mattress today, the mattress had a strong urine odor.<br><br>An interview was conducted with S1ADM on 12/02/2024 at 4:20 p.m. He stated he was made aware of the condition of Resident #4's mattress this morning. He stated if the mattress had been soiled with a urine odor for a couple months, the CNA should have notified maintenance or someone in administration of the condition of the mattress so it could have been replaced. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965<br><br>Based on interviews and record review, the facility failed to ensure a resident's MDS assessment accurately reflected the PASARR status for 1 (#59) of 2 (#59 and #61) residents reviewed with Level II PASARRs.<br><br>Review of the facility's policy titled, MDS Policy and Procedure dated 06/25/2015 revealed the following, in part:<br><br>Policy:<br><br>All MDS are to be completed and transmitted according to the most current Resident Assessment Instrument manual.<br><br>Review of Resident #59's Clinical Record revealed an admitted [DATE] and diagnoses, which included Bipolar Disorder and Major Depressive Disorder.<br><br>Review of Resident #59's BHSF Form 142 revealed she was approved for admission by Level II Authority with an effective period of 02/02/2024 through 01/31/2025.<br><br>Review of Resident #59's OBH-PASARR Level II Evaluation Summary & Determination Notice revealed the following, in part:<br><br>Evaluation Placement Recommendations - The individual has a serious mental illness and is recommended nursing home admission.<br><br>Review of Resident #59's Admission MDS with an ARD of 04/11/2024 revealed the following, in part:<br><br>Section A1500: Is the resident currently considered by the state level II PASARR process to have serious Mental illness and/or intellectual disability or a related condition? 0 - No<br><br>An interview was conducted with S9MDS on 12/02/2024 at 2:34 p.m. She reviewed Resident #59's admission MDS, with an ARD of 04/11/2024, and confirmed it was coded as Resident #59 did not have a Level II PASARR, which was inaccurate. She stated Resident #59's MDS should have been coded accurately and was not.<br><br>An interview was conducted with S1ADM on 12/02/2024 at 3:21 p.m. He stated Resident #59's admission MDS should have reflected Resident #59's Level II PASARR. |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868<br><br>Based on observations, interviews, and record reviews, the facility failed to implement a resident's comprehensive person-centered care plan for 2 (#76 and #86) of 22 sampled residents reviewed for comprehensive care plan by failing to ensure:<br><br>1. Resident #76's left upper extremity immobilizing splint was applied according to the Physicians order; and<br><br>2. Resident #76 and Resident #86 attended follow up care physician's appointments as ordered<br><br>This deficient practice resulted in an Immediate Jeopardy situation on 09/13/2024 for Resident #76, a severely cognitively impaired resident, when the resident removed an immobilizing splint ordered for treatment of a Left Humerus Fracture and the nursing staff did not reapply it. From 09/13/2024 through present, nursing staff did not implement the physician's order which caused the fractured left arm to remain mobile. On 11/01/2024, the facility failed to ensure Resident #76 attended the Orthopedics' follow up appointment for reassessment of the fracture. Staff interviews revealed Resident #76 exhibited signs of pain when the left arm was manipulated without the immobilizer. It could be determined a reasonable person would have experienced increased levels of pain during ADL care as a result of the Left Humerus Fracture at the Elbow and staff not applying the immobilizing splint as ordered. Failure of nursing staff to implement the physicians order and ensure the resident attended the follow up appointment created a likelihood that Resident #76 could suffer from further bone displacement, improper healing, and additional pain.<br><br>S1ADM was notified of the Immediate Jeopardy Situation on 12/05/2024 at 3:07 p.m.<br><br>The Immediate Jeopardy was removed on 12/05/2024 at 6:30 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit.<br><br>This deficient practice continued at a potential for more than minimal harm for the other 92 residents residing in the facility.<br><br>Cross Reference: F580, F697<br><br>Findings:<br><br>1.<br><br>Review of the American Academy of Orthopedic Surgeons' Guidance for Elbow Dislocation revealed, in part, the following:<br><br>Cause:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Elbow dislocations are not common. Elbow dislocations typically occur when a person falls onto an outstretched hand. When the hand hits the ground, the force is sent to the elbow. Usually, there is a turning motion in this force. This can drive and rotate the elbow out of its socket. Symptoms:<br><br>Elbow dislocation is extremely painful. Signs may include pain when moving the elbow.<br><br>Treatment:<br><br>An elbow dislocation should be considered an emergent injury.<br><br>-The goal of immediate treatment of a dislocated elbow is to return the elbow to its normal alignment. The long-term goal is to restore function to the arm.<br><br>-After the elbow has been restored to the correct position (reduced), an immobilizing splint is applied to keep the elbow still. This protects the elbow to avoid further injury. The splint should not be removed until you follow up with a physician.<br><br>-Simple elbow dislocations are treated by keeping the elbow in an immobilizing splint for 1 to 3 weeks.<br><br>-X-rays may be taken periodically while the elbow recovers to ensure that the bones of the elbow joint remain well aligned.<br><br>Surgical Treatment:<br><br>If the elbow joint does not remain well-aligned, surgery may be required.<br><br>Review of [NAME] State University - [NAME] Medicine's Guidance for Elbow Dislocation - Diagnosis and Treatment revealed, in part, the following:<br><br>Elbow dislocation occurs when the humerus, ulna and radius (the elbow bones) move out of place where they meet at the elbow joint.<br><br>Treatment Options for a Dislocated Elbow:<br><br>In many elbow dislocation cases, the bones in the elbow can be realigned and put back into place without surgery. Your doctor will recommend nonsurgical techniques to treat symptoms such as pain and swelling.<br><br>Noninvasive therapy to treat elbow dislocation includes:<br><br>-Activity Modification and Immobilization with a Splint.<br><br>-Icing or applying heat to the elbow joint.<br><br>-Pain or anti-inflammatory medication.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Review of Resident #76's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Cognitive Communication Deficit, History of Falling, and Contusion of Left Elbow. Further review revealed Resident #76 sustained a Left Humerus Fracture after a fall on 08/18/2024.<br><br>Review of Resident #76's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/11/2024 revealed the provider assessed the resident as having a Brief Interview for Mental Status (BIMS) of 03, which indicated severe cognitive impairment.<br><br>Review of Resident #76's September 2024 Physician Orders revealed the following:<br><br>09/04/2024, immobilizing brace with sling<br><br>Review of Resident #76's Current Care Plan revealed the facility included the following problems and approaches in part:<br><br>Problem: Resident required staff assistance for ADL care related to Left Elbow Contusion.<br><br>09/04/2024 Resident has new order to encourage and ensure resident wears immobilizing splint as directed<br><br>Review of Resident #76's NP Progress Note, dated 09/10/2024, revealed the following:<br><br>Resident #76 seen by previously established orthopedic physician today, immobilizing splint to LUE in place.<br><br>Review of Resident #76's Nurse's Notes revealed the following:<br><br>09/10/2024 - Resident #76 received an immobilizing splint to the left arm today.<br><br>09/13/2024 - Resident #76 constantly removed splint to left arm. Splint reapplied multiple times but resident continued to remove it.<br><br>Review of Resident #76's Orthopedic Physician's Progress Note, dated 09/17/2024, revealed the following:<br><br>Resident #76 to wear immobilizing splint to LUE, ok to remove for bathing.<br><br>Review of Resident #76's Orthopedic Physician's Progress Note, dated 10/01/2024, revealed the following:<br><br>Diagnosis: Left Distal Humerus Fracture<br><br>Plan: Immobilizing splint to LUE at all times, ok to remove for bathing, return to clinic in 1 month.<br><br>Review of Resident #76's December 2024 Physician Orders revealed the following:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 10/02/2024, Left elbow immobilizing splint, may be removed for cleaning<br><br>Review of Resident #76's Nurse's Notes revealed the following:<br><br>10/02/2024 - Resident #76 constantly removed splint to left arm as ordered. Educated the resident on the importance of wearing the splint. Resident voiced understanding but continued to remove the splint from her arm after it is replaced by staff.<br><br>Further review revealed no notes regarding the resident's splint after 10/02/2024.<br><br>Review of Resident #76's Current Care Plan revealed the facility included the following problems and approaches in part:<br><br>Problem: Resident has impaired cognitive function/dementia or impaired thought processes related to Dementia.<br><br>09/11/2024 Resident is forgetful and confused at times; Resident requires assistance in decision making.<br><br>Interventions: Ask yes/no questions in order to determine the resident's needs, cue, reorient and supervise as needed, and engage the resident in simple structured activities.<br><br>Problem: Resident required staff assistance for ADL care related to Left Elbow Contusion.<br><br>10/02/2024 Resident constantly removing splint from left arm as ordered<br><br>Intervention: Continue to educate resident on importance of wearing the immobilizing splint, continue to encourage resident to wear the immobilizing splint as directed<br><br>Further review revealed no new notes or interventions regarding the splint after 10/02/2024.<br><br>On 12/02/2024 at 2:47 p.m., an observation was conducted of Resident #76 without the LUE immobilizing splint.<br><br>On 12/03/2024 at 8:14 a.m., an observation was conducted of Resident #76 without the LUE immobilizing splint.<br><br>On 12/03/2024 at 9:46 a.m., an observation was conducted of Resident #76 without the LUE immobilizing splint.<br><br>On 12/03/2024 at 1:10 p.m., an observation was conducted of staff returning Resident #76 to her room. Resident #76 was noted without the LUE immobilizing splint and staff did not attempt to apply the splint at this time.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/04/2024 at 9:07 a.m., an interview was conducted with S13LPN. She stated Resident #76 had a fall in August 2024 and was diagnosed with a left upper arm fracture. She stated the resident's physician ordered an immobilizing splint on 10/01/2024 to be worn at all times, but the resident learned how to take it off. S13LPN stated Resident #76 currently had the immobilizing splint on. S13LPN observed Resident #76 and confirmed the resident was not wearing the immobilizing splint as ordered. S13LPN did not immediately apply the brace but exited the room and went to the computer and stated yes, it is still a current order'. She confirmed she did not attempt to apply the immobilizing splint today from 7:00 a.m. to 9:00 a.m.<br><br>On 12/04/2024 at 9:18 a.m., an interview was conducted with S14CNA. She stated she had been assigned to care for Resident #76 for the past month. S14CNA stated she did not know the resident needed an immobilizing splint. She confirmed she had never seen the resident wear one and never attempted to put it on the resident.<br><br>On 12/04/2024 at 9:21 a.m., an interview was conducted with S15CNA. She stated Resident #76 did not wear the splint and always removed the immobilizing splint after it was applied. She stated she provided care to Resident #76 from 08/14/2024 to current. S15CNA stated during ADL care Resident #76 moaned and told the staff, don't touch my arm, that's my broken arm. She stated Resident #76 continued to guard her left arm during ADL care. She stated when she dressed the resident, Resident #76 would guard her left arm while she slowly and very gently fed her arm through the shirt. She stated she did not tell the nurse because they already knew about the fracture. She stated she never reported the following; removing the splint, guarding her left arm or moaning during ADL care, to the nurse because she assumed the nurses knew.<br><br>On 12/04/2024 at 10:29 a.m., an interview was conducted with S16CNA. She stated Resident #76 always removed the immobilizing splint after it was applied. S16CNA stated Resident #76 guarded her left arm and grimaced when they turned her from side to side during ADL care. She stated she never reported the following; removing the splint, guarding her left arm or grimacing during ADL care, to the nurse because she assumed the nurses knew.<br><br>On 12/04/2024 at 10:56 a.m., a telephone interview was conducted with Resident #76's family member. She stated when they visited the facility in November, Resident #76 did not have the immobilizing splint on and she was not moving/using her left arm.<br><br>On 12/04/2024 at 11:58 a.m., a telephone interview was conducted with S12LPN. She stated Resident #76 was ordered to wear the immobilizing splint when she first saw the specialist in September 2024 for her left arm fracture. S12LPN stated Resident #76 was confused and continued to remove the immobilizing splint, despite education. She stated she did not know if Resident #76 still needed to wear the splint. She stated she was assigned to care for Resident #76 on 11/27/2024, 11/28/2024, 12/02/2024 and 12/03/2024. S12LPN confirmed she did not attempt to apply the splint during those shifts and Resident #76 did not have the splint in place on 12/02/2024 and 12/03/2024. She further confirmed she did not review the resident's current orders on 12/02/2024 and 12/03/2024 as to whether the resident still needed to wear the splint.<br><br>On 12/05/2024 at 12:52 p.m., an interview was conducted with S20PT. She stated Resident #76 had a history of being non-compliant due to her cognitive impairment.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/05/2024 at 12:44 p.m., an interview was conducted with S9MDS. S9MDS stated care plans are updated according to nurse note entries or verbal report. She confirmed there were 2 notes that stated Resident #76 constantly removed the immobilizing brace on 09/13/2024 and 10/02/2024. She stated she was not aware after Resident #67 was not wearing the immobilizing splint as ordered after 10/02/2024. When asked if education was an appropriate intervention for a cognitively impaired resident, she shrugged her shoulders and stated they can't force her to wear it.<br><br>On 12/05/2024 at 2:04 p.m., an interview was conducted with S2DON. She stated the resident's assigned nurse was responsible to apply the splint and the resident's CNA should report to the nurse if the resident removed it. She confirmed Resident #76 had a current order to wear the immobilizing splint at all times and the resident should be wearing the splint. She stated when Resident #76 removed the splint, they educated and encouraged her to wear it but no other interventions were initiated because they could not force the resident. She confirmed there was only one nurse's note on 10/02/2024 indicating Resident #76 removed the immobilizer splint and she was not aware Resident #76 was not wearing the immobilizing splint. S2DON confirmed facility staff would be expected to refer to a resident's chart to review their care plan and orders if they had questions about the care a resident required. S2DON confirmed the contents of a resident's chart should accurately reflect their medical status and/or care needs.<br><br>On 12/05/2024 at 5:00 p.m., an interview was conducted with S7NP. She stated she was the NP for the facility, was aware Resident #76 had a left arm fracture but was not the treating physician. She stated she only saw the resident wearing the immobilizing splint following the ER visit in September and had not seen it since then. She stated staff reported Resident #76 constantly removed the immobilizing splint and she encouraged staff to reapply the device. She stated Resident #76 was noncompliant at times due to her cognitive impairment. She stated she did not notify the orthopedic surgeon because she assumed at her age the physician would not have performed surgery.<br><br>On 12/04/2024 at 10:43 a.m., a telephone interview was conducted with a representative of the treating orthopedic physician. She confirmed Resident #76 was last seen by the Orthopedic physician on 10/01/2024 and the resident was not wearing the immobilizing splint at the appointment. She stated on 10/01/2024 an x-ray was obtained and a new splint was applied to Resident #76's left arm with orders to wear at all times. She stated the physician should have been made aware if Resident #76 was not wearing the splint in order to alter treatment including the possibility of surgical intervention. She stated because of the type of fracture Resident #76's had, not wearing the splint could cause further pain, a displacement of the bone and/or the bone to not heal properly.<br><br>2.<br><br>Resident #76<br><br>Review of Resident #76's Lymphedema Progress Notes, dated 01/11/2024 revealed the following:<br><br>Plan: Resident #76 to return to clinic for revaluation within 3-6 month.<br><br>Review of Resident #76's Orthopedic Physician's Progress Note, dated 10/01/2024, revealed the following:<br><br>Diagnosis: Left Distal Humerus Fracture<br><br>(continued on next page) |

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|---|---|---|---|
| | 195620 | A. Building<br>B. Wing | 12/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pointe Coupee Healthcare | 1820 False River Road<br>New Roads, LA 70760 |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Follow up appointment: 11/01/2024 at 11:15 a.m.<br><br>Review of Resident #76's Care Plan revealed the following:<br><br>No entry for orthopedic follow up appointment and lymphedema follow up appointment.<br><br>On 12/03/2024 at 3:33 p.m., an interview was conducted with S8TRP. She stated she was responsible for scheduling appointments and transporting residents to and from appointments. She stated Resident #76 was transported to and from appointments via ambulance and upon return to the facility the ambulance transport team should provide the progress notes to the nurse. She stated the nurse would then provide her a copy to ensure appointments were scheduled and transportation arranged. She stated Resident #76 did not have an appointment scheduled with the Lymphedema specialist since January 2024. She reviewed her appointment book and stated she was not aware Resident #76 had an appointment scheduled with the orthopedic specialist on 11/01/2024. She confirmed the resident missed the appointment. She confirmed she did not have Resident #76 currently scheduled for any pending appointments. She further confirmed she did not check her appointment log to ensure all progress notes were received.<br><br>On 12/04/2024 at 9:07 a.m., an interview was conducted with S13LPN. She stated normally when a resident returned from an outside appointment, the nurse received a copy of the progress note and if the resident needed a follow up appointment, a copy was provided to S8TRP. She stated when Resident #76 returned from her appointment on 10/01/2024, the splint was not discontinued. She further stated she could not remember if she provided a copy of the note to S8TRP.<br><br>On 12/03/2024 at 1:30 p.m., an interview was conducted with S2DON. She stated when a resident went out to a physician's appointment the progress notes should be physically sent back to the facility or faxed to the facility. She stated Resident #76 was transported via ambulance to appointments. She stated the ambulance transport team should provide the progress notes to the nurse and the nurse would provide a copy to S8TRP. She stated she assumed medical records monitored the scheduled appointments to ensure the facility received a progress note, but she was new to her role and she wasn't sure if this was done. She reviewed Resident #76's lymphedema clinic notes from 01/11/2024 and stated S8TRP should have been provided a copy of the note and scheduled a follow up appointment. She reviewed Resident #76's orthopedic specialist note and confirmed she had a scheduled appointment on 11/01/2024. She confirmed S8TRP should have been provided a copy of the note and arranged transportation.<br><br>On 12/04/2024 at 4:16 p.m., an interview was conducted with S19LPN. She stated normally when a resident returned from an outside appointment, the nurse received a copy of the progress note, and provided a copy to S2DON, S8TRP, S19LPN and S9MDS. She further confirmed she did not check the appointment log to ensure all progress notes were received and did not know if anyone did.<br><br>On 12/05/2024 at 12:44 p.m., an interview was conducted with S9MDS. She confirmed MD appointments were not placed on the care plan.<br><br>On 12/04/2024 at 10:43 a.m., an interview was conducted with a representative of the treating orthopedic physician. She stated Resident #76 did not show up to the scheduled follow up appointment on 11/01/2024 and currently did not have a follow up appointment scheduled. She stated Resident #76 should have been seen for the follow up prior to 12/04/2024 to determine if Resident #76 had a further bone displacement or improper healing to her left arm fracture.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/05/2024 at 5:00 p.m., an interview was conducted with S7NP. She stated she provided care for Resident #76 but was not the treating physician for the left arm fracture or Lymphedema. She stated she would expect follow up appointments to be made per the specialist recommendations and the resident should have attended both the Lymphedema follow up appointment and the followed up appointment on 11/01/2024 for further treatment recommendations.<br><br>Resident #86<br><br>Review of Resident #86's Clinical Record revealed she admitted to the facility on [DATE] and had diagnoses, which included Fibromyalgia.<br><br>Review of Resident #86's Quarterly MDS with an ARD of 11/13/2024 revealed a BIMS of 13, which indicated she was cognitively intact.<br><br>Review of Resident #86's Nurses Notes dated May 2024 through December 2024 revealed no documentation she was seen by Rheumatology or a reason she was not seen by Rheumatology.<br><br>Review of Resident #86's Physician Telephone Orders dated 05/10/2024 revealed S7NP ordered Resident #86 to return to her Rheumatology Physician regarding Fibromyalgia.<br><br>On 12/03/2024 at 12:32 p.m., a telephone interview was conducted with S7NP. She confirmed she wrote an order for Resident #86 to follow-up with Rheumatology in May 2024. She stated she did not think the appointment was scheduled.<br><br>On 12/03/2024 at 12:39 p.m., an interview was conducted with S8TRP. She confirmed the NP wrote an order on 05/10/2024 for Resident #86 to see the Rheumatologist. She stated Resident #86 had not been seen by Rheumatology. She stated she called Resident #86's Rheumatology Clinic in May 2024, and they needed a written referral. She stated she had not followed up with Resident #86's Rheumatology Clinic on the status of the referral. She stated the facility should have followed up with the Rheumatology Clinic regarding the status of the referral and appointment and did not.<br><br>On 12/03/2024 at 1:30 p.m., an interview was conducted with S2DON. She reviewed Resident #86's order to refer to Rheumatology and confirmed S8TRP should have scheduled an appointment for Resident #86 with the Rheumatology Clinic and did not.<br><br>The surveyors confirmed the following had been initiated and/or implemented prior to exit:<br><br>1. All residents in facility have the potential to be affected by the alleged non-compliance.<br><br>2. Nursing staff will be in serviced by DON on 12/05/2024 to apply braces and/or splints as ordered and to notify physician of any non-compliance and policy on notification of MD for any change in condition requiring an alteration in treatment. All floor nurses will be in-serviced that they are responsible for ensuring that follow up appointments are scheduled and carried out as ordered. Nursing staff present in facility on 12/05/2024 will be in-serviced and other nursing staff will be trained prior to starting their shift until 100% of nursing staff are trained.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 3. For resident 76, resident will have nurse hourly rounds starting 5:00 p.m. to assure brace in place. If brace is not in place, nurse will redirect resident and reapply brace if allowed. MD will be notified of any refusals to reapply brace. Hourly rounds to continue until ortho appointment 12/10/2024.<br><br>4. Resident 76 will have an x-ray of the fracture site today to determine appropriate and/or delayed healing; results will be sent to primary physician and ortho physician.<br><br>5. The ortho physician states they will see resident 76 in office on 12/10/2024 and reevaluate the need for the brace at that time.<br><br>6. DON will perform 6 chart reviews at random weekly for 3 weeks ending on 12/27/2024 to review physician's orders to ensure they are being carried out as appropriate including any follow up appointments/referrals. Monitoring will be done via record review and any issues found will be addressed immediately with staff education and progressive disciplinary action as applicable.<br><br>As of 12/5/2024, the provider asserts the likelihood for serious harm to any recipient no longer exists.<br><br>44965 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868<br><br>Based on observation, record review and interviews, the facility failed to ensure services provided by the facility to meet professional standards of quality. The facility failed to ensure medications were administered safely by leaving medications at bed side for 1 (#81) of 22 residents observed in the final sample.<br><br>Findings:<br><br>Review of Resident #81's Clinical Record revealed she was admitted to the facility on [DATE].<br><br>Review of Resident #81's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/30/2024 revealed she had a BIMS of 13, indicating she was cognitively intact.<br><br>On 12/02/2024 at 9:00 a.m., an observation was conducted of a cup of medications noted at Resident #81's bed side.<br><br>On 12/02/2024 at 10:00 a.m. an interview was conducted with S12LPN. She stated she left Resident #81's medications at bed side and should not have. S12LPN stated Resident #81 liked to take her medications at 10:00 a.m. and she had always left the medications at bedside.<br><br>On 12/05/2024 at 2:04 p.m., an interview was conducted with S2DON. She stated Resident #81 wanted to take her medications when she woke up at 10:00 a.m. and staff were instructed to leave medications at the bedside. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48333<br><br>Based on observations, interviews and record reviews the facility failed to ensure that residents who were unable to carry out ADLs (Activities of Daily Living) received the necessary services to maintain good grooming and personal hygiene. The facility staff failed to provide hair hygiene for 1 (Resident # 46) of 2 (#46 and #63) residents sampled for ADL's. This deficiency had the potential to affect all 92 residents in the facility who required assistance with ADL's.<br><br>Findings:<br><br>Review of the clinical record revealed Resident #46 was admitted to the facility on [DATE] with diagnosis that included Difficulty in Walking, Muscle Wasting and Atrophy of Right Upper Arm and Left Upper Arm, Lack of Coordination, and Dementia.<br><br>Review of Resident #46's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/23/2024 revealed Resident #46 had a BIMS of 9, which indicated moderate cognitive impairment, did not reject care, and required max assistance for personal hygiene.<br><br>Review of ADL documentation report dated October 19, 2024 through November 25, 2024 revealed no documented evidence staff washed Resident #46's hair. Further review revealed Resident #46 was scheduled for bathing assistance every Monday, Wednesday, and Friday PM.<br><br>On 12/02/2024 at 11:29 a.m., an interview and observation was conducted with Resident #46. Observed Resident #46's hair was oily and pinned to her scalp. Her scalp was dry and crusted with thick yellow colored flakes. Resident #46 reported she desired staff to wash her hair at least once a week and the staff did not. Resident #46 stated staff reported to her she could only have her hair washed by the beautician.<br><br>On 12/03/2024 at 8:48 a.m., an observation was conducted of Resident #46. Observed her hair remained unwashed and stuck to her scalp with thick yellow flakes.<br><br>On 12/03/2024 at 9:08 a.m., an interview was conducted with S10CNA who reported Resident #46 was dependent on staff for personal hygiene. She confirmed Resident #46's hair needed washing and was always flaky. She encouraged Resident #46 to get her hair washed by the beautician at least once a month due to the buildup of flakes. She confirmed that the facility's process was to perform hair washing with each bed bath.<br><br>On 12/03/2024 at 11:06 a.m., an interview was conducted with facility beautician. She reported Resident #46 was not a regular customer. She confirmed she had a very dry and flaky scalp and when she had seen Resident #46 in the past she had to wash Resident #46's hair 2 or 3 times to get it clean.<br><br>On 12/03/2024 at 11:54 a.m., an interview was conducted with S2DON who observed Resident #46's hair and confirmed it needed to be washed. She confirmed resident #46 was dependent on staff for all personal hygiene needs. S2DON further confirmed residents who require assistance with personal hygiene should have their hair washed with each scheduled bed bath three times per week. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868<br><br>Based on observations, interviews and record reviews, the facility failed to ensure residents received care, consistent with professional standards of practice to promote prevention and healing of pressure ulcers for 1 (#22) of 1 residents reviewed for pressure ulcers.<br><br>Findings:<br><br>Review of the facility policy titled Skin Protocol dated 11/25/2014, revealed the following, in part:<br><br>Purpose: To maintain healthy skin integrity, to prevent skin breakdown and prevent further skin breakdown.<br><br>Procedure: 4. Residents will be turned/repositioned every two hours or as appropriate.<br><br>Review of Resident #22's Clinical Record revealed she was admitted to the facility on [DATE] with diagnosis which included Hemiplegia and Cerebral Vascular Accident.<br><br>Review of Resident #22's Quarterly MDS with an ARD of 10/30/2024 revealed the provider assessed the resident as having a BIMS of 99, which indicated the resident was rarely or never understood. Further review revealed the provider assessed Resident #22 as totally dependent on staff for bed mobility and transfers.<br><br>Review of Resident #22's Care Plan revealed the facility included the following problems and approaches in part:<br><br>Problem: Resident #22 is at risk for skin impairment related to CVA and Hemiplegia<br><br>Intervention: Turn and reposition every two hours.<br><br>Review of Resident #22's Current Physician Orders revealed the following:<br><br>Start date- 08/01/2024. Turn and reposition every 2 hours<br><br>Review of MD Progress Note, dated 09/27/2024 revealed the following:<br><br>09/27/2024- Diagnosis- Functional Quadriplegic- dependent on staff for all ADL's and positional changes.<br><br>On 12/02/2024 at 2:33 p.m., an interview was conducted with Resident #22's family member. She reported there was a camera in Resident #22's room and staff do not turn the resident every two hours.<br><br>On 12/03/2024 at 9:15 a.m., an observation was conducted of Resident #22. Resident #22 was turned toward her left side with the wedge placed under her right side.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/03/2024 at 12:12 p.m., an observation was conducted of Resident #22 who remained in the same position turned toward the left with the wedge placed under her right side.<br><br>On 12/03/2024 at 12:46 p.m., an observation and interview was conducted with S15CNA and S18CNA in Resident #22's room during incontinence care. S15CNA and S18CNA confirmed Resident #22 was in the same position turned toward her left with the wedge placed under her right side and had not been turned to a different position since the last incontinent care provided on 12/03/2024 at 9:15 a.m.<br><br>On 12/05/2024 at 8:26 a.m., an interview was conducted with S2DON. She stated high risk residents for skin breakdown should be turned every 2 hours to prevent new pressure ulcers and facilitate proper healing for current pressure ulcers. S2DON confirmed Resident #22 was high risk for skin breakdown and required staff assistance for turning every 2 hours. |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868<br><br>Based on observations, interviews and record review, the facility failed to provide pain management for a resident following diagnosis of the Left Humerus Fracture at the Elbow consistent with the comprehensive person-centered care plan and professional standards of practice for 1 (#76) of 2 (#76 and #86) residents reviewed for pain.<br><br>This deficient practice resulted in an Immediate Jeopardy situation on 09/16/2024 when Resident #76, a severely cognitively impaired resident, received her last dose of pain medication following a fall that resulted in a Left Humerus Fracture at the Elbow. Resident #76 was treated by an Orthopedic Specialist on 10/01/2024 and returned with an order to wear an immobilizing brace to the LUE at all times to prevent further injury and to decrease pain. Staff did not apply Resident #76's immobilizing splint to her LUE from 10/02/2024 through present. Staff observed Resident #76 exhibited signs of pain when they manipulated her LUE without the immobilizing splint in place while providing ADL care and did not received pain interventions upon the onset of symptoms from 09/16/2024 through present. It could be determined a reasonable person would have experienced increased levels of pain during ADL care as a result of the Left Humerus Fracture at the Elbow and staff not applying the immobilizing splint as ordered. Failure of nursing staff to provide pain relief through pharmacological and non-pharmalogical methods, including wearing the immobilizing splint, created an increased likelihood of Resident #76 suffering bone displacement, improper healing, and on-going pain.<br><br>S1ADM was notified of the Immediate Jeopardy Situation on 12/05/2024 at 3:07 p.m.<br><br>The Immediate Jeopardy was removed on 12/05/2024 at 6:30 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit.<br><br>Cross Reference: F580, F656<br><br>Findings:<br><br>Review of the American Academy of Orthopedic Surgeons' Guidance for Elbow Dislocation revealed, in part, the following:<br><br>Symptoms:<br><br>Elbow dislocation is extremely painful. Signs may include pain when moving the elbow.<br><br>Treatment:<br><br>The goal of immediate treatment of a dislocated elbow is to return the elbow to its normal alignment. The long-term goal is to restore function to the arm.<br><br>After the elbow has been restored to the correct position (reduced), an immobilizing splint is applied to keep the elbow still. This protects the elbow to avoid further injury. The splint should not be removed until you follow up with a physician.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Simple elbow dislocations are treated by keeping the elbow in an immobilizing splint for 1 to 3 weeks.<br><br>X-rays may be taken periodically while the elbow recovers to ensure that the bones of the elbow joint remain well aligned.<br><br>Surgical Treatment:<br><br>If the elbow joint does not remain well-aligned, surgery may be required.<br><br>Review of [NAME] State University - [NAME] Medicine's Guidance for Elbow Dislocation - Diagnosis and Treatment revealed, in part, the following:<br><br>Elbow dislocation occurs when the humerus, ulna and radius (the elbow bones) move out of place where they meet at the elbow joint.<br><br>Treatment Options for a Dislocated Elbow:<br><br>In many elbow dislocation cases, the bones in the elbow can be realigned and put back into place without surgery. Your doctor will recommend nonsurgical techniques to treat symptoms such as pain and swelling.<br><br>Noninvasive therapy to treat elbow dislocation includes:<br><br>-Activity Modification and Immobilization with a Splint.<br><br>-Icing or applying heat to the elbow joint.<br><br>-Pain or anti-inflammatory medication.<br><br>Review of the facility's policy titled, Pain Assessment Policy and Procedure, dated 12/05/2014, revealed the following:<br><br>Purpose: To identify and assess residents individual needs for pain management.<br><br>Procedure: 2. Pain medication regiment is to be reviewed with each assessment.<br><br>Review of Resident #76's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Alzheimer's Disease, Cognitive Communication Deficit, History of Falling, and Contusion of Left Elbow. Further review revealed Resident #76 sustained a Left Humerus Fracture after a fall on 08/18/2024.<br><br>Review of Resident #76's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/11/2024 revealed the provider assessed the resident as having a Brief Interview for Mental Status (BIMS) of 3, which indicated severe cognitive impairment.<br><br>Review of the facility's Incident Report, dated 08/18/2024, revealed the following:<br><br>(continued on next page) |

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| | 195620 | A. Building<br>B. Wing | 12/06/2024 |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 08/18/2024: Resident #76 was found on the floor near the bed. On 08/19/2024 at 4:30 a.m., Resident #76 reported increased pain to the left arm. NP notified. Orders received for Tylenol for pain and a portable, in-house x-ray (XR). XR resulted as negative for fracture.<br><br>09/03/2024: Resident #76 was sent to the local emergency department due to continued reports of pain and the presence of swelling to the left upper arm. CT Scan revealed Minimally Displaced Supracondylar Humeral Fracture.<br><br>Review of Resident #76's Physician Orders, dated September 1, 2024 through December 4, 2024, revealed the following:<br><br>08/01/2024 - Tylenol 325mg 2 tablets by mouth every 4 hours as needed (PRN) for pain;<br><br>09/04/2024 - Tramadol 50mg by mouth 4 times a day for pain. Discontinued on 09/07/2024; and<br><br>09/04/2024 - Left elbow immobilizing splint with sling.<br><br>10/02/2024- Left elbow immobilizing splint at all times.<br><br>Review of Resident #76's Current Care Plan revealed the following new problem:<br><br>Problem: Resident #76 at risk for pain related to a history of falls.<br><br>09/03/2024 - Resident #76 sent to ER to evaluate left arm pain.<br><br>09/11/2024 - Resident #76 complained of mild generalized pain. Resident #76 verbalized relief with medication administration.<br><br>Interventions: administer pain medications as ordered, monitor/record/report to the nurse any signs and symptoms of nonverbal pain; vocalizations (grunting, moaning, yelling out); Face (grimacing), notify physician if interventions are unsuccessful.<br><br>Further review revealed no new updates or interventions added related to pain after 09/11/2024.<br><br>Problem: Resident required staff assistance for ADL care related to Left Elbow Contusion.<br><br>09/04/2024 - Resident has new order to encourage and ensure resident wears immobilizing splint as directed.<br><br>10/02/2024 - Resident constantly removing splint from left arm as ordered.<br><br>Intervention: Continue to educate resident on importance of wearing the immobilizing splint, continue to encourage resident to wear the immobilizing splint as directed<br><br>Further review revealed no new updates or interventions added after 10/02/2024.<br><br>Review of Resident #76's Medication Administration Record (MAR), dated September 2024, revealed the following:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Tramadol 50mg by mouth 4 times per day for pain. Discontinued 09/07/2024:<br><br>09/04/2024 at 8 p.m.,<br><br>09/05/2024 at 8 a.m., 12 p.m., 4 p.m., and 7 p.m.;<br><br>09/06/2024 at 8 a.m., 12 p.m., 4 p.m., and 7 p.m.; and<br><br>09/07/2024 at 8 a.m., 12 p.m., and 4 p.m.<br><br>Tylenol 325mg 2 tablets by mouth every 4 hours PRN for pain:<br><br>09/11/2024 at 6:56 p.m.;<br><br>09/13/2024 at 7:41 p.m.;<br><br>09/14/2024 at 8:26 p.m.; and<br><br>09/16/2024 at 7:58 p.m.<br><br>Review of Resident #76's MAR, from October 2024 through December 2024, revealed no documentation to indicate PRN Tylenol was administered for the treatment of pain.<br><br>Review of Resident #76's Nurses Notes, dated September 1, 2024 through December 4, 2024, revealed the following:<br><br>09/10/2024 - Resident #76 received an immobilizing splint to left arm today.<br><br>09/13/2024 - Resident #76 constantly removed splint to left arm. Splint reapplied multiple times but resident continued to remove it.<br><br>10/02/2024- Resident #76 constantly removed splint to left arm as ordered. Educated the resident on the importance of wearing the splint. Resident voiced understanding but continued to remove the splint from her arm after it is replaced by staff.<br><br>Further review revealed no new notes or interventions regarding, the splint after 10/02/2024; pain was observed or reported during care; and staff notified the physician of continued unresolved pain to LUE.<br><br>On 12/02/2024 at 2:47 p.m., an observation was conducted of Resident #76 without the LUE immobilizing splint in place.<br><br>On 12/03/2024 at 8:14 a.m., an observation was conducted of Resident #76 without the LUE immobilizing splint in place.<br><br>On 12/03/2024 at 9:46 a.m., an observation was conducted of Resident #76 without the LUE immobilizing splint in place.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/03/2024 at 1:10 p.m., an observation was conducted of staff returning Resident #76 to her room without the LUE immobilizing splint in place. Staff did not attempt to apply the splint at this time.<br><br>On 12/04/2024 at 9:21 a.m., an interview was conducted with S15CNA. She confirmed she was Resident #76's regularly assigned CNA. She stated she had provided ADL care to Resident #76 on 12/02/2024, 12/03/2024 and 12/04/2024 and observed Resident #76 moan, grimace her face and said don't touch my arm, that's my broken arm. She confirmed she had never reported Resident #76's signs and symptoms of pain to her nurse. She stated it was not reported because the nurses were already aware her left arm fracture.<br><br>On 12/04/2024 at 10:29 a.m., an interview was conducted with S16CNA. She confirmed she was Resident #76's regularly assigned CNA. S16CNA stated Resident #76 frequently removed her immobilizing splint. S16CNA confirmed she did not notify anyone of Resident #76 removing the splint because they could see it was not on her. S16CNA confirmed she provided ADL care to Resident #76 on 12/01/2024 and 12/04/2024. She stated during ADL care, Resident #76 always guarded her left arm and grimaced her face as they turned, repositioned or dressed her when they moved her LUE. She confirmed she had never reported Resident #76's signs and symptoms of pain to her nurse. She stated it was not reported because the nurses were already aware her left arm fracture.<br><br>On 12/04/2024 at 10:56 a.m., a telephone interview was conducted with Resident #76's family member. She stated when they visited the facility in November, Resident #76 did not have the immobilizing splint on and she was not moving/using her left arm.<br><br>On 12/04/2024 at 2:21 p.m., an interview was conducted with S13LPN. S13LPN confirmed she was Resident #76's regularly assigned nurse. S13LPN stated Resident #76 had a fall in August 2024 resulting in a diagnosis of a left elbow fracture. S13LPN stated she did recall Resident #76's Orthopedic Specialist ordered an immobilizing splint on 10/01/2024 to be worn at all times, but the resident learned how to take it off. S13LPN confirmed she did not notify the Orthopedic Specialist of Resident #76 constantly removing the immobilizing splint because she thought S7NP would do so. S13LPN confirmed Resident #76's CNAs had not reported any signs or symptoms of pain observed while performing her care. S13LPN stated if a CNA observed Resident #76 demonstrate nonverbal signs and symptoms of pain, she would have expected them to notify her immediately so she could treat her pain. S13LPN stated if she would have been made aware Resident #76 showed unresolved signs and symptoms of pain, she would have notified S7NP to obtain orders for treatment.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 12/05/2024 at 5:00 p.m., an interview was conducted with S7NP. She stated she was the NP for the facility, was aware Resident #76 had a left arm fracture but was not the treating physician. S7NP stated staff notified her Resident #76 constantly removed the immobilizing splint and she encouraged staff to attempt to reapply the splint. S7NP stated she would expect staff to attempt to apply the splint at least once a shift. S7NP stated Resident #76 had difficulty understanding and was noncompliant at times due to her severe cognitive impairment. S7NP stated she did not notify the orthopedic surgeon. S7NP stated she was not aware if staff notified the treating physician of Resident #76 removing the splint. S7NP stated she was not made aware Resident #76 continued to show signs and symptoms of pain during ADL care. S7NP stated she was not made aware Resident #76 had not been receiving her PRN pain medications as ordered. S7NP stated she should have been notified immediately of Resident #76's continued signs and symptoms of pain, especially if currently ordered interventions were not working. S7NP stated if she had known of Resident #76's continued nonverbal signs and symptoms of pain, she would have ordered a scheduled pain medication.<br><br>On 12/04/2024 at 10:43 a.m., an interview was conducted with a representative of Resident #76's treating Orthopedic Specialist. She confirmed Resident #76 was last seen by the MD on 10/01/2024 and was ordered to wear the immobilizer splint at all times, except when bathing. She stated the MD should have been contacted immediately if Resident #76 would not wear the immobilizing splint and/or had unresolved pain and he was not notified of either. She stated because of the type of fracture Resident #76's had, not wearing the splint could cause further pain, a displacement of the bone and/or the bone to not heal properly.<br><br>On 12/05/2024 at 2:04 p.m., an interview was conducted with S2DON. S2DON confirmed Resident #76 had a current order to wear the immobilizing splint to the LUE at all times. S2DON stated she would expect the nurse to attempt to apply the splint daily and to notify her if the resident continued to remove it. S2DON stated she was not made aware Resident #76 was not wearing the immobilizing splint and therefore had not notified the Orthopedic Specialist. S2DON stated if she would have been made aware Resident #76 continued to remove the splint, they would have discussed next steps in the morning meeting with administrative staff. S2DON confirmed Resident #76 received Tramadol for pain 09/04/2024 through 09/07/2024 and the order was discontinued on 09/07/2024 with no new order for pain medication obtained. S2DON confirmed Resident #76 had a standing order for PRN Tylenol with the last dose of the PRN pain medication administered on 09/16/2024. S2DON stated she was not made aware Resident #76 continued to show signs and symptoms of nonverbal pain while receiving ADL care. S2DON further stated if Resident #76 continued to show signs and symptoms of nonverbal pain during care, the CNA should have immediately informed their nurse and the nurse should have notified herself and the physician. S2DON stated if Resident #76 continued to demonstrate unresolved nonverbal signs and symptoms of pain during care and did not received any of the ordered interventions to treat the pain, the facility had not appropriately managed her pain and they should have.<br><br>The surveyors confirmed the following had been initiated and/or implemented prior to exit:<br><br>1. Residents identified to have the potential to be affected as a result of the alleged noncompliance include residents with recent unhealed/healing fractures and any resident who is severely cognitively impaired with the potential to experience pain.<br><br>2. Residents identified will have a pain assessment completed by a licensed nurse today<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 12/05/2024, and LPN floor nurse will interview staff taking care of those residents to assess for signs of pain during ADL care.<br><br>3. Residents who verbalize the presence of pain or who exhibit nonverbal signs of pain will have their physician notified on 12/05/2024 for orders for pain management regime.<br><br>4. DON will in-service nursing staff on signs of pain, verbal and nonverbal, and notify the physician if the resident is in pain and does not have a pain regimen ordered, and/or administer pain medication as ordered. Nursing staff present in facility on 12/05/2024 will be in-serviced and other nursing staff will be trained prior to starting their shift until 100% of nursing staff are trained.<br><br>5. Following pain assessment performed by LPN floor nurse on 12/05/2024, primary physician was notified and new pain medication will be ordered for resident #76 to initiate on 12/5/2024.<br><br>6. The DON will monitor by observing 5 care interactions on cognitively impaired residents weekly for 3 weeks ending on 12/27/2024 to assess for signs of pain and ensure the resident is receiving pain management as appropriate. The monitoring will be done via direct observation and any issues will be addressed immediately with intervention and staff education.<br><br>As of 12/5/2024, the facility asserts the likelihood for serious harm to any recipient no longer exists. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965<br><br>Based on interviews and record reviews, the facility failed to provide sufficient nursing staff to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care and considering the acuity and diagnoses of the facility's resident population by failing to respond to a resident's requests for assistance with ADLs timely for 1 (#59) of 22 residents reviewed in the final sample.<br><br>Review of the facility's PBJ Staffing Data Report for Fiscal Year Quarter 3 revealed a one-star staffing rating.<br><br>Review of the facility's Daily Assignment Sheet revealed the facility required 8 regularly staffed CNA's assigned per shift.<br><br>Review of the facility's census dated 12/01/2024 revealed there was a total census of ninety-two residents and four hallways. Further review revealed there were twelve residents residing on Hall B.<br><br>Review of the facility's Daily Assignment Sheet dated 12/03/2024 revealed the following, in part:<br><br>6:00 a.m. to 6:00 p.m.:<br><br>S4CNA - Hall B<br><br>Further review revealed no other staff member assigned to Hall B.<br><br>Review of the facility's Daily Assignment Sheet dated 12/04/2024 revealed the following, in part:<br><br>6:00 a.m. to 6:00 p.m.:<br><br>S5CNA - Hall B<br><br>Further review revealed no other staff member assigned to Hall B.<br><br>Resident #59<br><br>Review of Resident #59's Clinical Record revealed an admitted [DATE]. Further review of the Clinical Record revealed Resident #59 required two staff assistance for bed mobility, toilet use, bathing, and transfers and was always incontinent.<br><br>Review of Resident #59's Quarterly MDS with an ARD of 09/25/2024 revealed a BIMS of 14, which indicated she was cognitively intact. Further review revealed she required extensive assistance with ADLs and was always incontinent.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted with Resident #59 on 12/02/2024 at 8:52 a.m. She stated sometimes the CNAs worked short and took too long to meet her needs. She stated there were times when she initiated her call light for incontinence care, and a staff member would report to her room and tell her they would return. She stated twenty minutes later, and sometimes longer, the staff member would return to provide incontinence care. She stated this occurred almost daily.<br><br>An interview was conducted with S4CNA on 12/03/2024 at 8:36 a.m. She stated she was a full time CNA on Hall B from 6:00 a.m. to 6:00 p.m. She confirmed, on her shifts, she was always the only CNA assigned to Hall B. She explained the acuity of Hall B was too much for one CNA to be able to complete all care timely. She stated Resident #59 required two staff members for ADL assistance. She stated, at least daily, Resident #59 initiated her call light and she had to explain she would return after she completed another residents' task who was waiting. She explained she would then have to find another staff member to assist. She stated when a resident who required two staff members for assistance needed assistance, she had to go to another hall and find another CNA to assist. She stated sometimes it took a while to find someone else. She explained the other CNAs had a resident assignment and other tasks to complete. She stated she had to wait for the CNA to complete their task before they were available to assist. She stated it sometimes took fifteen to twenty minutes before she found someone, which left the resident waiting. She stated Resident #59 initiated her call light a lot for assistance. She stated she frequently told Resident #59 she would be back once she found another staff member to assist. She stated, daily, Resident #59 had to wait at least twenty minutes before she could meet her request for incontinence care. She stated twenty minutes was too long for any resident to have to wait.<br><br>An interview was conducted with S5CNA on 12/04/2024 at 7:40 a.m. She stated she was a full time CNA on Hall B. She confirmed, on her shifts, she was always the only CNA assigned to Hall B. She explained the acuity of Hall B was too much for one CNA to be able to complete all care timely. She stated Resident #59 required two staff members for assistance with ADLs. She stated when a resident who required two staff members for assistance needed assistance, she had to go to another hall and find another CNA to assist. She stated sometimes it took a while to find someone else. She explained the other CNAs had a resident assignment and other tasks to complete. She stated she had to wait for the CNA to complete their task before they were available to assist. She stated some residents often had to wait thirty to forty minutes before she could meet their request. She stated this happened a few times per week, and it was dependent on what other staff were completing on their halls. She stated there had been times when Resident #59 initiated her call light for incontinence care and it was forty minutes before she was able to meet Resident #59's request. She confirmed thirty to forty minutes was too long for any resident to have to wait for their needs to be met.<br><br>An interview was conducted with S3CSUP on 12/03/2024 at 9:44 a.m. She confirmed she was responsible for the CNA schedules. She stated when the facility was fully staffed on day shift, two CNAs were assigned to Hall A, Hall C, and Hall D, then one CNA split between Hall C and Hall D, and one CNA was assigned to Hall B. She confirmed Resident #59 required two staff members to assist with incontinence care. She stated the expectation was for the CNA assigned to Hall B to find another staff member available to assist with residents who required two person assistance and any other tasks requiring two staff members. She stated it was not acceptable for a resident to have to wait twenty minutes or longer for their needs to be met after requesting incontinence care.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted with S2DON on 12/04/2024 at 2:42 p.m. She stated S3CSUP was responsible for the CNA schedule. She stated she oversaw S3CSUP. She stated typically, the facility staffed two CNAs on Hall A, Hall C, and Hall D, and one CNA on Hall B. She stated for any resident who required two staff members for assistance with bed mobility, incontinence care, and transfers, the Hall B CNA would have to summon another qualified staff member for assistance. She stated a resident having to wait for twenty, thirty, or forty minutes for their needs to be met was appropriate depending on the circumstances. She was unable to confirm what circumstances. She stated the facility had to work with the staff to resident ratios they had. She stated she expected the staff to do the best they could with the resources they had. She stated the amount of time the resident had to wait for their requests to be responded to would depend on how long it took that staff member to complete their rounds.<br><br>An interview was conducted with S1ADM on 12/04/2024 at 2:10 p.m. He stated the facility staffed nursing personnel by the minimum state required standard of 2.35 hours per patient, per day, and did not staff based on acuity. |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868<br><br>Based on record review, interviews and observations the facility failed to ensure a resident's Medication Administration Record (MAR) was accurately documented for 1(#76) of 3(#54, #76, and #77) sampled residents reviewed for use of orthopedic devices.<br><br>Findings:<br><br>Review of Resident #76's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Cognitive Communication Deficit and Left Distal Humerus Fracture.<br><br>Review of Resident#76's Current Physician Orders revealed the following:<br><br>Start date-10/02/2024. Left elbow brace -may be removed for cleaning.<br><br>Review of Resident #76's December 2024 MAR revealed the following:<br><br>10/02/2024 Left elbow brace every shift, with a check indicating the left elbow brace was applied and in place every shift on 12/01/2024, 12/02/2024, and 12/03/2024.<br><br>On 12/2/2024 at 2:47 p.m., an observation was conducted of Resident #76 without a left elbow brace in place.<br><br>On 12/03/2024 at 8:14 a.m., an observation was conducted of Resident #76 without a left elbow brace in place.<br><br>On 12/03/2024 between 8:00 am and 10:00 a.m., observations were conducted of Resident #76 in dining area without a left elbow brace in place.<br><br>On 12/03/2024 at 12:48 p.m., an observation was conducted of Resident #76 without a left elbow brace in place.<br><br>On 12/04/2024 at 9:21 a.m., an interview was conducted with S14CNA. She reported she had been assigned to Resident #76 for one month and she was not aware of the resident having a left elbow brace. S14CNA stated she had never observed Resident #76 wearing a left elbow brace.<br><br>On 12/04/2024 at 11:58 a.m., an interview was conducted with S12LPN. She reported caring for Resident #76 on 12/02/2024 and 12/03/2024 and confirmed she did not apply the immobilizing brace to Resident #76's left arm on the above dates. She reviewed the December 2024 MAR and confirmed on 12/02/2024 and 12/03/2024 she documented a 1 on the MAR, but did not know what a 1 indicated.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195620 | A. Building<br>B. Wing | 12/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pointe Coupee Healthcare | 1820 False River Road<br>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.

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | On 12/04/2023 at 12:14 p.m., an interview was conducted with S2DON. S2DON reviewed Resident #76's December 2024 MAR. She confirmed a check mark with a 1 on the MAR indicated Resident #76's left elbow brace was in place. She was made aware S12LPN marked 1 on the MAR but reported she did not apply the left elbow brace on Resident #76. She further confirmed staff nurses should not document the left elbow brace was in place, if it was not worn by Resident #76, and this was inaccurate documentation. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590<br><br>Based on interviews and record reviews, the facility failed to meet the following Hospice requirements by failing to:<br><br>1. Designate a member of the facility's interdisciplinary team (IDT) to be responsible for working with Hospice representatives to coordinate care of the resident provided by facility and Hospice staff for 1 of 1 (#10) residents reviewed for Hospice care; and<br><br>2. Maintain a system to ensure a Hospice resident's Hospice Binder contained the most current Hospice orders, most recent Hospice plan of care and a current Recertification of Terminal Illness for 1 of 1 (#10) residents reviewed for Hospice care.<br><br>This deficient practice had the potential to affect any of the 5 residents receiving Hospice services in the facility.<br><br>Findings:<br><br>A review of the facility's Hospice Care Policy and Procedure, effective 11/17/2015, revealed, in part, the following:<br><br>Purpose:<br><br>To ensure that all disciplines are working together to provide quality care to the resident in need of hospice services.<br><br>A review of the facility's signed Annual Resident Hospice Services Agreement with Resident #10's hospice agency, undated, revealed, in part, the following:<br><br>III. Services and Responsibilities of the Nursing Facility<br><br>3.5 Patient Care:<br><br>Nursing facility shall familiarize itself with the administrative, record-keeping and personal care needs of Hospice Patients. Nursing facility will be competent to perform under this agreement in accordance with recognized professional standards for the care of terminally ill patients. Nursing facility shall ensure that the level of care provided is appropriately based on the Hospice Patient's needs.<br><br>3.6 Facility Protocols:<br><br>Nursing facility shall institute, maintain and conduct administrative procedures and protocols, which are: (a) consistent with procedures and protocols of Hospice; (b) according to recognized professional standards for care for terminally ill patients; and (c) reasonably necessary to implement this agreement.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3.10 Information:<br><br>Nursing facility shall maintain in the Hospice Patient's records at least the following: most recent Hospice Plan of Care; Hospice Election Form; Hospice Physician Certification and Recertification of the Terminal Illness; Hospice Medication Information; and Hospice and Attending Physician Orders for the Hospice Patient.<br><br>V. Admission and Coordination of Services<br><br>5.2.1 Coordination of Care:<br><br>The coordinated plan of care shall be maintained by the Hospice and by the Nursing Facility in their respective medical records.<br><br>5.2.6 Physician Orders:<br><br>Hospice and Nursing Facility will maintain adequate records of all physician orders communicated in connection with the Hospice Plan of Care.<br><br>5.2.7 Designation of Liaison:<br><br>(a) Liaison: By execution of this agreement, Hospice and Nursing Facility shall designate a liaison to facilitate cooperative efforts in performance of their respective obligations under this Agreement, provided that the Nursing Facility liaison shall have a clinical background.<br><br>V1. Records<br><br>6.1 Compilation of Records<br><br>6.1.1 Preparation<br><br>Nursing Facility and Hospice each shall prepare and maintain complete, detailed clinical records for each Hospice Patient receiving services under this agreement in accordance with prudent record-keeping procedures, and as required by applicable federal and state laws and regulations or Medicare/Medicaid guidelines.<br><br>A review of Resident #10's Clinical Record revealed he was admitted to the facility on [DATE]. Further review revealed Resident #10 was a patient of a local hospice agency with Certification Periods of 07/18/2024 through 09/15/2024; 09/16/2024 through 11/14/2024; and 11/15/2024 through 01/13/2024.<br><br>A review of Resident #10's most recent Minimum Data Set, with an Assessment Reference Date of 10/16/2024, performed on 12/03/2024 at 3:10 p.m., indicated he was assessed to have a Brief Interview of Mental Status score of 15, indicating Resident #10 was cognitively intact. Further review revealed, in part, K1. Hospice Care - Yes.<br><br>A review of Resident #10's Hospice Binder, performed on 12/03/2024 at 3:30 p.m., revealed, in part, the most recent Recertification of Terminal Illness (CTI) present in the Hospice Binder was for the Certification Period of 09/16/2024 through 11/14/2024.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #10's Hospice Plan of Care and Physician Orders, performed on 12/03/2024 at 3:30 p. m., revealed, in part, the most recent Plan of Care and Physician Orders present in the Hospice Binder were printed on 10/28/2024 for the Certification Period of 09/16/2024 through 11/14/2024. Further review revealed the most recent Hospice Physician Orders present were written on 11/01/2024.<br><br>A review of Resident #10's Hospice Nurse Visit Notes, performed on 12/03/2024 at 3:28 p.m., revealed, in part, the most recent Hospice Nurse Visit Note present in the Hospice Binder was created on 10/27/2024. Further review of the note revealed Resident #10 was noted sitting upright in bed, alert and oriented x4, and required max assist for activities of daily living but was able to feed himself.<br><br>An interview was conducted on 12/03/2024 at 3:15 p.m. with S22SW. S22SW stated Resident #10 went out to the hospital a few months back and found out his cancer had returned, since then he had been on a slow, steady decline since he arrived back to the facility. S22SW stated his decline had gotten much faster over the past month or so. S22SW stated Resident #10 used to talk to people and really enjoy getting up in his wheelchair to sit in the lobby but over the past month he wanted to stay in bed and rarely responded to her verbally when she went in to check on him. S22SW stated Resident #10 had quit eating and refused attempts for interventions to assist with his appetite or attempts to assist him with actually eating. S22SW stated Resident #10's Hospice nurse came yesterday for a routine visit and due to his decline; she would now start seeing him on daily visits. S22SW confirmed she was not the facility's designated member of the IDT responsible for handling the facility's relationship with a hospice agency.<br><br>An interview was conducted on 12/03/2024 at 3:35 p.m. with S2DON. S2DON confirmed she would expect her staff to review a resident's Hospice Binder if they had questions about the level of care they required or if there were questions about who was responsible for providing specific care needs. S2DON reviewed Resident #10's Hospice Binder and confirmed his CTI, Plan of Care, Physician Orders and Nurse Visit Notes were from his previous Certification Period and were no longer up to date. S2DON confirmed Resident #10 had experienced a decline in status and the contents of his Hospice Binder no longer accurately reflected his medical status or care needs and should. S2DON confirmed a resident's most up to date Hospice documentation would only be located in the resident's Hospice Binder and nowhere else in the facility. S2DON stated the Hospice nurse was responsible for maintaining Hospice Binders. S2DON stated the Hospice nurse should bring updated records and place them into the resident's Hospice Binder during their visits. S2DON confirmed the facility did not have anyone responsible for reviewing Hospice Binders to ensure the Hospice nurse was updating them during their visits. S2DON confirmed the facility did not have a designated member of their IDT in charge of handling the facility's relationship with a hospice agency and was not aware they should.<br><br>An interview was conducted on 12/03/2024 at 3:37 p.m. with S1ADM. S1ADM confirmed the facility did not have a designated member of their interdisciplinary team in charge of handling the facility's relationship with a hospice agency and was not aware they should. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48333<br><br>Based on observation and interviews the facility failed to maintain resident's bed equipment in safe operating condition for 1 of 1 (#36) residents observed with care equipment concerns. This failure had the potential to affect all 92 residents in the facility who sleep in a bed.<br><br>Findings:<br><br>Review of clinical record revealed Resident #36 was admitted to the facility on [DATE] with diagnosis which included Generalized Muscle Weakness, Muscle Atrophy of the Right Upper Arm, Left Upper Arm, and Right and Left Thigh, Abnormalities of Gait and Mobility, Lack of Coordination, COPD (Chronic Obstructive Pulmonary Disease), and Reduced Mobility.<br><br>Review of Resident #36's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/13/2024 revealed Resident #36 had a BIMS of 13, which indicated he was cognitively intact, and had a history of shortness of breath when lying flat.<br><br>Review of Resident #36's Care Plan revealed: Resident required head of bed to be elevated for difficulty breathing.<br><br>On 12/01/2024 at 9:09 a.m., an interview and observation was conducted with Resident #36. Resident #36 was lying supine in his bed, which was flat and in the lowest position. Resident #36 reported he desired to get out of bed and into his wheelchair, but staff had not got him out of bed for the previous 2 days.<br><br>On 12/02/2024 at 10:45 a.m., an interview was conducted with S11CNA who reported Resident #36 was not out of bed yet due to his bed being broken. She reported that maintenance cut Resident #36's bed remote control off on 11/26/2024 due to it being tangled in his bed frame. She reported his bed was not functioning and did not go up and down.<br><br>On 12/02/2024 at 3:00 p.m., an interview was conducted with S6MS who stated, on 11/26/2024, Resident #36's bed controller cord was entangled and severed by his bed frame. He stated the facility did not have an available and/or functioning bed to switch resident into from 11/26/2024 until 12/02/2024.<br><br>On 12/04/2024 at 1:35 p.m., an interview was conducted with S11CNA who reported Resident #36 remained in bed on 11/29/2024, 11/30/2024, and 12/01/2024 due to the bed controller was not safely operating the bed.<br><br>On 12/04/2024 at 1:55 p.m., an interview was conducted with S1ADM who confirmed residents should always be provided with safely operating equipment such as a bed to meet resident's needs, and Resident #36 was not provided a safe operating bed. |