

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Lafon Nursing Facility of the Holy Family		STREET ADDRESS, CITY, STATE, ZIP CODE  6900 Chef Menteur Hwy New Orleans, LA 70126	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49259</p> <p>Based on observation, interviews, and record review, the facility failed to keep a resident's environment free of accidents/hazards by failing to ensure the facility's staff used mechanical lift slings that were in good condition for 2 (Resident #3 and Resident #R4) of 4 (Resident #1, Resident #2, Resident #3, Resident #R4) residents investigated for mechanical lift transfers.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 04/12/2024 at 4:10 p.m. for Resident #3, when S6Certified Nursing Assistant (CNA) and S10CNA transferred Resident #3 using a mechanical lift, the mechanical lift sling's strap broke, and Resident #3, hit her head when she fell to the floor and had to be sent to the emergency room (ER). The Immediate Jeopardy situation continued on 07/30/2024 at 3:42 p.m., when S4CNA and S5CNA were observed transferring Resident #R4 using a mechanical lift sling on which the blue straps of the sling had been altered/removed.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 07/30/2024 at 6:45 p.m.</p> <p>The Immediate Jeopardy was removed on 07/31/2024 at 5:20 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimum harm for any resident residing in the facility who required the use of a mechanical lift for transfers.</p> <p>Findings:</p> <p>Review of the provider's policy titled, Lift Machine, Using a Mechanical last review date 02/22/2024, revealed, in part, the facility's policy was not a substitute for the manufacturer's instructions. Further review revealed the staff were to discard any worn, frayed or ripped slings.</p> <p>Review of the Invacare User Manual for Invacare Reliant 450 Manual/Electric Portable Patient Lift, Copyright date 2011, revealed, in part, the mechanical lift slings are not to be altered. Further review revealed, the mechanical lift slings should be inspected for any cuts or frays, as these mechanical lift slings are unsafe and could result in injury.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 195632	If continuation sheet Page 1 of 3

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's Electronic Medical Record (EMR) revealed, in part, Resident #3 was admitted to the facility on [DATE]. Further review revealed Resident #3 had diagnoses of Peripheral Vascular Disease, Cerebral Infarction and age related debility.</p> <p>Review of Resident #3's nurse's note dated 04/12/2024 at 6:57 p.m. written by S2Director of Nursing (DON) revealed, in part, Resident #3 had hit her head during a transfer with a mechanical lift and was sent to the emergency room (ER) for evaluation.</p> <p>Review of facility's documented investigation regarding the incident on 04/12/2024 revealed, in part, Resident #3 fell when S6CNA and S10CNA transferred Resident #3 using a mechanical lift, and the mechanical lift sling's strap broke. Further reviewed revealed, Resident #3 hit her head on the floor as a result of the fall and was evaluated at the ER.</p> <p>Review of Resident #3's ER note dated 04/12/2024 revealed, in part, Resident #3 was seen in theER on [DATE] at 7:24 p.m. due to a mechanical lift fall. Further review revealed Resident #3 was diagnosed with a closed head injury.</p> <p>In an interview on 07/30/2024 at 10:31 a.m., S6CNA indicated the straps of the mechanical lift sling broke when she and S10CNA transferred Resident #3 from her bed to the wheelchair on 04/12/2024.</p> <p>In an interview on 07/30/2024 at 1:55 p.m., S11LPN indicated the facility's CNA's were to check the mechanical lift slings for any defects prior to them being used, and defective mechanical lift slings were to be discarded and replaced with new mechanical lift slings.</p> <p>Observation on 07/30/2024 at 3:42 p.m., revealed while preparing to transfer Resident #R4 using a mechanical lift, S4CNA instructed S5CNA to use the blue loops of the mechanical lift sling's straps to hook the sling to the mechanical lift. Further observation revealed S4CNA inspected the sling and then instructed S5CNA to use the green loops of the mechanical lift sling's straps instead of the blue loops. After Resident #R4 was transferred, further observation by the surveyor revealed the blue loops of the mechanical lift sling's straps had been removed, with only the base of the blue loop remaining attached to the mechanical lift sling's strap.</p> <p>In an interview on 07/30/2024 at 3:45 p.m., S4CNA acknowledged the blue loop of the mechanical lift straps were missing from the sling. S4CNA further indicated the blue loop of the mechanical lift sling's strap must have popped like the others and that some people like to keep the old slings so that they will have a spare. S4CNA further acknowledged the mechanical lift sling should have been discarded and not used to transfer Resident #R4.</p> <p>In an interview on 07/30/2024 at 3:47 p.m., S9LPN inspected the above mentioned mechanical lift sling used to transfer Resident #R4, and acknowledged the mechanical lift sling should not had been used to transfer Resident #R4 because the blue loops were missing.</p> <p>In an interview on 07/30/2024 at 3:55 p.m., S2DON indicated staff should visually check mechanical lift slings for defects prior to using the mechanical lift slings to transfer residents, and discard any sling that had cuts, tears or appeared worn.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/31/2024 at 9:50 a.m., S1Administrator indicated it was the facility's policy to discard any slings with defects. S1Administrator further indicated the facility's staff should not have used the mechanical lift sling that had been altered to transfer Resident #R4.</p>