| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195637 | A. Building<br>B. Wing | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Regency House of Alexandria | 5131 Masonic Drive<br>Alexandria, LA 71301 |

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) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51096<br><br>Based on record review and interview the facility failed to ensure an injury of unknown origin and a serious bodily injury of an unknown origin were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency for 2 (#1 and #2) of 3 (#1, #2 and #3) sampled residents reviewed for accidents. The facility failed to:<br><br>1. Ensure injury of unknown origin of Resident #1 was reported within 2 hours in accordance with State law through established procedures.<br><br>2. Ensure serious bodily injury and injury of unknown origin of Resident #2 was reported within 2 hours in accordance with State law through established procedures.<br><br>Findings<br><br>Review of the facility undated policy titled Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation read in part . This policy is concerned with all incidents and accidents involving residents. Certain incidents and accidents involving residents must also be reported to the appropriate state agencies. The Policy also addresses proper investigation and documentation of incidents and accidents involving residents that are not caused by abuse, exploitation and misappropriation of resident property.<br><br>D. Suspicious Injuries of Unknown Origin. An injury should be classified as an injury of unknown origin when both of the following conditions are met: (1) the source of the injury was not observed by any person and the source of the injury could not be explained by the resident and (2) the injury is suspicious because of the extent of the injury or the location of the injury . suspicious injuries of unknown origin may include, but are not limited to: unwitnessed fractures that are unusual in nature.<br><br>VI. Investigations and Facility Response to Incidents or Accidents. a).The facility will report all instances of . suspicious injuries of unknown origin . in the following manner: b). Investigation and Reporting Steps. The Administrator will report to the State Agency and all other required agencies, according to regulations. All . instances that result in serious bodily injury must be reported within 2 hours. Serious Bodily Injury is defined as an injury . requiring medical interventions .<br><br>Resident #2<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the medical record for Resident #2 revealed she was admitted to the facility on [DATE], with diagnoses that included: Protein Calorie Malnutrition, Fall, Syncope and Collapse, Laceration without foreign body of Cheek and Temporomandibular area, and Fracture of Mandible. Resident #2 was discharged on [DATE].<br><br>Review of Resident #2's progress notes revealed a note authored by S7 RN dated 02/11/2025 at 2:29 a.m., which read in part . Around 1:10 a.m. I heard a knocking sound followed by a loud thump on resident's door. I opened the door and found the resident lying on the floor on her left side. Bleeding noted from a laceration on the back of her scalp . the laceration was cleaned and a pressure dressing was applied.<br><br>Review of Resident #2's Post Fall Evaluation authored by S2 DON dated 02/13/2025 at 10:58 a.m., revealed in part . Fall Details: Date / Time of Fall: 02/11/2025 1:10 AM Fall was not witnessed . The reason for the fall was not evident . Did an injury occur as a result of the fall: Yes. Injury details: laceration to scalp. Did fall result in an ER visit/hospitalization : Yes. Skin: Skin note: laceration to back of head. Skin Issue: #001: New skin Issue. Location: Rear scalp. Issue type: Laceration. Progress: New: new wound. Wound acquired in-house. Wound is new. Incision approximated: No.<br><br>Interview with S1 Administrator on 03/17/2025 at 4:15 p.m. revealed that she was notified at 6:01 a.m. of Resident #2's fall with major injury.<br><br>Interview with S2 DON on 03/18/2025 at 11:45 a.m. revealed that if an unwitnessed fall with a head injury does occur, the Resident is sent out. The Administrator/EMS/Physician and Family are all notified immediately and the Administrator has 2 hours to report the injury to the state agency.<br><br>Telephone Interview with S7 RN on 03/18/2025 at 2:07 p.m., revealed that S7 RN heard knocking at 1:00 a.m. on a door. S7 RN stated that she was unable to determine where it was coming from, she then heard a thumping sound against a door. S7 RN stated that she realized it was coming from Resident #2's room. S7 RN went in and Resident #2 was on the floor behind the door. S7 revealed that Resident #2 was laying on her side and Resident #2 could not tell S7 RN what happened. Resident #2 had a gash on the back of her scalp that was actively bleeding, and observed blood dripping from Resident #2's head on to her neck. S7 RN stated that she called S1 Administrator, the Physician, the Ambulance, the ER and Resident #2's Daughter while another nurse came in and dressed the wound.<br><br>Interview with S1 Administrator on 03/18/2025 at 3:31 p.m., revealed that she wanted to clarify her earlier statement of when she received the call of Resident #2's injuries. S1 Administrator stated that she was notified of Resident #2's fracture on 02/11/2025 at 6:01 a.m., but she received a phone call from S7 RN that Resident #2 had fallen at 1:48 a.m. on 02/11/2025, and was being sent out to the emergency room . S1 Administrator stated that she did not think Resident #2's unwitnessed fall was a reportable injury. S1 Administrator confirmed that no one saw Resident #2 fall and that Resident #2 was sent out to the emergency room . S1 Administrator confirmed that a reportable injury is an injury of unknown origin and unknown origin means that is not witnessed and no one is able to tell what happened. S1 Administrator stated that an injury would be a fracture, bruise, major injury or suspicion of abuse and a major injury would be a hematoma or a head injury. S1 Administrator stated that she reported the injury after it was revealed to be a fracture.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Phone Interview with S7 RN on 03/19/2025 at 2:24 p.m. confirmed that she called S1 Administrator about Resident #2's fall right after it occurred on 02/11/2025, and informed S1 Administrator that Resident #2 had bleeding from the back of her head.<br><br>51082<br><br>Resident #1<br><br>Record Review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included, in part .Alzheimer Disease; Fibromyalgia; Osteoarthritis of first Carpometacarpal Joint; Primary Osteoarthritis, Right Hip; Primary Generalized Osteoarthritis; Displaced Mid-cervical Fracture of Left Femur; and Low Back Pain.<br><br>Review of Resident #1's Quarterly MDS with an ARD of 05/16/2025 revealed a BIMS Score of 08, indicating moderate cognitive impairment. Resident #1 required partial/moderate assistance with toileting hygiene, dressing, personal hygiene, and transfers. Resident #1 used a wheelchair for mobility.<br><br>Review of Resident #1's Departmental Progress Notes revealed in part .<br><br>02/16/2025 8:46 a.m. S8 LPN documented: Resident #1 noted with complaint of pain to left knee this a.m. grimacing upon touch. Resident #1 denies hitting/bumping left knee during transfer. No bruising/discoloration noted. No swelling. PRN pain medication administered. MD notified of sign/symptoms of pain/discomfort with new order noted for x-ray to left knee. Imaging notified. RP made aware.<br><br>02/16/2025 11:07 a.m. S8 LPN documented: Imaging at facility at this time to obtain x-ray to left knee. 3 views obtained. Resident #1 tolerated well. Awaiting results.<br><br>02/16/2025 12:28 p.m. S8 LPN documented: Received results of x-ray with findings of suspected minimally displaced femoral peri arthroplasty acute to subacute fracture. RP notified. Resident #1's RP requested that resident is not sent to ER, if possible, and to keep Resident #1 as comfortable as possible with ordered pain medication. Notified NP of x-ray results and family request. NP stated that family can provide knee immobilizer to stabilize knee, or send Resident #1 to ER for stabilization.<br><br>Review of Radiology Results Report revealed in part .Examination date: 02/16/2025 11:10 a.m., Reported date: 02/16/2025 11:43 a.m. Impression: Suspected minimally displaced femoral peri arthroplasty acute to subacute fracture.<br><br>Interview on 03/18/2025 at 12:48 p.m. with S2 DON accompanied with S4 Admin Nurse revealed the facility did an onsite x-ray on 02/16/2025. S4 Admin Nurse stated x-ray results were given the same day, which confirmed a fracture. S2 DON stated all Administrative staff were in contact and S1 Administrator was notified on Sunday, 02/16/2025, of the findings.<br><br>During an interview on 03/18/2025 at 3:31 p.m. with S1 Administrator, stated that when she saw the report of the x-ray results for Resident #1 on 02/16/2025, she should have submitted the SIMS report within the 2 hour timeframe. S1 Administrator confirmed she should have reported the fracture as soon as she reviewed the x-ray results on 02/16/2025, but did not. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51082<br><br>Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. The facility failed to ensure a CNA staff reported Resident #1's complaint of pain to the nurse as indicated in the plan of care.<br><br>Findings:<br><br>Review of facility policy titled Pain Management, with a revision date of 12/31/2024 on 03/17/2025, read in part .Policy: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Pain Management and Treatment: 2.The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain, or may be included as a specific pain management need or goal.<br><br>Record Review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included, in part .Alzheimer Disease; Fibromyalgia; Osteoarthritis of first Carpometacarpal Joint; Primary Osteoarthritis, Right Hip; Primary Generalized Osteoarthritis; Displaced Mid-cervical Fracture of Left Femur; and Low Back Pain.<br><br>Review of Resident #1's Quarterly MDS with an ARD of 05/16/2025, revealed BIMS Score of 08, indicating moderate cognitive impairment. Resident #1 required partial/moderate assistance with toileting hygiene, dressing, personal hygiene, and transfers. Resident #1 used a wheelchair for mobility. Resident #1 rarely exhibits pain and had pain present during the 7 day lookback of this assessment.<br><br>Review of Resident #1's Care Plan revealed, in part .Resident #1 has (acute/chronic) pain related to low back pain/Fibromyalgia/Osteoarthritis/epigastric pain/spinal stenosis/headaches, OA .Interventions: Monitor/record/report to Nurse Resident #1 complaints of pain or requests for pain treatment-Position: CNA (initiated 09/19/2024).<br><br>Review of 03/2025 Physician Orders for Resident #1 revealed, in part .Hydrocodone-Acetaminophen Tablet 7.5-325mg. Give 1 tablet by mouth every 6 hours as needed for pain. Order dated 04/10/2020.<br><br>Observation of Resident #1 on 03/17/2025 at 10:13 a.m. revealed Resident #1 sitting in a wheelchair in her bedroom. Resident #1's left leg was observed with knee immobilizer on, and her call light within reach. Resident #1 was in a pleasant mood, no facial grimacing, moaning, or non-verbal indicators of pain observed at this time.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Telephone Interview with S6 CNA on 03/18/2025 at 4:14 p.m. revealed she worked with Resident #1 on 02/15/2025, on the 11:00 p.m. to 7:00 a.m. shift. S6 CNA stated she provided incontinent care to Resident #1, the morning of 02/16/2025 and when she uncovered Resident #1 to change her brief, Resident #1 said ouch. S6 CNA stated she asked resident #1 what was wrong and resident #1 told her that her leg was hurting. S6 CNA denied seeing any bruising or swelling after uncovering Resident #1. S6 CNA stated she asked Resident #1 if she wanted to get the nurse, and Resident #1 told her no. S6 CNA stated she got Resident #1 dressed, picked her up out of the bed, and placed her in the wheelchair. S6 CNA stated she notifies the nurse anytime Resident #1 complains of pain. S6 CNA stated she received training on reporting pain, and knew to notify nurses if a resident complained of, or appeared to be in pain, even if a resident told her not to report it. S6 CNA stated she didn't tell the nurse Resident #1 was in pain because Resident #1 told her not to. S6 CNA confirmed she should have notified the nurse about Resident #1 complaint of pain, but did not.<br><br>During an interview with S5 CNA Supervisor on 03/19/2025 at 11:18 a.m., she stated she expected all of her CNA staff to report all resident's pain to the nurse even if a resident told them not too. S5 CNA Supervisor confirmed S6 CNA should have reported Resident #1's complaint of pain to the nurse, but did not. |