STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORNERSTONE AT THE RANCH	**103 WEST MARTIAL AVE LAFAYETTE, LA 70506**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the resident's representative was immediately notified by failing to inform the resident's representative of weekly weights as per physician order [REDACTED]. Review of the nurse's notes from April 2020 to July 2020 revealed no documentation that the resident's daughter, who is Resident #2's representative, was informed weekly of the resident's weight as per the physician orders. On 7/21/2020 at 1PM, an interview was conducted with S2DON. S2DON stated that S1ADM had designated the SSD (Social Service Director) to inform Resident #2's daughter of the weights weekly. She stated that she was unsure if the resident's daughter had been notified of the resident's weights. On 7/21/2020 at 1:20PM, an interview was conducted with S1ADM. S1ADM confirmed that he was aware that Resident #2's daughter had requested to be informed of the resident's weights weekly. He stated that the SSD was responsible for notifying the resident's daughter of the weight weekly. During the interview, a review of emails provided by S1ADM that were sent from the SSD to Resident #2's daughter dated 6/5/2020, 6/12/2020, 6/19/2020, 6/26/2020, 7/3/2020, and one undated email revealed that the emails failed to include the resident's weight. S1ADM confirmed that the SSD failed to notify the Resident #2's daughter of the resident's weights weekly.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on record review and interview, the facility failed to assure that prompt efforts were made to resolve a grievance for 1 (#2) out of 5 (#1, #2, #3, #4, and #5) sampled residents. Findings: On 7/20/2020 at 10:30AM, an interview was conducted with Resident #2's daughter, who is the resident's representative. She stated that she tried to contact S1ADM by phone several times to voice her concerns about the care that Resident #2 was receiving. She stated the S1ADM didn't call her back. She stated that in March she sent a letter to the S1ADM expressing her grievances. She stated that she never was contacted by the S1ADM or anyone from the facility, after S1ADM had encouraged the family to just let him know if there were any concerns. A review of a letter provided by Resident #2's daughter revealed concerns about staff turnover, staffing patterns, long response to calls for assistance, and overall resident care in the facility. Review of the facility's grievance log and grievance complaint reports for May, June and July revealed no documentation that Resident #2's daughter grievance had been addressed by the facility. On 7/20/2020 at 2:30PM, an interview was conducted with S1ADM. S1ADM stated that he was unaware of a letter sent by Resident #2's daughter. S1ADM stated that he had designated the SSD (Social Service Director) to handle the facility grievances. He confirmed that if the grievance by Resident #2's daughter had not been documented by the SSD, then it was not addressed.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that services were provided as outlined in each resident's plan of care by failing to follow physician orders [REDACTED].#2) out of 5 sampled residents. Findings: Resident #2 was admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's current physician orders [REDACTED]. Review of Resident #2's MAR (Medication Administration Record) revealed an order for [REDACTED]. On 7/24/2020 at 11:30AM, an interview was conducted with S2DON. During the interview, the physician orders [REDACTED]. She also confirmed that the resident was administered the wrong dose on 7/18/2020, 7/19/2020, 7/20/2020, 7/21/2020, 7/22/2020.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure sufficient nursing staffing as evidenced by failing to: 1) answer call bells timely (Residents #2); 2) feed a resident timely (Resident #4); and 3) provide assistance with toileting timely (Resident #2). This failed practice was identified for 2 (#2 and #4) out of 5 sampled residents. The total facility census was 63. Findings: According to the Facility assessment dated [DATE] the required staff for an average census of 64 resident were as following: Day shift-2.5 RN(Registered Nurse), 3 LPN(Licensed Practical Nurse), 7 CNA (Certified Nursing Assistant); Evening shift: .5 RN, 2 LPN, 7CNA; Night shift: 0 RN, 2 LPN, 6 CNA. Further review of the Facility Assessment revealed that 51 resident require one or two staff for bathing, 53 residents require assistance of one or two staff for dressing, 50 residents require assistance of one or two staff for transferring, 43 residents requires assistance of one or two staff for toileting and 20 residents require assistance of one or two staff for eating. Review of the Time and Attendance Signature Report and Daily Assignment Sheet dated 7/18/2020 revealed in part: 3 LPNs and 5 CNAs for the 6:30AM-2:30PM shift; 1 LPN -6AM-6PM; 2 LPNs and 3 CNAs for the 2:30PM-10:30PM shift; 1 LPN (10:30PM-6:30AM) 1 LPN (6PM-6:30AM) and 5 CNAs for the 10:30PM-6:30AM shift. It was determined that the CNA scheduled for 2:30PM -7PM (noted on the daily assignment sheet) had no clocked in time, thus leaving only 2 CNAs for the entire facility on the 2:30PM-10:30PM shift. Review of the Time and Attendance Signature Report and the Daily Assignment Sheet dated 7/20/2020 revealed in part: 3 LPNs and 6 CNAs clocked in on the 6:30AM-2:30PM shift; 3 LPNs and 4 CNAs clocked in on the 2:30PM-10:30PM shift; 1 LPN clocked in for the 6A-6P shift; 2 LPNs and 4 CNAs clocked in on the 10:30PM-6:30AM shift. It was concluded that for the 6:30AM-2:30PM shift there was only 2 CNAs assigned to Hall A and on the 2:30PM-10:30PM shift there was one CNA on Hall B who did not report to work (not reflected on the daily assignment sheet), leaving only one CNA to work on the hall. There was no other staff name documented on the daily assignment sheet for Hall B until the 10:30PM-6:30AM shift and no CNA assigned for Hall D, resulting in only 4 CNAs working on the 2:30PM-10:30PM shift for the entire facility. Review of the Time and Attendance Signature Report and the Daily Assignment Sheet dated 7/21/2020 revealed in part: 3 LPNs and 6 CNAs clocked in for the 6:30AM-2:30PM shift, 1 LPN clocked in for 8:30AM-9:30PM, 1 LPN clocked in for 6AM-11PM; 1 LPN and 3 CNAs clocked in for the 2:30PM-10:30PM shift; 3 LPN and 5 CNAs clocked in for the 10:30PM-6:30PM shift. It was concluded that 2

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

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.

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) CNAs called in (noted as CI on the daily assignment sheet), therefore leaving only one CNA on Hall A. There was one CNA on Hall B who did not report for work, thus leaving only one CNA on Hall B and no CNA for Hall D (not reflected on the daily assignment sheet). This resulted in only 4 CNAs working on the 2:30PM-10:30PM shift for the entire facility. Review of the Time and Attendance Signature Report and the Daily Assignment Sheet dated for 7/22/020 revealed in part: 3 LPNs and 7 CNAs for the 6:30Am-2:30PM shift; 1 LPN-6A-6P; 2 LPN and 5 CNAs for the 2:30PM-10:30PM shift; 2 LPNs and 5 CNAs for the 10:30PM-6:30AM shift. It was concluded that 1 CNA was call off (noted on the daily assignment sheet) leaving only 1 CNA was assigned to Hall B on the 2:30PM-10:30PM shift and 1 CNA assigned on Hall B for the 10:30PM-6:30AM shift. Review of the Time and Attendance Signature Report and the Daily Assignment Sheet dated for 7/23/2020 revealed in part: 3 LPN and 6 CNAs for the 6:30Am -2:30PM shift; 2 LPNs and 5 CNAs for the 2:30PM-10:30PM shift; 3 LPNs and 6CNAs for the 10:30PM-6:30AM shift. It was concluded that there was 1 CNA working on Hall B for the 2:30PM-10:30PM shift and the 10:30PM-6:30AM shift. Resident #2 An interview conducted on 7/20/2020 at 11AM with Resident #2's daughter, who is the resident's representative, stated that she tried to contact S1ADM by phone several times to voice her concerns about the care that Resident #2 was receiving. She also stated that in March she expressed her concerns about the lack of care due to the shortage of staff in a letter sent to the Administrator. She stated that she never heard from S1ADM, after he had encouraged her sister to just let him know if they had any concerns. A review of a letter provided by Resident #2's daughter sent to the S1ADM revealed that the resident's daughter expressed her concerns about the length of time it was taking to responds to call lights due to staff being spread sparsely in the facility. Further review revealed that when residents do receive long-awaited assistance, they are told Sorry .we are short-staffed. On 7/20/2020 at 5:00 PM, an observation was made of one staff on Hall C. At 5:30 PM, the dietary staff was observed bringing the meal cart to Hall C and the only staff noted on the hall was the nurse. The meal cart remained unattended for at least 5 minutes before the nurse started passing the meal trays. On 7/21/2020 at 12:00PM, an observation was made of one staff on Hall C. 7/21/2020 at 3:00PM, an observation was made of no staff on Hall B and one Hall C. At 3:15 PM, the CNA was observed entering onto Hall C. An interview was conducted with S7CNA who stated that she was coming from Ha. She stated that she had to go on Ha to assist with residents. When asked, Who will be on this hall while you go to Ha?. She replied, no one. When asked, Do you always have to go to Ha to assist?. She replied, Yes, most of the time When asked, How many CNAs work on Hb?. She replied, Only one. An interview was conducted on 7/21/2020 at 3:30PM with S9CNA. S9CNA stated that there is not enough CNAs to help with resident care. She stated the most of the time she has to work alone on Ha and it's too much work for one person. She stated that while she is feeding, she is not able to answer the call lights in a timely manner and the residents have to wait until she can get there. She stated that the Administration is aware but nothing has been done about it. During the interview, S9CNA's beeper buzzed. When asked, What is the beeper for. She replied, The beeper is to let me know that one of the residents pressed the call light and need assistance. When asked, Is there someone else who can answer the call. She replied, No, I'm the only one. S9CNA stated, This is exactly what I am saying, if I was in another room assisting another resident, I would not be able to answer the call right away. An interview was conducted on 7/21//2020 at 4:30PM with S6LPN. She stated that staffing has been a problem on Hall B, especially on the evening shift. She stated that sometimes there is only one person to work the entire hall. She stated that on the weekend of 7/18/2020 there was only two CNAs to work in the entire facility. An interview was conducted on 7/24/2020 at 5:30PM with R1 who stated that it sometimes takes long for the CNAs to responsible to the call lights, especially around meal time when they are passing out or picking up meal trays. She stated that sometimes she has to call two to three times before she get assistance to be taken to the bathroom. Resident #4 On 7/24/2020 at 2:30PM, an observation was made at shift change of S10CNA complaining of the lack of staffing in the facility. An interview was conducted with S10CNA who stated that she was an agency CNA and most of the time she works there is never enough staff to work. She stated that she was doing a double shift today because there was no staff to work. She stated that she was responsible for the residents on Hall B and on Hall C. When asked, How do you answer the call lights on Hall C if you are on Hall B? She replied, They will have to wait. When asked Is there anyone else who can assist? She replied, No, not all the time. On 7/24/2020 at 5:00PM, an observation was made of a banging noise on Hall C. No CNA was observed on the ha. Upon passing in front of Resident #4's room, the resident was observed trying to get out of bed and the resident's daughter was observed banging on the window from outside of the facility yelling that the resident was trying to get out of the bed and that he would fall. The surveyor pressed the call bell for assistance and made an attempt to discouraged the resident from getting out of bed. The bed rails were observed up x 2 and fall mats were noted on both sides of the bed. The resident's daughter stated that she was sorry for hitting on the window but she didn't see anyone and she was afraid that the resident was going to fall. She stated that the resident has had approximately 10 falls since he was admitted in the facility. She stated that she asked the facility to move the resident to Hall C because she felt he was not getting the care he needed on the other hall. She stated that she also noticed that the resident had not been fed yet. An observation was made of the resident's meal tray on the bedside table. She stated that she has complained about the food and the lack of care because there is not enough staff. S10CNA entered the room and repositioned the resident in bed. S10CNA stated that she was unable to assist with feeding the resident at this time because one of the residents down the hall had a bowel movement and it was all over them and she needed to clean that resident. S10CNA then left the Resident #4's room. The resident's daughter was informed that I would go find someone to come feed the resident. An interview was conducted on 7/24/2020 at 5:30PM with Resident #6 who stated that it sometimes takes long for the CNAs to responsible to the call lights, especially around meal time when they are passing out or picking up meal trays. She stated that sometimes she has to call two to three times before she get assistance to be taken to the bathroom. Review of the Daily Assignment Sheet dated 7/24/2020 revealed that there was 1 CNA for Hall B and 1 CNA for Hall C. An interview was conducted on 7/20/2020 at 10:15AM with S1ADM. S1ADM stated that he had been using up to 5 different agencies to staff the facility because the staff just do not show up which has added to the challenge of staffing the facility.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain infection control and prevention COVID-19 by failing to don the appropriate PPE and failing to perform appropriate hand hygiene before exiting a resident's room who was on contact isolation precaution for 1(#2) of 5 (#1, #2, #3, #4, #5) sampled residents. Findings: Resident #2 was admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Resident #2 had a BIMS (Brief Interview of Mental Status) score of 9, indicating moderate cognitive impairment according to the PPS 5-day scheduled assessment MDS (Minimum Data Set) dated 4/21/2020. Review of the nurse's note dated 7/17/2020 at 1:44PM revealed .Resident placed on contact isolation precautions as per standing orders for 14 days. On 7/20/2020 at 5:10PM, an observation was made of a plastic container with PPE outside of Resident #2's room and sign was observed on the door. On 7/20/2020 at 5:30PM, an observation was made of S7CNA donning only gloves to enter into the Resident #2's room. On 7/20/2020 at 5:35PM, an interview was conducted with S7CNA who stated that Resident #2 was on isolation precaution. S7CNA stated that she was told that she did not have to wear a gown to go into Resident #2's room if she was only going in to bring the meal tray. On 7/20/2020 at 5:45PM, an interview was conducted with S4LPN who confirmed that a gown should be worn when entering the room. On 7/21/2020 at 12:00PM, an observation made of S8CNA donning only gloves to enter into Resident #2's room. S8CNA was observed exiting the resident's room with the gloves still on. She was also observed removing her gloves and putting them in her pocket. On 7/21/2020 at 12:05PM, an interview was conducted with S8CNA who stated that Resident #2 was on isolation precaution. S8CNA stated that she should have put on a gown to enter Resident #2's room. She also stated that she should have removed her gloves and washed her hands before she came out of the resident's room. On 7/21/2020 at 12:30PM, an interview was conducted S2DON. S2DON confirmed that the Resident #2 was on contact isolation precautions. She stated the CNAs should put on a gown and gloves before entering the resident's room. She confirmed that the S7CNA and S8CNA should have put on a gown to enter into Resident #2's room. She also confirmed that S8CNA should have removed her gloves in the room and washed her hands before exiting the room