STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195446	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW MANOR NURSING HOME	**400 HOSPITAL ROAD NEW ROADS, LA 70760**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and observations the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #39) of 6 (Resident #19, #30, #39, #68, #80, #487) residents requiring 2 person assistance for transfers. The facility failed to: 1. Follow Resident #39's plan of care related to transfers, and; 2. Ensure staff follow their policy and procedure related to reporting of falls to the nurse. An actual harm occurred for Resident #39 on 11/30/2019 (time unknown) when S2CNA (Certified Nursing Assistant) transferred Resident #39, who required two-person assistance, from her bed to her wheelchair without the assistance of another staff member. The resident fell to the floor during the transfer. S2CNA asked S1CNA to help her get Resident #39 off of the floor and did not report the fall to the nurse. On 12/01/2019, the nurse noted a bluish bruise to Resident #39's anterior lower right leg when the Resident complained of pain to the leg. On 12/01/2019 an x-ray revealed Resident #39 had an acute [MEDICAL CONDITION] Tibial Plateau, and she was transferred to the local hospital. The facility implemented corrective actions prior to the State Agency's investigation, thus it was determined to be a past noncompliance citation. Findings: A review of the facility's Moving, Transferring and Repositioning policy revealed in part .: Key points 5. Use 2 staff members when transferring residents who cannot stand without assist. Moving a resident, bed to chair/chair to bed If moving a resident bed to chair: b. If transferring the resident to a wheelchair: 1. Be sure the wheels are locked . Review of the facility policy titled Accident and Incidents revealed in part 1. Any employee witnessing an accident or incident involving a resident, employee or visitor must report such occurrence to the charge nurse as soon as possible regardless of how minor it may be, to include the following: a. Any resident fall, accident or injury . A record review revealed Resident #39 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. A review of Resident #39's care plan with a problem date of 03/09/2009 read in part . Potential For Falls related to impaired mobility .Provide 2 person assist for transfers. A review of Resident #39's MDS (Minimum Data Set) ARD (Assessment Reference Date) of 10/28/2019, revealed Resident #39 had a BIMS (Brief Interview For Mental Status) score of 14 (Intact Cognitive Response) and required a two person physical assistance for transfers. Record review of Resident #39's Departmental Notes dated 12/01/2019 at 11:01 a.m. stated in part .Upon assessment this nurse, S21LPN, visualized a faint bruise bluish in color to the anterior lower right leg. Leg has 2+ [MEDICAL CONDITION] and is warm to touch. Nurse questioned res (resident) about what happened. And res (resident) stated she fell on the ground. When asked when, resident stated it was recent. Yesterday. Resident stated she was dropped on the ground and stated the person who dropped her on the ground and her (Resident 39's) roommate were the only people in the room at the time of the fall. General Medicine notified and returned the call with orders to have an x-ray of the RLE (Right Lower Extremity) performed in facility. X-ray notified. On 12/1/2019 at 1:16 p.m. the facility's Departmental Notes read in part .swelling and slight discoloration, bluish in color noted to right shin. Resident c/o (complains/of) pain to this area. X-rays ordered per General Medicine. Family aware. A review of the x-ray report dated 12/01/2019 at 12:01 p.m. revealed the impression was listed as acute [MEDICAL CONDITION] plateau. A review of a local hospital's report dated 12/01/2019 at 10:15 p.m. revealed Resident #39 had an acute [MEDICAL CONDITION] plateau. A record review of the facility's Investigative Report dated 12/05/2019 at 5:14 p.m. revealed called this nurse (S14LPN) into the room stating resident leg was starting to bruise. Upon assessment res (resident) anterior RLE (Right Lower Extremity) had a light blue bruise, +2 [MEDICAL CONDITION] and hot to touch. Res (Resident) stated she fell on the ground and someone dropped her on the ground yesterday. Notified supervisor. Contacted General Medicine. New order to obtain x-ray in house. X-ray indicated fx (fracture) of the right tibial plateau. Orders to send resident to hospital. Sent via ambulance to a local hospital. Anterior RLE bruise right great toe bruised dark blue/purple in color, left heel bruised dark purple in color. Immediate Actions Taken: Notified supervisor, contacted General Medicine, notified Administrator and police was notified and obtained a statement. The resident's physician and family were notified at 1:16 p.m. A review of a witness statement to local law enforcement by S1CNA dated 12/04/2019 (no time indicated) read, On the morning of Saturday I S1CNA helped S2CNA get Resident #39 off the floor. I was at the nurse's station when she looked out the room door and asked me for help. So when I entered the room Resident #39 was on the floor so I helped her get off of the floor and put her in her wheelchair and she went to breakfast and after breakfast the nurse asked can S2CNA put her back in the bed because she was complaining about her toe was hurting so we put her back in after breakfast and that was the last time I saw Resident #39. A review of a witness statement to local law enforcement by S2CNA dated 12/06/2019 (no time indicated) revealed, When I worked with Resident #39 Saturday morning after changing her I forgot to check the wheelchair to make sure it was locked I began to transfer her from the bed to the chair and the wheelchair rolled back causing me to drop Resident #39 on the floor. She fell on her but(t) and her leg. I then asked S1CNA to help me get her up in to the chair I didn't report it because I was scared. Once we did get her in her chair. I told her I was sorry. An interview with Resident #39 on 03/10/2020 at 02:14 p.m. was conducted. The resident was alert and oriented to person, place and time. Resident #39 was sitting in her wheelchair. Resident #39 stated she may have been mistaken about how long ago she had her fall, but she thought it was around last November. When Resident #39 was asked what happened to her leg she stated she fell the day before the bruising was found but did not tell anyone. Resident #39 then stated, someone dropped me the day before. An interview with S7DON on 03/11/2020 at 10:47 a.m. was conducted. S7DON stated the incident for the resident was discovered on 12/01/2019 when a nurse was called by a CNA to the resident's room because the CNA saw the resident had a bruise just below her knee. She said the resident was given Tylenol and an x-ray was done. She said the x-ray revealed a fracture to the resident's tibial plateau. She said the investigation was done but could not find out what happened. She confirmed they got all the witness statements, and there did not seem to be anyone who was involved with an accident. She explained it wasn't until the police were called and their investigation began that S1CNA admitted to the police that she helped S2CNA get the resident up after the fall. She said S1CNA admitted she helped the resident up and was asked by S2CNA to not say anything about the resident falling. S7DON said S2CNA admitted keeping that promise not to tell until the police got involved. She explained the police told everyone that if no one said what really happened they would have to bring everyone in to the station and they could be charged with a felony. S7DON explained on 12/04/2019 the 2 CNAs (S1CNA and S2CNA) were suspended as soon as we found out what happened, and the 2 CNAs (S1CNA and S2CNA) did not work again. An interview with S15MDS/CP Coordinator on 03/11/2020 at 12:45 p.m. was conducted. S15MDS/CP confirmed the resident was a two person assist for transfers. An interview with S9ADM on 03/12/2020 at 8:44 a.m. was conducted. She stated, We had in-services and we looked at all our residents. We had fall meetings, and we had therapy demonstrate the proper techniques for transferring residents. S9ADM then stated, PT (Physical Therapy) did return demonstrations and ensured the in-services were understood by staff. An interview with S8PT on 03/12/2020 at 9:42 a.m. was conducted. She stated, We train at least quarterly. We

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) observe to see if CNAs are doing their job. We always ask to let us know if a CNA is having trouble. I go around and make sure residents are being transferred. If it's done incorrectly I would reeducate the CNA. I will let the nurse know and they reeducate them. There is therapy communication between the staff. A review of the facility's training records revealed training for Gait Belt policy/Transfer Safety and Reporting/Lifters began on 12/04/2019. The training included transfer safety along with printed documentation of signs for residents who were to be transferred by a lifter, by 1 person assist and by 2 person assist. An interview with S13CNA was conducted on 03/12/2020 at 10:36 a.m. She stated she knew how many people were required to transfer a resident by the sign over the bed. She stated Resident #5 was a 2 person transfer. She stated she had attended an in-service with therapy a few months ago. She said the nurse observed her doing transfers in the past few months but could not remember exactly when. She voiced she could not remember the specific nurse. An interview with S5CNA was conducted on 03/12/2020 at 11:47 a.m. S5CNA stated, I do work with Resident #36. Resident #36 is transferred with the lift. She transfers well. We have a list by the nurse's station to determine how a resident is transferred. If there is a change we are told and the list is also updated. There are also signs over their beds and there are notes in their charting. We are taught how to use the lift and were watched by a nurse to ensure we did the transfer correctly. An interview with S20CNA was conducted on 03/12/2020 at 1:45 p.m. S20CNA stated if she found a resident on the floor she would immediately call for help by using the call bell and stay with the resident. S20CNA stated she would not touch the resident until the nurse had assessed them and determined it was safe to move them. An interview was conducted with S19CNA on 03/12/2020 at 1:48 p.m. She stated if she found a resident on the floor she would hit the call light to call the nurse. She said she wouldn't touch the resident until the nurse assessed them. An interview with S17CNA was conducted on 03/12/2020 at 01:55 p.m. S17CNA stated if she found a resident on the floor she would use the call bell to contact the nurse to come and assess the resident. S17CNA stated she can't touch the resident until the nurse says it is safe. An interview with S18CNA on 03/12/2020 at 2:00 p.m. was conducted. S18CNA stated if she found a resident on the floor she would call the nurse to assess her. She said she wouldn't leave her side and wouldn't touch them until the nurse deemed it safe. An interview with S10CNA on 03/12/2020 at 2:01 p.m. was conducted. S10CNA stated if she found a resident on the floor she would stay with the resident and use the call bell to ask for the nurse to come in to assess the resident. S10CNA also stated staff were instructed to never move a resident who has fallen on the floor until a nurse has been able to assess the resident. When asked if she had received recent training on transfers, she replied that they received training on lifts and gait belts by the therapy department sometime in January or February, but she could not recall the exact date. An interview was held with S16CNA on 03/12/2020 at 3:36 p.m. She said if a resident fell she would notify the nurse immediately and not move the resident until the nurse checked the resident. She said she had never had a resident fall when she was transferring and not alert the nurse. An interview with S4ADON on 03/12/2020 at 3:45 p.m. was conducted. S4ADON confirmed the above in-services included the topic of reporting included not handling a resident that has fallen until a nurse assesses the resident. An observation of Resident #78 was conducted on 03/09/2020 at 9:26 a.m. The observation was made of Resident #78 which included a transfer of Resident #78 from her bed to her chair using a Hoyer lift. S11CNA and S12CNA transferred the resident. There were no concerns with the 2 person lifter transfer An observation of a lifter transfer of Resident #39 was conducted on 03/12/2020 at 1:03 p.m. by S6CNA and S3CNA. There were no issues with the transfer. Immediately after the transfer S6CNA and S3CNA were interviewed. S6CNA stated she was trained to use the lifter and knows there should be 2 people to use the lifter. S6CNA also stated she was instructed to not touch a resident until a nurse has assessed the resident after a fall. S3CNA stated she was trained to use the lifter and knows there should be 2 people to use the lifter. S3CNA also stated she was instructed to not touch a resident until a nurse has assessed a resident after a fall. She stated she was the CNA that found the resident with bruising on her shin and immediately reported it to the weekend supervisor. An observation of Resident #39's room on 03/12/2020 at 1:03 p.m. revealed there was an image of a lifter and an image of 2 figures with the words 2 person transfer under the image. The facility has implemented the following actions to correct the deficient practice effective 01/08/2020. On Sunday Dec. (December) 1, 2020 S22RN Weekend Supervisor reports Resident #39 c/o (complained of) her leg hurting, swelling/discoloration/bruising /pain to her right leg, just below the knee, and resident initially reporting she was dropped the day before by S2CNA. This employee was not working on 12/01/2019. 1. Physician notified and orders noted to obtain x-ray, mobile x-ray taken. Results noted fracture and MD (Medical Doctor) notified then ordered to send out to ER (emergency room). Resident was transported to a local hospital ER (emergency room) in a nearby town. S22RN Weekend Supervisor began obtaining statements from employees who have worked on B hall, including employees in other departments-not just nursing. 2. SIMS (Statewide Incident Management System) assessment initiated r/t (related to) fracture, by a nurse on duty. 3. Local police department was contacted by facility administrator on Sunday of resident having a fracture and her reporting she was dropped. 4. S22RN Weekend Supervisor initiated resident interviews of cognitively intact residents on 12/01/2019. On Monday 12/02/2019 a list of residents on the hall was reviewed noting their BIMS (Brief Interview for Mental Status) score to determine if any other residents needed to be interviewed. Upon completion of the interviews, it is determined that no other residents were affected or identified that they felt unsafe. 5. On 12/04/2019- An ins-serviced for all C.N.A's initiated-once it is determined that S1CNA and S2CNA did not follow p/p (policy/procedure) as established by the facility. The in-service included-transfers/use of lift/gait belt/following POC (plan of care) and reporting incidents immediately. In-servicing continued to get all C.N.A.'s in-serviced. 6. On 12/06/2019- Morning QA (Quality Assurance) meeting, we discussed that we will review all falls with fall meetings to ensure residents plan of care was follow for the amount of assistance needed with transfers or use of lift D.O.N. and A.D.O.N. (Assistant Director of Nursing) initiated the check off with return demonstrations. 7. On 12/08/2019-In-services were completed, with exception of prn (as needed) staff. They were in-serviced before returning to work for a scheduled shift. 8. On 12/10/2019-The D.O.N. reviewed PIP (Performance Improvement Project) on falls with major injury indicating this resident had a fall and sustained a fracture 9. On 01/08/20 falls reviewed from over the past month, with no indications noted upon review that staff failed to follow POC with transfers. 10. The POC was implemented on 01/08/2020.