STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195606	A. BUILDING _____ B. WING _____	**04/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COURTYARD MANOR NURSE CARE CENTER & ASSISTED LIV	**306 SYDNEY MARTIN ROAD LAFAYETTE, LA 70507**

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 record review and interview, the facility failed to immediately consult with the resident's physician when a bruise was discovered to a non-ambulatory resident's upper right thigh for one (#5) out of 4 (#1, #2, #4, #5) resident's sampled for incidents of a total sample of 5 (#1, #2, #3, #4, #5) residents. FINDINGS: A review of Resident #5's record revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #5's [DIAGNOSES REDACTED]. A review of Resident #5's current Care Plan revealed that the resident had a history of [REDACTED]. Resident #5 was care planned for limited physical mobility related to Alzheimer's and staff were to observe for any fall related injury. The resident's Care Plan included that staff were to provide optimum care and safety at all times, and to report significant findings. Further review of Resident #5's Care Plan revealed that she had an ADL (Activities of Daily Living) self-care performance deficit related to dementia and age process. The Care Plan included: Bed Mobility: resident requires total assistance to turn and reposition in bed, and Transfer: the resident is totally dependent on staff for transferring. A review Resident #5's most recent MDS (Minimum Data Set) assessment dated [DATE] was conducted. Resident #5's BIMS (Brief Interview for Mental Status) was coded a 2, which indicated severe impairment. Resident #5's functional status was coded as bed mobility 4/2 indicating she required total dependence by one staff to move in bed. Transfer was coded a 4/3 indicating she required total dependence by two staff for transferring. Walking was coded as 8/8 indicating the activity did not occur. For moving on and off toilet and surface to surface transfer Resident #5 was coded a 2 indicating that she was not steady to move on or off a toilet and was only able to stabilize with staff assistance. Resident #5 was coded with contractures and assessed as having a lower extremity impairment on one side, and that she used a wheelchair. Further review of Resident #5's record revealed that she was admitted to hospice care on 12/11/2017. A review of Resident #5's nurses notes revealed a noted dated 3/16/2020 at 0400 (4:00 AM) that included summoned to resident room by CNA noted a purplish bruise noted to the upper right thigh. ADON aware. Hospice (agency name) notified. The note was signed by S4LPN. Further review of the nurse's notes revealed an entry dated 3/16/2020 at 0700 (7:00 AM) late entry, which included CNA (S10CNA's name) came to nurse's station to inform this nurse that (Resident #5's name) had a bruise to her RT leg. (S4LPN's name) then informed this nurse that the bruise was reported to her on last night and that she had documented and informed proper personal (as written.). The note was signed by S11LPN. A nurse's note dated 3/17/2020 at 1701 (5:01 PM) included: resident C/O (complained of) pain to RT hip when touched and inward rotation noted. (S9NP's name) notified and new orders noted. Hospice (agency name) notified. The note was signed by S11LPN. Further review of documentation in Resident #5's chart, including nurse's notes, progress notes and orders, failed to reveal any documentation that S9NP or a physician was notified when the bruise was discovered on the resident's thigh on 3/16/2020. A review of a Progress Note from S9NP dated 3/17/2020 was conducted. The reason for the visit was Nurse Request. S9NP's documentation included staff reports hematoma to RT thigh. No known incident. S9NP documented that the resident's Past Medical history included [MEDICAL CONDITION], that she had contractures to her lower extremities. Her assessment included Lg (large) hematoma RT upper thigh, pain with movement. RT & LT legs. Assessment/plan: contusion RT thigh, B (bilateral) hip pain. X-ray B hips, RT thigh. A hand written order for an X-Ray of Bilateral hips and Right thigh dated 3/17/2020 from S9NP was noted in the resident's chart. An X-Ray report of Resident #5's right femur dated 3/18/2020 was noted. The X-Ray result was: slightly angulated non-displaced [MEDICAL CONDITION] shaft of the femur. Exam date 3/18/2020. Mobile services fax of X-ray results 3/18/2020 at 12:57 PM. A review of the hospice agency's electronic record provided by S18RNCC for Resident #5 was conducted. An entry dated 3/17/2020 at 1300 (1:00 PM) regarding a phone call made by S20LPN to the facility was noted. The entry included Called (facility name) and spoke with (S15LPN's name) for update. She reported that pt had a bruise to her inner thigh since Sunday and the nurse that was on was an agency nurse and did not know to call us. On 4/21/2020 at 9:25 AM, a telephone interview was conducted with S14LPN. She stated that during report on 3/16/2020 at 7:00 AM, S4LPN had given report to both she and S11LPN. During this report S4LPN had not notified S11LPN about a bruise to Resident #5's right thigh. S10CNA had come on at 6:00 AM on 3/16/2020 and found the bruise to Resident #5's thigh, and reported it to S11LPN. When S4LPN heard the aide, she reported that there was a small bruise to the resident's thigh and said she had forgotten about it and she had not told doctor about the bruise. On 4/21/2020 at 4:05 PM, a telephone interview was conducted with S11LPN. She stated that on 3/16/2020 at 7:00 AM, report on the residents had already been received from S4LPN. After report S10CNA came to notify me of a bruise to Resident #5's leg. S11LPN stated that at this point she looked at S4LPN and she told her Oh yes, I forgot she has a small bruise to her leg. S11LPN stated When I went to assess her, I saw that it was a big bruise, but not a solid bruise, splotches of bruised areas from her knee to her hip, the entire upper aspect of her right thigh. She stated that S4LPN had reported to her that she had called the family. S11LPN stated I don't know about the doctor or Hospice, she said she had notified people. I did not notify anyone because she said she had done it. On 4/22/2020 at 2:46 PM, a telephone interview was conducted with S9NP. She stated that she was available to facility staff Monday through Friday and that they have her cell phone number. S9NP stated that she was in the facility on most Monday mornings and would have assessed Resident #5 if and when she would have been made aware of the bruise. She further stated that she could not assess a resident if she was not made aware of an injury. She stated when she was made aware of Resident #5's bruise and complaints of pain on 3/17/2020, she immediately went into the resident's room to assess her. She stated that staff should have made her aware of the injury when it was discovered on 3/16/2020. S9NP stated that Resident #5 was a hospice patient and the staff would usually notify the hospice nurse of an injury but that she and (S12MD's name) had assumed the responsibility for the hospice patients during the COVID restrictions and hospice personnel were not coming into the facility. Four unsuccessful attempts to conduct a telephone interview with S4LPN were conducted from 4/22/2020 to 4/23/2020. A review of the Resident #5's Hospice documentation provided by the facility for March 2020 revealed face to face visits by the Hospice RN on 3/3/2020 and 3/10/2020. The next hospice note was dated 3/22/2020 at 6:00 PM, and revealed that Resident #5 had no respirations or pulse and her body was to be released to the funeral home. Further review of Hospice documentation, including notes and orders, in the chart failed to reveal any documentation between 3/10/2020 and 3/22/2020 or regarding the bruise discovered on 3/16/2020. On 4/24/2020 at 8:27 AM, a telephone interview was conducted with S18RNCC, staff of the hospice agency providing care to Resident #5. She stated that around 3/13/2020, the facility removed the hospice patients from the hospice agency's care and the facility medical director and nurse practitioner took over the patients' care. She stated that at that time the facility nursing staff would not give report of patient issues to the hospice agency, stating that it was a HIPAA issue, because their own practitioners had assumed care of those residents, including Resident #5. S18RNCC stated that there would be no physical documentation in Resident #5's chart after 3/13/2020 as their staff were not entering the facility building. She stated any communication regarding Resident #5 would be

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) electronic documentation in their own hospice records. S18RNCC stated that even though they were not physically assessing Resident #5, if the facility would have called the hospice nurse regarding a patient issue, it would have been in their own hospice electronic documentation. S18RNCC then reviewed the notes for the resident and stated that S19RN had documented on 3/17/2020 the facility had made her aware of the bruise to Resident #5's thigh. She stated that there was no documentation that the facility had made them aware of the bruise on 3/16/2020 at 4:00 AM. She further stated that the hospice doctor would have given an order for [REDACTED]. On 4/24/2020 at 10:02 AM, a telephone interview was conducted with S9NP. She confirmed that she was physically in the facility on 3/16/2020 and that she was not notified of Resident #5's bruise until 3/17/2020. S9NP stated that she remembers very clearly that S11LPN notified her of Resident #5's bruise and immediately they both went to the resident's room. She stated that the resident had a very large bruise to her right thigh and that it was painful for the resident when S9NP palpated it. She stated at that point she ordered the X-ray and the results revealed that Resident #5 had a fracture. She further stated that the resident was probably 85 pounds and very osteoporotic. She confirmed that they facility staff did not notify her of the bruise until 3/17/2020. S9NP reported that she was not aware if hospice was notified as she and S12MD were assessing the hospice residents in the facility.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure that an injury of unknown source was reported no later than 2 hours after the discovery was made to the State Agency as evidenced by a bruise discovered on the right thigh of a non-ambulatory resident (#5) on 3/16/2020 at 4:00 AM and a there was no evidence of a report submitted to the State Agency until 3/18/2020 at 12:18 PM for one (#5) of four (#1, #2, #4, #5) residents reviewed for incidents, of a total of five (#1, #2, #3, #4, #5) sampled residents. FINDINGS: A review of an Incident Report provided by the facility dated 3/16/2020 at 4:40 AM with a revision date of 3/16/2020 at 17:57 (5:57 PM) revealed that S4LPN documented on the Incident Report that a bruise had been discovered on the front of Resident #5's right thigh. A review Resident #5's most recent MDS (Minimum Data Set) assessment dated [DATE] was conducted. Resident #5's BIMS (Brief Interview of Mental Status) was coded a 2, which indicated severe impairment. Resident #5's functional status was coded as bed mobility 4/2 indicating she required total dependence by one staff to move in bed. Transfer was coded a 4/3 indicating she required total dependence by two staff for transferring. Walking was coded as 8/8 indicating the activity did not occur. For moving on and off toilet and surface to surface transfer Resident #5 was coded a 2 indicating that she was not steady to move on or off a toilet and was only able to stabilize with staff assistance. A review of Resident #5's Care Plan revealed that she had an ADL (Activities of Daily Living) self-care performance deficit related to dementia and age process. The Care Plan included: Bed Mobility: resident requires total assistance to turn and reposition in bed, and Transfer: the resident is totally dependent on staff for transferring. A review of Resident #5's nurse's notes included the following entries: 3/16/2020 0400 (4:00 AM) the entry included: summoned to resident room by CNA (Certified Nursing Assistant) noted a purplish bruise noted to the upper right thigh. ADON aware. The note was signed by S4LPN. 3/16/2020 0700 (7:00 AM) late entry included: When receiving report from off going agency nurse (S4LPN's name), CNA (S10CNA's name) came to nurses station to inform this nurse that Resident #5 had a bruise to her RT (right) leg. S4LPN then informed this nurse that the bruise was reported to her on last night and that she had documented and informed proper personal (as written.). This nurse assessed resident after report. Resident #5 was lying in bed on RT side. No moaning or grimacing noted at this time. Will continue to monitor. The note was signed by S11LPN. 3/18/2020 1147 (11:47AM) included: X-ray report in from mobile care X-ray and impression shows slightly angulated nondisplaced [MEDICAL CONDITION] shaft of the femur. The note was signed by S11LPN. A review of the investigation documentation provided by the facility was conducted. The review revealed a document by S3ADON. The note included Investigation of Unknown Bruise to Left (as written.) Inner Thigh and was dated 3/17/2020. Further review revealed that ADON had conducted interviews with staff who had provided care to Resident #5 inquiring about the bruise. A review of an X-ray results report sent to the facility for Resident #5 was conducted. The facsimile time stamp on the report was 3/18/2020 at 10:29 AM. The report included: Study is positive for a nondisplaced slightly angulated supracondylar fracture. There is a 10 degree volar angulation at the fracture site without evidence of distraction or overlap. Impression: Slightly angulated nondisplaced fracture of distal shaft of the femur. A review of the Health Standards Incident Report created by the facility that was submitted to Louisiana Department of Health (LDH) was conducted. The incident ID # information included: Event Entered: March 18, 2020, 12:18 PM. Event Discovered: March 18, 2020, 10:57AM. Incident Category: Injury of Unknown Origin. The Reporter was S1ADM. Further review of the incident report to LDH failed to reveal that a bruise of unknown origin had been discovered on 3/16/2020 at 4:00 AM, or that the facility had started an investigation of an unknown bruise on 3/17/2020 for Resident #5. On 4/23/2020 at 3:40 PM, a telephone interview was conducted by two surveyors with S1ADM. She confirmed that on 3/17/2020, S3ADON had initiated an investigation regarding a bruise to Resident #5's right thigh, not her left thigh as S3ADON's document had stated. S1ADM confirmed that she had documented that the injury of unknown origin was discovered on March 18, 2020 at 10:57 AM on the Health Standards Incident Report and entered it to LDH on March 18, 2020 at 12:18 PM. At 3:45 PM, S2DON and S6LPN/MDS Coordinator joined the telephone interview. S1ADM was questioned about the timing of the report. S1ADM stated that on 3/18/2020 at 10:29 AM, the facility received X-Ray results confirming a fracture to Resident #5's right femur. She stated that she initiated and submitted the Incident Report within the required two hour window of the discovery of the injury of unknown origin, which was upon the X-Ray receipt of the confirmation of the fracture. S1ADM, S2DON, and S6LPN/MDS Coordinator all confirmed that a purplish bruise had been discovered S4LPN on Resident #5's upper right thigh on 3/16/2020 at 4:00 AM, but stated that the bruise was not an injury of unknown origin. S2DON confirmed that the facility had started an investigation of an Unknown Bruise to Resident #5 on 3/17/2020. Neither S1ADM, S2DON, nor S6LPN/MDS could offer an explanation of how the bruise occurred to Resident's right thigh on 3/16/2020. Neither S1ADM, S2DON, nor S6LPN/MDS were able to confirm how Resident #5 sustained the fracture to her right thigh. On 4/24/2020 at 12:00 PM, a telephone interview was conducted with S3ADON. She stated that when she was the Assistant Director of Nursing at the facility, she handled the Incident and Accident reports for the facility. She reported that on 3/16/2020 between 8:00 AM and 12:00 PM she became aware of reports of a bruise to Resident #5's right thigh. She made an observation of Resident #5 and noted that there was a large bruise to her right upper thigh. An Incident Report had not been initiated by S4LPN, the nurse who was working with the resident when the bruise was discovered so she contacted S4LPN and instructed her that she needed to return to the facility and complete an Incident Report. S3ADON stated that S4LPN completed the Incident Report on 3/16/2020 at 5:57 PM, after she (S3ADON) had left for the day. She stated that the next morning, on 3/17/2020 at 9:00 AM, during the morning meeting, she reviewed the findings of the Incident Report with the staff present, including S1ADM and S2DON, and that they were made aware at that time that an injury of unknown origin, the bruise to Resident #5's upper right thigh had been discovered on 3/16/2020 at 4:00 AM.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs, evidenced when an aide failed to notify the nurse of a bruise discovered on a resident's right thigh, for one (#5) of four (#1, #2, #4, #5) residents sampled for accidents of a total sample of five (#1, #2, #3, #4, #5) residents. FINDINGS: A review of the facility's following Policies and Procedures were conducted and included the following policies: 1. Change in a Resident's Condition or Status/Reporting to MD, which included: 1. The nurse will notify the resident's attending physician or physician on call when there had been a (an) a. accident in incident involving the resident; and b. discovery of injuries of an unknown source; 2. Abuse Prevention and Prohibition of, which included: V. Investigation. Pursuant to Federal Requirements at 42 CFR 483.13 (c) the nursing facility must report all allegations of abuse including injuries of unknown source. Resident abuse must be reported immediately to the Director of Nursing and Administrator; and 3. Accidents and Incidents - Investigating and Reporting; and 4. Falls-Clinical Protocol- Notification. A review of the policies and procedures failed to reveal specific procedures for a CNA (Certified Nurse Aide) on reporting an injury of unknown origin to a nurse upon discovery. A review of Resident #5's

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Care Plan revealed that the resident had a pathological bone fracture related to the [DIAGNOSES REDACTED]. A review of an Incident Report provided by the facility dated 3/16/2020 at 4:40 AM with a revision date of 3/16/2020 at 17:57 (5:57 PM) revealed that S4LPN created the Incident report consistent with the previous, and that Resident #5 had a bruise to the front of her Right thigh. A review of Resident #5's nurses notes revealed a noted dated 3/16/2020 at 0400 (4:00 AM) that included summoned to resident room by CNA noted a purplish bruise noted to the upper right thigh. The note was signed by S4LPN. A review of the investigation documentation provided by the facility revealed a noted dated 3/17/2020 by S3ADON in regards to Resident #5. The note included the following: Investigation of Unknown Bruise to Left (as written) Inner Thigh. Spoke with S5CNA, agency CNA from (agency name) who reports that the bruise was there Sunday 3/15/2020 during day shift. She reports she thought the bruise was old and failed to report it to the nurse. Further review of nurses notes, incident reports, and documentation provided by the facility failed to reveal evidence that S5CNA reported the bruise to any facility staff when she provided care to the resident on 3/15/2020. On 4/21/2020 at 3:50 PM, a telephone interview was conducted with S10CNA. She stated that it was the facility policy that the aides tell a nurse when they see a bruise on a resident. On 4/22/202 at 12:45 PM, a telephone interview was conducted with S5CNA. She confirmed that she worked with Resident #5 on 3/15/2020 during the day shift, from 6:00 AM - 6:00 PM, and that it was her first time working with the resident. She stated that during her shift she saw a large splotchy bruise that looked old on the resident's right thigh. S5CNA stated she assumed that it was known by the nurses already so did not report it to anyone. On 4/23/2020 at 12:29 PM, a telephone interview was conducted with S1ADM. She stated that she had forwarded the policies and procedures on Falls, Abuse, Accidents and Incident Reporting, and Changes in a Resident's Condition or Status/Reporting to MD. She stated that although these policies and procedures don't speak specifically to a CNA, they work together to ensure that staff report incidents appropriately, including the CNAs reporting findings to the nurse. On 4/23/2020 at 3:40 PM, a telephone interview was conducted with S1ADM by this surveyor along with one other surveyor. She confirmed that the bruise was found on Resident #5's Right thigh, not Left thigh as stated on the Investigation document that S3ADON had created. She confirmed that S5CNA reported that she saw a bruise on 3/15/2020 on the day shift and that she thought it was old and failed to report it to the nurse. S1ADM confirmed that S5CNA was an agency CNA and that the aide was not familiar with Resident #5 as this was the first time she had worked with the resident. When this surveyor questioned S1ADM for clarification of an aide's responsibility on reporting bruises to a nurse, she confirmed that S5CNA should have reported the bruise to the nurse when she discovered it. She further confirmed that the facility documentation revealed that the aide failed to demonstrate competency when she did not report the bruise to a nurse when she discovered it.