STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195310	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANY HEALTHCARE AND REHABILITATION CENTER	**120 NATCHITOCHES HWY 6 EAST MANY, LA 71449**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a shower chair device that was provided for a resident's bath was the correct size for 1 (#3) of 6 (#1, #2, #3, #4, #5, #6) sampled residents. Findings: Review of Resident #3's MD Orders revealed [DIAGNOSES REDACTED]. Review of the Admission MDS assessment dated [DATE] revealed the resident had a short and long term memory problem and moderately impaired decision making skills. Further review revealed the resident had verbal behaviors directed toward others, rejected care 1 to 3 days, required physical help of one person in part of the bathing activity, weighed 96 pounds was 61 inches tall. Review of the fall history revealed a fall was experienced in the last 2 - 6 months prior to admission. Review of the Fall Risk assessment dated [DATE] revealed the resident had a weak gait, overestimated or forgot limitations and had a Fall Risk Score of 40 (moderate risk 25-44). Observation on 03/03/2020 at 8:48 a.m. revealed the resident was seated on a shower chair in the shower room with S5 CNA. S5 CNA assisted the resident with her bath. The shower chair in use appeared to be extra wide, and the resident's feet dangled above the floor greater than 4 inches. S4 RN Charge Nurse entered the shower room on 03/03/2020 at 8:53 a.m. and observed the resident seated on the shower chair. S4 RN Charge Nurse confirmed the chair used for the resident's bath was a large shower chair, and the resident's feet were dangling off of the floor. Interview and observation on 03/03/2020 at 10:00 a.m. with S2 DON revealed the shower chair was an extra wide shower chair, and staff should have used the regular sized shower chair for resident #3's bath.
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 resident #6's family was immediately notified after they received a report of an allegation of abuse concerning the resident for 1 (#6) of 6 (#1, #2, #3, #4, #5, #6) sampled residents. Review of resident #6's MD Orders revealed [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment with an ARD of 02/26/2020 revealed a BIMS of 99 (unable to complete interview), had a memory problem with long and short term memory, and that bed mobility, transfer, and personal hygiene required the extensive assistance of 2 people. Review of the Care Plan revealed a problem of potential for impaired cognitive function, impaired thought processes related to Alzheimer's and altered Mental Status with a Target Date of 05/26/2020. Interventions included communicate with the resident/family/caregivers regarding resident's capabilities and needs. Interview on 03/03/2020 at 3:00 p.m. with S1 Administrator revealed staff had conducted an investigation into an allegation by a CNA of potential abuse of resident #6. Review of the investigation revealed there was no information concerning notification of the resident's family of the allegation of abuse. Interview on 03/03/2020 at 3:15 p.m. with the resident's wife revealed she visited the resident almost every day; however, had not been informed of an investigation of abuse of resident #6. Interview on 03/05/2020 at 10:00 a.m. with S1 Administrator revealed the resident's wife was not informed concerning the allegation of abuse investigated on 02/20/2020. Interview on 03/05/2020 at 11:05 a.m. with S2 DON confirmed she had not immediately notified the resident's family (wife) of the allegation of abuse, but should have.
F 0689 **Level of harm** - Minimal harm or potential for 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 interview and record review the facility failed to ensure resident #2 received adequate supervision during transportation in a facility van to a medical appointment, and failed to ensure resident #1's environment remained as free of accident hazards as possible for 2 (#1 and #2) of 6 (#1, #2, #3, #4, #5, #6) sampled residents. Findings: Review of Resident #2's MD Orders revealed the [DIAGNOSES REDACTED]. Review of the MD Progress Note dated 01/21/2020 revealed the resident had a history of [REDACTED]. Review of the Quarterly MDS assessment dated [DATE] (ARD) revealed the resident had no speech, required extensive assistance of 2 people for bed mobility, transfer, personal hygiene, and was totally dependent on 2 people for transfer off the unit. Further review revealed the resident was always incontinent of bladder and bowel. Review of the Care Plan revealed: 1. Problem of [MEDICAL CONDITION] disorder and goal to remain free of injury related to [MEDICAL CONDITION] activity (Target Date 05/13/2020). The interventions included monitor for s/s of [MEDICAL CONDITION] activity and promote a safe environment for resident; 2. Problem of at risk for skin breakdown due to impaired bed mobility and incontinence and goal to promote skin free of breakdown without complications (Target Date 05/13/2020). The interventions included reposition with 2 staff members assisting. Telephone interview on 03/02/2020 at 8:16 a.m. with the resident's Mother revealed the resident was transported in the facility van to a Medical appointment with a second resident in January 2020. Further interview revealed there was only 1 CNA that accompanied the 2 residents and the van driver to the appointments, the other resident was dropped off first for his appointment, the CNA stayed with that resident, and her son was left without a CNA in the van with him. Review of the facility Driver and Vehicle Safety Policy (Section 5.4) revealed employees driving the company vehicle shall have another employee ride with the driver if transporting residents who need assistance including, but not limited to, lifting or medical assistance. Interview on 03/04/2020 at 10:00 a.m. with S3 ADON revealed 2 CNAs were assigned to go with the 2 residents for the above MD appointments, however 1 of the CNAs called in just before they left for the appointments, and 1 CNA left with the two residents and the driver in the van for the appointments. Interview on 03/04/2020 at 10:00 a.m. with S1 Administrator confirmed the resident was taken to a Medical appointment with a second resident in the facility van in January 2020. Further interview with S1 Administrator confirmed 1 CNA had gone with the 2 residents for medical appointments, and 2 CNAs should have gone. 2. Review of Resident #1's MD Orders revealed [DIAGNOSES REDACTED]. Review of the Progress Note dated 02/26/2020 at 12:56 p.m. revealed the resident wandered in and out of residents rooms, picked up items and carried them around the facility. Review of the Wandering Risk Evaluation dated 02/07/2020 revealed the resident was at high risk for wandering. Review of the Annual MDS assessment dated [DATE] (ARD) revealed the resident had impaired short and long term memory with moderately impaired cognitive skills for daily decision making. The resident required set up assistance and supervision for locomotion on and off the unit. Review of the Care Plan Problem of Wandering Behavior revealed the goal of care was resident will be safe and secure without injury within the facility (Goal Date 05/06/2020). The interventions included monitor, document, and redirect resident when found wandering in unauthorized areas, and remove resident from unsafe situations. Observation on 03/04/2020 at 7:40 a.m. revealed the resident was seated on a couch in the dining room/day room by the nurses' station with a group of residents. Further observation revealed there were no staff members

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) observed in the day room or at the nurses' desk. Observation on 03/04/2020 at 7:44 a.m. revealed the resident stood up and ambulated to the nurses' desk and moved the metal hole punch device around on the desk, grasped it and pulled it toward herself. Further observation revealed there were no staff members within sight of the resident. S6 LPN was observed passing medications on the hall and returned to the nurses station on 3/04/2020 at 7:45 a.m. S6 LPN confirmed the resident was trying to retrieve the hole punch device, and staff were not present in the day room or the nurses' station. Interview on 03/05/2020 at 1:55 p.m. with S2 DON revealed the hole punch device was heavy and the resident should not have had access to it.