STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195573	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA ESTATES	**1511 DULLES DRIVE 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 record review and interview, the facility failed to: 1- Immediately inform the resident's representative when there was an injury that required physician intervention as evidenced when Resident 1 sustained a fall at 9:00 PM on 6/14/202 and the facility did not inform the family until 5:00 AM on 6/15/2020; and 2- Immediately inform the Nurse Practitioner of Resident #1's additional complaints of pain after sustaining a fall on 6/14/2020, for 1 (Resident #1) of 3 (#1, #2, #3) residents reviewed for Falls, of a total of 5 (#1, #2, #3, #4, #5) sampled residents. The total census was 131. FINDINGS: A review of the facility's policy and procedure titled Change in Resident Condition presented by S1DON was conducted. The purpose of the policy was To provide guidelines for communicating information regarding a change in a resident's condition. It included that the resident's primary physician or designated alternate will be notified immediately of any significant change in a resident's physical or mental condition, the resident's family and/or representative will also be notified in a timely manner, that notification of the family and/or representative will be documented in the resident's medical record, and that all attempts made to contact the physician, family and or representative, including time date and any messages left were to be documented in the resident's medical record. 1. A review of Resident #1's nurses' notes revealed an entry dated 6/14/2020 at 21:00 (9:00 PM), which included -summoned to resident room per CNA (certified nurse aide). On entering resident was noted sitting in flipped wheelchair with seatbelt secured. Her chair was flipped and resident upper body was on the floor. Assisted off floor x 2 assist and placed in bed, bed in low position and mattress pad next to bed for fall precaution. Assessment done and resident noted with skin tears to BUE (bilateral upper extremity) treatment nurse notified and tx (treatment) completed (See TAR-treatment administration record) VS WNL (vital signs within normal limits), MAE (moves all extremities) slowly, co (complained of) pain to neck, able to move and turn neck side to side. S2NP notified new orders xray of neck/chest. Further review of the nurses' notes failed to reveal evidence that the Resident #1's family or responsible party had been notified of the fall when it occurred. A review of an Incident and Accident report dated 6/14/2020 at 2100 regarding a fall sustained by Resident #1 was conducted. The person preparing report was documented as MAG TEMP 1. The incident description included that the resident was found in her wheelchair in her room on the 100 hall, with the wheelchair facing down on the floor and S2NP had been notified on 6/14/2020 at 2100. Further review of the report revealed documentation that a family member had been notified of the accident on 6/14/2020 05:00 (5:00 AM), which was before the accident had occurred. A review of an assessment document titled Fall Follow-Up Observations (72 hours) dated 6/14/2020 at 2100 (9:00 PM) was conducted. An area titled Family Notification had been left blank. On 7/24/2020 at 1:15 PM, an interview was conducted with S1DON. She reviewed Incident and Accident report regarding Resident #1's fall on 6/14/2020 at 9:00 PM. She stated that the documentation that the family was notified on 6/14/2020 at 5:00 AM was an error that they were actually notified on 6/15/2020 at 5:00 AM. She confirmed that MAG TEMP 1 was S7LPN, an agency nurse, and had not notified Resident #1's family of the fall until 6/15/2020 at 5:00 AM, 8 hours after the resident had fallen. S1DON confirmed that S7LPN had failed to follow the facility's notification policy and had failed to notify Resident #1's family or responsible representative in a timely manner that the resident had sustained a fall. 2. A review of a document titled Fall Follow-Up Observations (72 Hours) for Resident #1 dated 6/14/2020 21:00 (9:00 PM) was conducted. Initial observations on 6/14/2020 at 2100 included the current pain level as 6. The assessment was signed by S7LPN. Further review of the Fall Follow-Up Observation document revealed a 15 minute post fall assessment at 9:15 with a pain level of 6 and that Resident #1 was asked if she was still in pain and she stated that her butt hurts, and she denied having head, neck, or chest pains. The assessment was signed by S7LPN. Further review failed to reveal that S2NP had been made aware of this new complaint of pain to a different area of the resident's body. A 45 minute post fall assessment conducted at 9:45 PM revealed that Resident #1 continued to complain of pain to buttocks. The assessment was signed by S7LPN. Further review failed to reveal that S2NP had been made aware of this new continued complaint of pain to the resident's buttocks. A 2 hour post fall assessment conducted at 11:00 PM revealed a pain level of 4 and that Resident #1 now had complaints of lower back pain. The assessment was signed by S7LPN. Further review failed to reveal that S2NP had been made aware of the previous complaints of pain to the resident's buttocks, or the new complaints of lower back pain. A 4 hour post fall assessment conducted dated 6/15/2020 at 1:00 AM revealed a current pain level of 7. The assessment was signed by S7LPN. Further review failed to reveal that S2NP had been made aware of the previous complaints of pain to the resident's buttocks, or to her lower back, or that her pain level had increased. A 6 hours post fall assessment conducted at 3:00 AM revealed that Resident #1 remained in bed and continued to report complaints of pain to her lower back. S7LPN documented that she had notified S2NP regarding the complaints of low back pain. There was no evidence that S2NP had been made aware of the previous complaints of buttock pain. Further review failed to reveal that S2NP had been made aware of the complaints voiced by the resident regarding her buttocks. A review of the nurses' notes dated 6/14/2020 21:00 (9:00 PM) revealed that Resident #1 had complaints of pain to her neck, S2NP was notified and an x-ray of the neck and chest were ordered. A review of Resident #1's nurses' notes dated 6/15/2020 at 4:00 AM revealed that S2NP was notified that Resident #1 continued to complain of back pain and a new order to add lower back xray to previous xray order for this morning was noted. A review of nurses' notes dated 6/15/2020 at 4:17 PM revealed that the resident had complained of increased pain to her Right Lower Extremity and that new orders for a STAT (immediately) xray was received. A review of nurses' notes dated 6/15/2020 at 6:40 PM revealed that Resident #1 had a Right [MEDICAL CONDITION]. On 7/27/2020 at 11:30 AM, an interview with S1DON was conducted. She confirmed that S7LPN, agency nurse was on duty when Resident #1 fell . She reviewed the nurses' notes and the Fall Follow-Up Observation document for the 6/14/2020 fall and confirmed that there was no evidence S7LPN had made S2NP aware of Resident #1's complaints of pain to her buttocks after the fall, or that she had been made aware that the resident's pain level had increased over the shift after pain medication had been administered. She confirmed that the nurses' notes revealed that S2NP had not been made aware of the complaints of pain made a 3:00 AM until 4:00 AM. S1DON stated that S7NP should have notified S2NP of Resident #1's new complaints of pain and increased level of pain after medication had been administered, and that there was no evidence that she had done so. She further stated that S7LPN had reported to her (S1DON) that Resident #1 had complained of pain all over her back, neck and butt during the shift after she had fallen. On 7/27/2020 at 1:30 PM, an interview was conducted with S2NP. She stated that she had received a telephone call from an agency nurse at 9:00 PM on 6/14/2020 notifying her that Resident #1 had fallen and she had neck pain. She stated that the only other communication she received from the agency nurse regarding Resident #1's complaints of pain was on 6/15/2020 at 4:00 AM, when she was informed about complaints of low back pain. On 7/29/2020 at 4:38 PM, a telephone interview was conducted with S7LPN. She stated that she was an agency nurse and confirmed that on 6/14/2020 she was assigned to work on the 100 and 200 halls for the 6:00 PM to 6:00 AM shift. She stated that at on

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) 6/14/2020 at 9:00 PM she was administering medications on the 200 hall, and she was notified that Resident #1 had fallen in her wheelchair on the 100 hall. She stated Resident #1 had fallen forward in her wheelchair, the residents face, neck, upper body and abdomen were on the floor with her neck turned toward the window, and she was still buckled into the wheelchair, which was on top of her. S7LPN stated that the resident's only complaint of pain at that time was to her neck. She stated that she called S2NP to alert her about the fall and the neck pain. She stated that after the fall the resident had additional complaints of pain to her buttocks and to her lower back, and that she would reposition her and put pillows behind her back. S7LPN stated that she texted S2NP at 4:00 AM on 6/15/2020 to notify her that the resident was complaining of pain to her low back. S7LPN stated that after the fall, when the resident had new complaints of pain her interventions were to reposition her. She stated that she did not inform S2NP that the resident had complaints of pain to her buttocks or low back pain previously during the shift, or that the medication administered was not effective in relieving Resident #1's pain.
F 0659 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to ensure that services were provided in accordance with each resident's written plan of care for 1 (Resident #1) who required services through the Restorative program, out of 5 (#1, #2, #3, #4, #5) sampled residents as evidenced by staff failing to provide PROM (Passive Range Of Motion) to the resident's BLE (Bilateral Lower Extremities) on 7/17/2020, 7/18/2020, 7/19/2020, 7/22/2020, 7/23/2020, 7/27/202, and 7/28/2020. FINDINGS: Resident #1 was on the COVID (Coronavirus) unit from 5/11/2020 to 6/14/2020 and from 6/29/2020 to 7/8/2020. A review of Resident #1's Care Plan revealed that she was care planned for the following: Restorative Program- PROM BLE (Passive Range of Motion to Bilateral Lower Extremities) 3 x (times) 10 reps (repetitions), straight leg lifts, heel slides and ankle ROM (Range of Motion). Staff were to encourage the resident to participate 6-7 days per week as tolerated. Goals included: assist me with exercises to maintain ROM, strength, muscle tone, and to prevent contractures; Assist and maintain current level of function for ADLs (Activities of Daily Living); and Restorative Program: Nursing Rehab: dressing/grooming. Pt (patient) to perform grooming (bedside or WC level) and reaching tasks (shoulder arc or rings) for a total of 15 minutes a day, 6-7 days a week. On 7/28/2020 at 4:10 PM, an interview was conducted with S17Restorative and S18Restorative. S17Restorative confirmed that they conducted restorative therapy with Resident #1. When asked what kind of restorative therapy was conducted with the resident S17Restorative stated that she assisted her with grooming, assisting her with brushing her hair, and reaching tasks, like reaching for her comb. Neither restorative aide reported any PROM to the resident's BLE, so this surveyor asked what kind of therapy were they providing in terms of ROM to her lower extremities, and again S17Restorative responded that for ROM they encourage her to reach for things with her hands. They were asked if they were conducting any leg lifts, or ROM to the resident's ankles, or if they were supposed to be doing this. S17Restorative did not initially answer and then responded that I would have to speak to her supervisor. This surveyor attempted to clarify the question and asked S17Restorative if she conducted PROM to Resident #1 legs when she provided restorative therapy to her and again she responded that I would need to speak to her supervisor and then confirmed that her supervisor was on vacation. S17Restorative would not confirm whether or not she was conducting PROM BLE with Resident #1. On 7/28/2020 at 4:20 PM, S1DON presented printed flow sheets of Restorative tasks provided to Resident #1 from 6/29/2020 to 7/28/2020. A review of the forms revealed that S17Restorative had documented that she had conducted BLE PROM (straight leg lifts, heel slides and ankle ROM) 3x10 reps for 15 minutes a day on 7/17/2020, 7/18/2020, 7/19/2020, 7/22/2020, 7/23/2020, 7/27/202, and today 7/28/2020 at 3:13 PM. On 7/28/2020 at 4:30 PM, an interview was conducted with S19Therapy. She stated that while Resident #1 was on the COVID unit she was receiving PROM from the staff on the COVID unit and this was to be carried over when she discharged back to her regular room. She stated that Resident #1 was hospitalized from [DATE] until 6/29/2020 and at that point the restorative aides who provided care outside of the COVID unit should have resumed PROM to BLE. S19Therapy confirmed that assisting the resident with brushing her hair, reaching tasks, including reaching for her comb were not PROM to BLE, and if that is what the restorative aides were providing they were not providing the appropriate restorative therapy. On 7/28/2002 at 4:45 PM, an interview was conducted with S20ADM. She stated that she spoke with S17Restorative who informed her that she was conducting PROM to BLE and that she told me that I would have to speak with her supervisor because that is what they are told to do if they get confused and don't know how to answer a question posed to them. This surveyor clarified to S20ADM that I was very specific about PROM to BLE and S17Restorative stated that the ROM that she conducted with the resident was having her reach for items, and when I inquired about BLE services, and what she did with res when she conducted ROM she would not answer but instead told me to speak to her supervisor.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for 1 (Resident #1) of 3 (#1, #2, #3) residents reviewed for Falls, of a total of 5 (#1, #2, #3, #4, #5) sampled residents. FINDINGS: A review of an Incident and Accident report dated 6/14/2020 at 21:00 (9:00 PM) regarding a fall sustained by Resident #1 was conducted. The person preparing report was documented as MAG TEMP 1. The incident description included that the resident was noted belted in her wheelchair with wheelchair facing down on the floor. The immediate action taken included that the wheelchair was picked up off the floor, the resident complained of neck pain but was able to move her neck without difficulties. S2NP was notified and new orders for a neck and chest xray in the morning and Tylenol 325 mg 2 tabs every 6 hours PRN (as needed) for Pain were received. Further review of the report included the following: Resident stated c/o (complaints of) neck pain following incident. PRN Tylenol received post incident. On 6/15 in the afternoon, resident with new c/o pain to right hip while being evaluated by therapy. NP notified and received order for STAT x-ray of right hip. A review of Resident #1's orders revealed a Physician's Telephone Order dated 6/15/2020 at 1615 (4:15PM) STAT (Immediate) xray rt (Right) leg dx (Diagnosis) Pain. A review of an X-Ray reported dated 6/15/2020 at 1850 (6:50 PM for Hip Xray included: See note: Findings 2 views of the right hip demonstrate an acute comminuted intertrochanteric fracture. IMPRESSION: Acute Right Intratrochanteric fracture. FEMUR: Acute Right intertrochanteric fracture. A review of Resident #1's nurses' notes revealed an entry dated 6/14/2020 at 21:00 (9:00 PM), which included -summoned to resident room per CNA (certified nurse aide). On entering resident was noted sitting in flipped wheelchair with seatbelt secured. Her chair was flipped and resident's upper body was on the floor. Assisted off floor x 2 assist and placed in bed, bed in low position and mattress pad next to bed for fall precaution. Assessment done and resident noted with skin tears to BUE (bilateral upper extremity) treatment nurse notified and tx (treatment) completed, VS WNL (vital signs within normal limits), MAE (moves all extremities) slowly. Further review of the nurses' note revealed that Resident #1 had co (complained of) pain to neck and was able to move and turn her neck side to side. S2NP was notified and new orders for an x-ray of neck/chest, and Tylenol 325 mg every 6 hours PRN (as needed) pain were documented. There was no documentation noted in this nurses' note that pain medication had been administered to the resident. A review of the nurses' note dated 6/15/2020 at 4:00 AM revealed that Resident #1 continued to complaint of back pain. There was no documentation noted in this nurses' note that pain medication had been administered to the resident. A review of the nurses' note dated 6/15/2020 at 4:17 PM revealed that the resident had complained of increased pain to her Right Lower Extremity and that new orders for a STAT (immediate) xray was received. There was no documentation noted in this nurses' note that pain medication had been administered to the resident. There were no other nurse' note between the 6/15/2020 4:00 AM and 4:17 PM entries. A review of the nurses' note dated 6/15/2020 at 6:40 PM revealed that Resident #1 had sustained a Right [MEDICAL CONDITION]. There was no documentation noted in this nurses' note that pain medication had been administered to the resident. A review of an assessment document titled Fall Follow-Up Observations (72 hours) dated 6/14/2020 at 2100 (9:00 PM) was conducted. Initial observations on 6/14/2020 at 2100 included the current pain level as 6. There was no documentation noted in this assessment that pain medication had been administered to the resident. The assessment was signed by S7LPN. Further review of the Fall Follow-Up Observation document revealed a 15 minute post fall assessment at 9:15 PM with a pain level of 6 and that Resident #1 was asked if she was still in pain and she stated that her butt hurt, and she denied having head, neck, or chest pains. There was no documentation noted in this assessment that pain medication was administered to the resident. The assessment was signed by S7LPN. A 45 minute post fall assessment conducted at 9:45 PM revealed that Resident #1 continued to complain of pain to buttocks. There was no documentation noted in this assessment that pain medication was administered to the resident. The assessment was signed by S7LPN. A review of the 1 hour post fall at 10:00 PM was reviewed. S7LPN documented that she was UTO (unable to obtain) a pain level on Resident #1 at that time. There was no documentation noted in this assessment that pain medication was administered to the

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) resident. The assessment was signed by S7LPN. A 2 hour post fall assessment conducted at 11:00 PM revealed a pain level of 4 and that Resident #1 now had complaints of lower back pain and that Tylenol 325 mg given po (by mouth). Further review of the 11:00 PM assessment failed to reveal that 2 tabs of Tylenol had been administered to Resident #1. The assessment was signed by S7LPN. A 4 hour post fall assessment conducted on 6/15/2020 at 1:00 AM revealed that Resident #1's pain level had increased from 4 to 7. There was no documentation noted in this assessment that pain medication had been administered to the resident. The assessment was signed by S7LPN. A 6 hour post fall assessment conducted at 3:00 AM revealed that Resident #1 remained in bed and continued to report complaints of pain to her lower back with a current pain level of 5. S7LPN documented that she had notified S2NP regarding the complaints of low back pain. There was no documentation noted in this assessment that pain medication had been administered to the resident. The assessment was signed by S7LPN. A 12 hour post fall assessment conducted at 9:00 AM revealed that Resident #1 continued to report complaints of pain to her lower back with a current pain level of 2. There was no documentation noted in this assessment that pain medication had been administered to the resident. The assessment was signed by S8LPN. An 18 hour post fall assessment conducted at 3:00 PM revealed that Resident #1 continued to report complaints of pain to her lower back with a current pain level of 3. There was no documentation noted in this assessment that pain medication had been administered to the resident. The assessment was signed by S9LPN. A review of Resident #1's June 2020 MAR (Medication Administration Record) was conducted. An order dated 6/2/2020 for Tylenol 1000 mg (milligrams) po q (every) 8 hours PRN pain was noted. Review of the administration record revealed that the pain medication had not been administered to Resident #1 on 6/14/2020 or 6/15/2020. Further review of the MAR failed to reveal that Tylenol, in any dosage, had been administered to the resident on 6/14/2020 or 6/15/2020, after the fall had occurred. On 7/27/2020 at 1:00 PM, an interview was conducted with S1DON. She reviewed the Fall Follow-Up Observation assessments of Resident's pain from 6/14/2020 at 9:00 PM through 6/15/2020 at 3:00 PM, which was the last assessment conducted by the facility before Resident #1 was transported to a local hospital. She identified MAG TEMP 1 as S7LPN, an agency nurse who was assigned to Resident #1 on 6/14/2020 when the resident had fallen. She confirmed that Resident #1 complained of pain to her neck, her buttocks, and her lower back, and that her pain level had increased during the post fall observation and assessment period. She confirmed that S7LPN had documented that she administered Tylenol 325 mg at 11:00 PM on 6/14/2020, two hours after Resident #1 had fallen and could not confirm if it was one or two tabs. She confirmed that there was no further evidence that Resident #1 had received any additional pain medication even as she continued to complain of pain after the fall. S1DON further stated that if a pain medication had been administered to Resident #1 it would be reflected in the MAR. She reviewed the resident's June 2020 MAR indicated [REDACTED]. In addition, she confirmed that the MAR indicated [REDACTED]. She stated that the facility documentation revealed that Resident #1 received Tylenol 325 mg at 11:00 PM, 2 hours after she had fallen face forward in her wheelchair that her pain was not relieved but continued to increase during the assessment period. She stated that Resident #1 had sustained the fracture to her Right hip as a result of the fall on 6/14/2020 at 9:00 PM. S1DON also confirmed that the facility failed to administer any additional Tylenol to Resident #1 even as her complaints of pain increased. On 7/27/2020 at 1:30 PM, an interview was conducted with S2NP. She stated that she had received a telephone call from an agency nurse at 9:00 PM on 6/14/2020 notifying her that Resident #1 had fallen and she had neck pain. She stated that the only other communication she received from the agency nurse regarding Resident #1's complaints of pain was on 6/15/2020 at 4:00 AM, when she was informed about complaints of low back pain. On 7/29/2020 at 3:00 PM, a telephone interview was conducted with S21LPN. She stated that on 6/15/2020 she had reported for the 6:00 PM shift and received report that Resident #1 had fallen the night before on 6/14/2020 that the resident not been out of bed since the fall because of pain. She further stated that Resident #1 had complained of hip pain recently and that an xray had been ordered. She stated that the xray technician arrived during the report to conduct the xray and that the results revealed a fracture. She stated that the resident complained to her that her hip was aching but that she was told in report that her pain medication had just been administered and it was not due. She confirmed that she did not administer pain medication to Resident #1. On 7/29/202 at 3:10 PM, a telephone interview was attempted with S9LPN, who had documented the assessment dated [DATE] at 3:00 PM, which was the last assessment conducted on Resident #1 before she was sent to the hospital. A message was left on S9LPN's answering machine but no return call was received. On 7/29/2020 at 3:12 PM, a telephone interview was conducted with S8LPN, who had documented the assessment dated [DATE] at 9:00 AM on Resident #1. This surveyor questioned S8LPN about that assessment and she stated that she did not remember working with Resident #1, that she could not recall that shift or anything related to the fall or the assessment with her name on it. On 7/29/2020 at 4:38 PM telephone interview was conducted with S7LPN. She confirmed that she was assigned to Resident #1 on 6/14/2020 from 6:00 PM to 6:00 AM on 6/15/2020. She stated that at 9:00 PM she was notified that the resident had fallen. When she got into the resident's room she observed that she had fallen forward in her wheelchair and she was still buckled in. The wheelchair had fallen forward, and the resident's face, neck, upper body, and abdomen were on the floor. Her face and neck were turned to its side, facing the window. S7LPN stated that she unbuckled the resident and pulled her wheelchair off of her and that the resident was complaining of pain to her neck. S7LPN stated that she administered Tylenol 325 mg 2 tabs at that time. S7LPN stated that she went into Resident #1's room between 1:00 AM and 2:00 AM and she complained of pain so she used a pillow to reposition her. She stated that at 4:00 AM on 6/15/2020, she texted S2NP alerting her that Resident #1 complained of pain. S7LPN stated that she did not give Resident #1 any more pain medication on her shift as the CNA assigned to the resident did not report to her that the resident had complained of pain. A review of the ambulance documentation dated 6/15/2020 with an arrival time at the facility of 6:58 PM was conducted. Resident #1's chief complaint was Pain and she was assessed as having a deformity to her Right Pelvis/Hip. Her pain was assessed as 10 out of 10, with 10 being the highest pain level. Comments included: fell yesterday with obvious [MEDICAL CONDITION]. The Narrative History included: Patient lying in nursing home bed with staff in room. Patient was a/o (awake oriented), Obvious deformity to right side hip, Bruising to face and forehead, Patient in obvious pain. Resident #1 was administered [MEDICATION NAME] 100 mcg through intravenously. [MEDICATION NAME] is a powerful Opioid Narcotic pain medication used to treat severe pain. Resident #1's vital signs were as follows: 7:12 PM- Pulse 98, Respirations 18, Pain 10 7:13 PM Blood Pressure 106/63, Pulse 77, Respirations 15, Pain 10 7:15 PM Blood Pressure 94/61, Pulse 100, Respirations 15, Pain 10 A review of the Resident #1's hospital triage records revealed that she arrived on 6/15/2020 at 8:02 PM with [DIAGNOSES REDACTED]. Her Blood Pressure was 92/68, Pulse was 100, and Respirations were 13.
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 reviews and interviews, the facility failed to ensure that nursing staff provided appropriate and accurate nursing assessments of residents after sustaining a fall for 1 (#1) of 3 (#1, #2, #3) residents reviewed for falls, out of a total sample of 5 (#1, #2, #3, #4, #5) residents as evidenced by the facility failing to continually assess the ROM and skin after the initial assessment for a resident who sustained an unwitnessed fall on 6/14/2020 at 9:00 PM, and who continued to complain of pain. The resident was diagnosed with [REDACTED]. FINDINGS: A review of Resident#1's record revealed that she tested positive for COVID-19 and was on the COVID unit from 5/11/2020 to 6/14/2020. A review of skilled assessment conducted before the resident was transferred off of the COVID unit dated 6/14/2020 at 11:48 AM revealed Resident #1 was assessed with [REDACTED].#1 was conducted. The person preparing report was identified as MAG TEMP 1. The incident description included that the resident was noted belted in her wheelchair with wheelchair facing down on the floor. The immediate action taken included that the wheelchair was picked up off the floor, the resident complained of neck pain but was able to move her neck without difficulties. S2NP was notified and new orders for a neck and chest X-Ray in the morning and Tylenol 325 mg 2 tabs every 6 hours PRN (as needed) for Pain were received. Further review of the report included the following: Resident stated c/o (complaints of) neck pain following incident. PRN (as needed) Tylenol received post incident. On 6/15 in the afternoon, resident with new c/o pain to right hip while being evaluated by therapy. NP notified and received order for STAT (immediate) X-Ray of right hip. A review of an X-Ray reported dated 6/15/2020 at 1850 (6:50 PM) for Hip X-Ray included: See note: Findings 2 views of the right hip demonstrate an acute comminuted intertrochanteric fracture. IMPRESSION: Acute Right Intratrochanteric fracture. FEMUR: Acute Right intertrochanteric fracture. A review of Resident #1's nurse' notes dated 6/14/2020 at 19:00 (7:00 PM) included the following: Resident was transferred back to room on Hall A hall via wheelchair. Report received from S22RN In COVID unit. Resident sitting in room in WC (wheelchair) in locked position skin .noted CB (Call Bell) within reach. The next nurse' note entry was dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195573	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA ESTATES	**1511 DULLES DRIVE 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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) 6/14/2020 at 21:00 (9:00 PM) included -summoned to resident room per CNA (certified nurse aide). On entering resident was noted sitting in flipped wheelchair with seatbelt secured. Her chair was flipped and resident's upper body was on the floor. Assisted off floor x 2 assist and placed in bed, bed in low position and mattress pad next to bed for fall precaution. Assessment done and resident noted with skin tears to BUE (bilateral upper extremity) treatment nurse notified and tx (treatment) completed, VS WNL (vital signs within normal limits), MAE (moves all extremities) slowly. Further review of the nurses' note revealed that Resident #1 had co (complaints of) pain to neck and was able to move and turn her neck side to side. S2NP was notified and new orders for an x-ray of neck/chest, and Tylenol 325 mg every 6 hours PRN (as needed) pain were documented. A review of the nurse' note dated 6/15/2020 at 4:00 AM revealed that the resident continued c/o (complaints of) back pain. A review of the nurse' note dated 6/15/2020 at 16:17 (4:17 PM) revealed that the resident had increased pain to RLE (Right Lower Extremity). Further review of the nurse' notes failed to reveal that the nurses conducted assessments on Resident #1's ROM or skin assessments. A review of the nurse' note dated 6/15/2020 at 7:10 PM revealed that the ambulance arrived and the resident was transferred to a local hospital via a stretcher in stable condition. A review of an assessment document titled Fall Follow-Up Observations (72 hours) dated 6/14/2020 at 21:00 (9:00 PM) was conducted. Initial observations on 6/14/2020 at 21:00 included Resident #1's current pain level as 6. Documentation included Resident flipped while in wheelchair, face and trunk of body on floor, resident seat belt secure around her wasit (Sic.). The assessments conducted included ROM (Range of Motion)- normal for the resident; Skin Color-Normal for Resident; Skin Diaphoresis: NO; and Injuries: YES -BUE (Bilateral Upper Extremity)-Skin Tear The assessment was signed by S7LPN. Further review of the fall assessment documentation included the following entries: 6/14/2020 at 9:15 PM: pain level of 6 and she stated that her butt hurt. There was no assessment of Resident's ROM or skin. The assessment was signed by S7LPN; 6/14/2020 at 9:45 PM: UTO (Unable to Obtain) pain level, the resident continued to complain of pain to buttocks. There was no assessment of Resident's ROM or skin. The assessment was signed by S7LPN; 6/14/2020 at 10:00 PM: UTO a pain level. There was no assessment of Resident's ROM or skin. The assessment was signed by S7LPN; 6/14/2020 at 11:00 PM: pain level of 4 and Resident #1 now had complaints of lower back pain. There was no assessment of Resident's ROM or skin. The assessment was signed by S7LPN; 6/15/2020 at 1:00 AM: pain level of 7. There was no assessment of Resident's ROM or skin. The assessment was signed by S7LPN; 6/5/2020 at 3:00 AM: pain level of 5 revealed, Resident #1 continued to report complaints of pain to her lower back. There was no assessment of Resident's ROM or skin. The assessment was signed by S7LPN; 6/15/2020 at 9:00 AM: pain level of 2. There was no assessment of Resident's ROM or skin. The assessment was signed by S8LPN; and 6/15/2020 at 3:00 PM: pain level of 3. There was no assessment of Resident's ROM or skin. The assessment was signed by S9LPN. On 7/27/2020 at 11:00 AM, an interview was conducted with S14PT. She stated that on 6/15/2020 she was made aware that Resident #1 had fallen on 6/14/2020. She stated that on 6/15/2020 she was on the resident's hall with another resident when she heard Resident #1 holler out that she wanted to move in bed and that her leg hurt. She stated Resident #1 was in her bed with her right leg bent up at the knee and she (S14PT) repositioned the resident and reported the complaints of pain to the a nurse. On 7/27/2020 at 11: 30 AM, an interview was conducted with S1DON. She reviewed Resident #1's MAR (Medication Administration Record), TAR (Treatment Administration Record), Nurse's Notes, and Fall Follow-Up Observation document for the 6/14/2020 unwitnessed fall. She reported that MAG TEMP 1 was the identifier for the agency nurse S7LPN, who was the nurse assigned to Resident #1 on 6/14/2020 when she fell . She reported that S21LPN was the nurse who sent Resident #1 out to the hospital on [DATE]. She confirmed that no skin assessments or ROM assessments had been documented by nursing staff during the fall observation period after the initial fall assessment on 6/14/2020 at 9:00 PM or before she was sent out to the hospital on the evening of 6/15/2020. On 7/29/2020 at 12:30 PM, a telephone interview was conducted with S1DON and S20ADM. S1DON stated that the last assessment conducted on Resident #1 was part of the 72-hour post fall observation and was completed on 6/15/2020 at 3:00 PM. She confirmed that the facility staff had not conducted a skin assessment, or body audit on Resident #1 before she was transferred to the hospital, and further stated that the assessment provided to the ambulance staff would have been pulled from the 3:00 PM fall assessment. She stated that it was the facility policy that if a resident was sent out to a hospital and the reason for transfer was known, it was not considered an acute issue, and no resident assessment was required before the transfer. S1DON reported that the facility received an X-Ray on 6/15/2020 at 6:50 PM, confirming a fracture to the resident's right femur and facility staff knew it had occurred from the fall on 6/14/2020 at 9:00 PM. Because the facility staff were sure that the fracture occurred when the resident fell , it was not considered an acute issue, and no assessment was required by staff prior to the resident being transferred to the hospital. She confirmed that there was no assessment reflecting the resident's ROM or skin condition after the initial fall assessment was conducted on 6/14/2020 at 9:00 PM. She further reported that there was no assessment conducted on the resident reflecting the condition of her hip, face, forehead, chest, or abdomen after that initial assessment through the time she was transferred out of the facility by the ambulance staff. On 7/29/2020 at 3:00 PM, a telephone interview was conducted with S21LPN. She stated that on 6/15/2020 she had reported to work her 6:00 PM scheduled shift and received report from the off-going nurse that Resident #1 had fallen the night before on 6/14/2020. S21LPN then reported that shortly after her shift began the X-Ray report was received confirming that Resident #1 had a fracture. She stated that all assessments conducted on a resident who falls are documented on the Fall Follow-Up but could not recall if she documented an assessment for Resident #1. On 7/29/2020 at 3:10 PM, a telephone interview was attempted with S9LPN, who had conducted Resident #1's assessment dated [DATE] at 3:00 PM, which was the last assessment conducted before the resident was transferred out to the hospital. A message was left on S9LPN's answering machine but no return call was received. On 7/29/2020 at 3:12 PM, a telephone interview was conducted with S8LPN, who had documented the assessment dated [DATE] at 9:00 AM on Resident #1. The surveyor questioned S8LPN about that assessment and S8LPN stated that she did not remember working with Resident #1, and she could not recall that shift or anything related to the fall or the assessment with her name on it. On 7/29/2020 at 4:38 PM, a telephone interview with S7LPN. She stated that she worked the 12 hour shift from 6:00 PM on 6/14/2020 until 6:00 AM on 6/15/2020. She further stated that she did not work with Resident #1 normally, and both she and the aide who worked with Resident #1 that evening were agency staff and neither were familiar with the resident. She reported that early in the shift she saw staff transferring Resident #1 from the COVID unit back to her room on Hall B but she did not assess her at that time because she had just been assessed by the nurse transferring her from the COVID unit. She stated that during that shift she was working on both Hall B and Hall C and had been administering medications to the residents on the Hall C when she got the call that the resident had fallen on Hall B. S7LPN further stated that her first interaction with Resident #1 during that shift was at 9:00 PM that night when she was summoned to the resident's room to assess her because she had fallen. She reported that when she got into the resident's room, she saw that the resident had fallen forward in her wheelchair. She was inside her wheelchair and still buckled in her seatbelt, her neck and face were on the floor turned on the side facing the window, and her upper body and abdomen were on the floor. She stated that the resident kept saying that she was tired of sitting in her wheelchair and wanted to get out. S7LPN reported that she pulled the resident's wheelchair off of her and did not see any bruises to her face or her abdomen, which had also been positioned on the floor. She stated that she gave her pain medication at 9:00 PM, and if the administration was documented at 11:00 PM, it was because she did not have time to document it when she gave it to her. She stated, There was a lot going on and after I got her situated in her bed, I had to go back to Hall C to finish administering medications to the residents on that hall. S7LPN continued, I probably actually only saw her to assess her 3 or 4 times during the 12 hour shift after she fell as I was assigned to Hall B and Hall C. But the CNA was seeing her every 2 hours and reporting back to me. She could not recall the assessments that she conducted on Resident #1 after she fell but stated that it was all documented on Fall Follow-Up Observation form. She also reported that she really could not be sure what time the resident fell , or how long she was on the floor before she was called into her room. A review of the ambulance documentation dated 6/15/2020 with an arrival time at the facility of 6:58 PM revealed that Resident #1's chief complaint was Pain and she was assessed as having a deformity to her Right Pelvis/Hip. Her pain was assessed as 10 out of 10, with 10 being the highest pain level. Comments included: fell yesterday with obvious [MEDICAL CONDITION]. The Narrative History included: Patient lying in nursing home bed with staff in room. Patient was a/o (awake oriented), Obvious deformity to right side hip, Bruising to face and forehead, Patient in obvious pain. A review of the Resident #1's hospital triage records revealed that she arrived on 6/15/2020 at 8:02 PM and her pain level was assessed at a 10 to her right hip. Hospital staff assessed Resident #1 as having skin tears over her left thigh and right elbow, and bruising all about the chest, abdomen, and forehead.