STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195247	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN COURT HEALTH AND REHABILITATION CENTER	**4405 AIRLINE DRIVE BOSSIER CITY, LA 71111**

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

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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 interviews the facility failed to ensure a resident's responsible party (RP) was notified of a resident's change in condition for 1 (#1) out of 5 (#1, #2, #3, #4, #5) sampled residents reviewed for notification of change. The facility failed to ensure the RP was notified of Resident #1's fall. Findings: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's progress note dated 5/3/2020 by nurse practitioner revealed the resident was seen due to a fall. Resident #1 was sitting up in wheelchair and then was found on the floor by his wheelchair; no signs of injury at this time and no signs of head injury. Will continue to monitor and do neurologic checks. Review of Resident #1's facility physician's verbal orders revealed an order dated 5/3/2020 for neurologic checks every 4 hours for 24 hours status [REDACTED].#1's nurses notes failed to reveal information regarding the circumstances of resident's fall. Review of facility's Event Facility Report (incident log) for May 2020 failed to reveal any incidents for Resident #1. During an interview on 8/6/2020 at 10:20am S1 DON (Director of Nursing), after review of nurses notes for Resident #1, acknowledged there was no information by nursing staff, including notification to the family, of Resident #1's fall in the facility. During an interview on 8/6/2020 at 11:40am S1 DON, after review of the facility's Event Facility Report, confirmed there was not an incident report completed and the family was not notified regarding Resident #1's fall in the facility on 5/3/2020.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure the comprehensive plan of care was being implemented for 1 (#2) of 5 (#1, #2, #3, #4, and #5) residents reviewed for accident hazards. The facility failed to ensure: 1.) Wander guard placement was checked each shift. 2.) Functionality of wander guard was checked each shift. Findings: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with a readmission on 3/17/2020. Review of Resident #2's [DIAGNOSES REDACTED]. Review of Resident #2's 6/24/2020 MDS (Minimum Data Set) revealed Resident #2 had a BIMS (Brief Interview Mental Status) score of 5, indicating severe cognitive impairment. Review of July 2020 physician orders [REDACTED]. Review of July 2020 MAR (Medication Administration Record) failed to reveal wander guard placement was checked for the following: - 6-2 shift on 7/1/2020 to 7/12/2020, 7/22/2020 and 7/27/2020 to 7/31/2020 - 2-10 shift on 7/23/2020 and 7/24/2020 - 10-6 shift on 7/26/2020 and 7/27/2020 Review of August 2020 physician orders [REDACTED]. Review of August 2020 MAR (8/1/2020 to 8/4/2020) failed to reveal function of wander guard was checked. During an interview on 8/7/2020 at 1:55pm S1 DON (Director of Nursing) reviewed the July 2020 physician orders [REDACTED].#2's wander guard was not checked for placement for the 6-2 shift from 7/1/2020 to 7/12/2020, 7/22/2020, and 7/27/2020 to 7/31/2020; for the 2-10 shift for 7/23/2020, 7/24/2020; and for the 10-6 shift for 7/26/2020 to 7/27/2020. S1 DON further reviewed the August 2020 MAR and agreed Resident #2's wander guard functionality was not being checked.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure care and services were provided to meet professional standards of quality for 1 (#1) of 3 (#1, #4, #5) residents reviewed for pressure wounds. The facility provided wound care to Resident #1's left lateral foot and heel without indication of pressure wounds or physician's orders for wound care. Findings: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's nurse practitioner's progress note dated 4/24/2020 revealed skin inspection of no rashes or ulcers. Review of Resident #1's admission physician's orders on 4/24/2020 failed to reveal wound care orders. Review of Resident #1's Interdisciplinary Progress Note revealed: 4/24/2020 New Admit. Head to toe body audit completed. Heels are firm, nontender without redness or discoloration. 4/27/2020 Weekly body audit completed. No new areas of concern identified. 4/28/2020 Heels remain firm/not boggy. Review of Resident #1's April 2020 Treatment Record revealed: Treatment provided once daily from 4/27/2020 through 4/30/2020 to left foot (lateral) with wound cleanser, clean with [MEDICATION NAME], cover with [MEDICATION NAME] foam dressing each day and prn (as needed), and Treatment provided once daily from 4/27/2020 through 4/30/2020 to left lateral foot/heel with wound cleanser, pat dry, apply cover with [MEDICATION NAME] dressing each day and prn. During an interview and review of Resident #1's records on 8/6/2020 at 10:20am S1 DON (Director of Nursing) acknowledged there were no physician's orders for wound care to Resident #1's left lateral foot and heel, and no indication of left lateral foot and heel wounds in the treatment nurse's initial head to toe body audit or nurse practitioner's admission progress note from 4/24/2020. On further review of Resident #1's April 2020 Treatment Record, S1 DON confirmed wound care was administered to resident's left lateral foot and heel and was done without indication of pressure wounds or physician's orders for wound care.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on record review, policy review and interviews, the facility failed to ensure the resident environment remained as free of potential accident hazards as possible by failing to ensure: 1.) Nursing staff were trained how to check the functionality of wander guards. 2.) Facility doors were checked for functionality on weekends. 3.) Wander guard alarm had been checked at facility front door. Findings: 1.) During an interview on 8/5/2020 at 2:30pm S2 LPN (Licensed Practical Nurse) indicated she did not know how to check the functionality of a wander guard. S2 LPN further indicated she had only been working at the facility since the last of June 2020. During an interview on 8/6/2020 at 1:14pm S1 DON (Director of Nursing) indicated she was responsible for nursing staff orientation/training and she does not instruct new nursing staff on how to check the functionality of a wander guard. S1 DON further indicated monitoring of wander guard placement and functioning was on the MAR (Medication Administration Record) to be done each shift. 2.) Review of Policy/Procedure titled Best Practices-Elopement/Wandering Risk (8/30/17) revealed in part: Electronic Monitoring: - Check doors daily for function by Plant operations or Designee Review of July 2020 to 8/4/2020 Door Check Logs failed to reveal the facility doors had been checked on the weekends. During interview on 8/5/2020 at 1:15pm S4 Maintenance Director reviewed the Door Check logs

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** - Some	(continued... from page 1) and indicated he was not at the facility on the weekends and he did not know who checked them. During an interview on 8/5/2020 at 1:38pm S3 Administrator indicated the facility doors were not being checked on the weekends. During an interview on 8/5/2020 at 2:02pm S4 Maintenance Director indicated his daily check of the doors included checking the door latch, checking that the door is locking and check that the magnet was functioning like it should. 3.) Review of Policy/Procedure titled Best Practices-Elopement/Wandering Risk (8/30/17) revealed in part: Electronic Monitoring: - Obtain enunciator device to check functionality of bracelets and doors . During an interview on 8/5/2020 at 2:02pm S4 Maintenance Director indicated the front door was the only door with a wander guard alarm. S4 Maintenance Director further indicated he did not have the tool needed to check the wander guard alarm on the front door and was not checking the functioning of the wander guard alarm and should have been.