STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195318	A. BUILDING _____ B. WING _____	**09/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR VILLAGE NURSING & REHABILITATION CENTER	**315 HARRY GUILBEAU ROAD OPELOUSAS, LA 70570**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observation, interview and record review; the facility failed to implement a resident's care plan for falls for 1 (#4) out of 5 sampled residents. Findings: Resident #4 was initially admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]., [MEDICATION NAME] Hemorrhage, [MEDICAL CONDITIONS] and a History of Falls. A review of the facility's incident/accident log revealed Resident #4 had falls on 6/6/2020, 8/19/2020 and 9/7/2020. A review of Resident #4's care plan revealed she was care planned to be at risk for falls with an intervention that included to ensure the resident has and wears proper footwear. On 9/23/2020 at 11:25 AM, Resident #4 was observed sitting in a wheelchair to the left side of her bed. The resident had on blue and white regular socks with no grip strips on the bottom. On 9/23/2020 at 12:20 PM, Resident #4 remained seated in her wheelchair with one leg crossed over the other. No grip strips were visible on the bottom of her blue and white socks. On 9/24/2020 at 11:50 AM, Resident #4 was observed feeding herself lunch in her wheelchair. She was observed wearing with same regular blue and white socks with no grip strips on the bottom that were observed on 9/23/2020. An interview on 9/24/2020 at 12:50 AM was conducted with S1DON. She reviewed the resident's care plan and acknowledged the intervention of esnuring proper footwear. She stated that she had observed the resident earlier and confirmed that the resident had on regular socks. She further stated that the resident should either have on nonslip socks with grip strips or shoes.

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.