STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195365	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAISON DE LAFAYETTE	**2707 KALISTE SALOOM ROAD LAFAYETTE, LA 70508**

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 0689 **Level of harm -** Immediate jeopardy **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 observation, interview and record review the facility failed to ensure adequate supervision to residents to ensure the plan of care for those needing assistance with transfers from staff were being followed for 3 (#4, #6, #7) of 10 (1-#10) sampled residents. This failed practice resulted in an Immediate Jeopardy situation on 12/15/2019 at 1:10 p.m., when Resident #4, who required 2-person assistance for transfers, was dropped to the floor when one CNA (Certified Nursing Assistant) attempted to transfer the resident from a wheelchair to a recliner. After the fall, the resident complained of left arm pain and was transferred to a local hospital where she was diagnosed with [REDACTED]. The facility did not conduct ongoing monitoring and supervision to ensure safe transfer of residents which resulted in continued improper transfers. On 04/22/2020, Resident #4 was assisted again by one CNA during a transfer, became weak and was lowered to the bathroom floor. The Administrator was notified of the Immediate Jeopardy on 07/01/2020 at 2:00 pm. The Immediate Jeopardy was removed on 07/01/2020 at 6:00 p.m. when the facility presented an acceptable plan of removal which included the following: IJ Plan of Removal Goal/Expected Outcome To assure all 54 identified residents are free of harm from improper 2 person transfers. The facility has initiated the following to assure at risk residents are transferred appropriately and appropriate monitoring systems are in place. 1. As of 07/01/2020 any resident who has been assessed and deemed a two person assist will be identified. Staff members are being in serviced on two person assist transfers. This includes meaning of door identifier, instructions in task bar, and care plans. 2. Competency levels will be documented. A monitoring log will include the date, shift, staff member's name/signature, and trainer's name/signature. 3. The monitoring will be ongoing weekly x 4 weeks or until compliance is met. 4. To ensure continued compliance, the DON/designee will perform random two person assist transfer audits once a week. A monitoring log will be kept for long term compliance. 5. Upon return, staff that are PRN or on leave will be trained upon return to work date. 6. If you perform a two person assist without adequate assistance, the disciplinary action will be as following: 1st Offense - Suspension 2nd Offense - Termination This deficient practice has the likelihood to affect the 54 residents identified by the facility as requiring 2 person assistance for transfers. Findings: Resident #4: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Quarterly MDS (Minimum Data Sheet) dated 12/20/2019 revealed: Functional Status: Bed mobility 3/3 (extensive assistance; 2 person physical assistance); Transfer 3/3 (extensive assistance; 2 person physical assistance); Toilet use 3/3 (extensive assistance; 2 person physical assistance); Mobility Devices - wheelchair Review of the Quarterly MDS (Minimum Data Sheet) dated 03/21/2020 revealed: Functional Status: Bed mobility 3/3 (extensive assistance, 2 person physical assist); Transfer 3/3 (extensive assistance, 2 person physical assist); Toilet use 3/3 (extensive assistance, 2 person physical assist) Mobility- wheelchair. A review of the resident's current Care Plan (no date) revealed ADL (Activities of Daily Living) Required assistance. Intervention in place was that the resident was a two person assist for transfers with a gait belt. On 12/16/2019 a BSC (Bed Side Commode) was added as a new intervention. Review of a Post Fall Assessment Report dated 12/15/2019 at 1:10 PM, revealed that Resident #4 called for assistance on the call bell. A CNA responded and did not seek for or wait for assistance. The CNA attempted to transfer Resident #4 from her wheelchair to the recliner by herself. Resident #4's recliner slipped backwards and the CNA dropped the resident on the floor. Resident #4 complained of left arm and right hip pain and was transported to the emergency room for evaluation and treatment. Further review of the report revealed that the facility's intervention was to reeducate staff on transfer x 2 people, dycem (Non slip material) under recliner legs, and suspension of CNA until further investigation. A review of the emergency room assessment dated [DATE] at 2:51 PM, revealed that a x-ray of the resident's left arm was obtained. The results of that x-ray on 12/15/2019 at 3:51 PM, revealed a closed [MEDICAL CONDITION] end of the left humerus. Review of the Witness Statement dated 12/15/2019 by the CNA revealed that she was transferring Resident #4 from the wheelchair to the recliner. When she picked her up, the recliner slid backwards and Resident #4 slid to the floor. On 6/23/2020 at 11:15 AM, an interview was conducted with Resident #4 who was awake, alert and able to answer questions appropriately. Resident #4 stated that on the day her arm was hurt she had called for help. The aide came and wanted to transfer her by herself. Resident #4 stated that she told the aide that she needed 2 people. Resident #4 stated that the aide said no I can do it, I can do it. Resident #4 stated that she was in the bathroom in her wheelchair and she wanted to get to the recliner. The aide insisted that she could do it but she dropped me and I hurt my left arm. Resident #4 added that the aide called for the nurse and they helped pick me up. Resident #4 stated that when she first came into the nursing home she was evaluated and the nurse who evaluated her saw that she needed 2 people for transfers. Review of another Post Fall Assessment Report dated 04/22/2020 at 12:38 PM, revealed that Resident #4 called for assistance via call bell. S3CNA responded to the call and she (S3CNA) attempted to transfer the resident by herself. Resident #4 became weak and was lowered to the bathroom floor. Resident #4 did not sustain any injuries during this incident. The facility's intervention was for the staff to please read all identifiers related to resident on the door and in chart. A review of the Witness Statement dated 04/22/2020, signed by S3CNA, revealed that the resident told her she could stand with assistance in the bathroom and that the resident stated she could hold on to the rail. S3CNA documented that the resident was going down so she put her on the floor. A review of the Care Plan revealed that no new interventions were added after the 04/22/2020 incident. On 06/25/2020 at 12:30 PM, an interview was conducted with S7ADM who stated that when the CNA's were hired the certification they had qualified them to perform all the tasks that were incumbent for a CNA to perform. S7ADM stated that the CNAs had to perform these tasks in order to get their certification, therefore when they were hired they were already competent to perform the work. On 06/29/2020 at 7:40 AM, an interview was conducted with S32LPN who stated that on 04/22/2020 she assessed the resident and found no abnormalities. The resident was able to move all her extremities except for her left arm which was her paralyzed arm. 06/30/2020 at 11:00 AM, an interview was conducted with S8LPN who worked on Hall B/C. S8LPN confirmed that the nurses are responsible for supervising the CNA's. 07/01/2020 at 8:45 AM, an interview was conducted with S3CNA. S3CNA stated that when the incident occurred on 04/22/2020, she thought that Resident #4 could stand and assist her during transfer. S3CNA confirmed that she did not feel like she needed to call for assistance. S3CNA stated that Resident #4 was previously on Hall C and stated that when she cared for Resident #4 on the Hall C, she always transferred the resident by herself. S3CNA stated the resident moved to Hall D and had been on that hall for a few days when she cared for her on 04/22/2020. S3CNA stated that she was not aware the resident was a two person assist. When S3CNA was asked about the door indicators and resident information from the kiosk, S3CNA stated that the door indicators were not on the outside of the door at the time. S3CNA added that the kiosk charting was the last thing she did before her shift ended, so she would not have been aware that the resident was a 2 person assist. S3CNA stated that after the incident there was a memo that was put out for staff to read and sign. S3CNA stated that she never attended an in service about 2 person assist transfers. 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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) 07/01/2020 at 10:40 AM, an interview was conducted with S9LPN on Hall C. S9LPN was asked how she supervised CNAs. S9LPN stated that if she was in the area giving medications and walked into the resident's room while the CNA was giving care, then she will observe the CNA. S9LPN stated that for her to get up and go check on the CNA to ensure the CNA was doing things correctly, no I don't have time for that. On 07/01/2020 at 11:10 AM, an interview was conducted with S17DON who stated that the nurses on the hall were supposed to supervise the CNA's and she did not know why some nurses said they didn't have time to properly monitor the CNA's. Resident #6: A review of the face sheet revealed that the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS revealed on 06/09/2020 an annual review was conducted which revealed that resident's cognitive skills for daily decision making - severely impaired. ADL's reveal bed mobility 3/3; Transfer 3/3; Dressing 4/2; Eating 3/2 and toilet use 3/3. Ability to hear -moderate difficulty; Speech Clarity - no speech; Makes self-understood - rarely/never understood; Ability to understand others - rarely/never understands; Vision - moderately impaired. Bowel and Bladder revealed the resident - always incontinent. BIMS score was left blank. On 06/24/2020 at 8:35 AM, an observation was made of Resident # 6 during a 2 person assist transfer by S1CNA and S2CNA. S1CNA sat Resident #6 up in bed and S2CNA assisted by supporting the resident's head and shoulders. The resident was leaning to her right side, her legs were not straightened, and her feet were not touching the floor. After S1CNA and S2CNA sat up straight in the bed, S1CNA grabbed the resident under the left arm. S2CNA asked S1CNA if she was not going to use a lift. S1CNA stated no, the resident could be transferred with them holding her under her arms. S2CNA then grabbed the resident under her right arm and S1CNA told S2CNA to grab the resident's pants. S1CNA and S2CNA lifted the resident off of the bed by picking her up from under her arms and S2CNA grabbed the back of her pants. The CNA's then pivoted with the resident and placed her in the geri chair. On 06/25/2020 at 11:10 AM, an interview was conducted with S21PT (Physical Therapist) who stated that grabbing a resident under the arm and transferring them was not recommended because of possible injury to the axillary and arm area. Resident #7: Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS (Minimum Data Sheet), ARD (Assessment Reference Date), 04/08/2020 Section G: for Functional Status revealed the resident was coded 3-Extensive Assistance - resident involved in activity, staff provide weight bearing support; 3 - Two plus person assistance for transfers. Section C: Cognition was coded 2 indicating severe impairment. Review of the Tasks sheet for CNAs (Certified Nursing Assistants) regarding routine daily care of Resident #7 revealed the resident required 2 persons for transferring. Review of the resident's current Care Plan (no date) - ADL (Activities of Daily Living) assistance required. Interventions/Tasks - Assist x 2 with ADL's and transfers. The Witness Statement dated 04/17/2020 at 8:00 (p.m.) by S6CNA read Transferring (Resident #7) into her bed her leg brush again her wheel chair . (Sic) During an observation and interview with Resident #7 on 06/29/2020 at 11:50 a.m., the sign outside of the room on the wall name plate had 2 stick figures, indicating the resident was a 2 person assist for transfers. The resident was observed to be small, thin and had thin skin with bruises noted on the back of her hands. She was lying in bed and was oriented to place, time of day and person. When asked how many people came to help her move from the bed to the chair or the chair to the bed, she stated that usually one person helped but sometimes 2 people came. She stated that she had scrapes on her arms and legs from bumping on the bed and wheelchair but they were better. She was unable to recall the details of the incidents. On 06/30/2020 at 12:00 p.m., an interview was conducted with S6CNA. She stated that she transferred Resident #7 on 04/17/2020 with S15CNA and the resident bumped her leg on the bed frame. On 06/30/2020 at 12:10 p.m., an interview was conducted with S15CNA. She stated that she did not assist S6CNA with the transfer of Resident #7 on 4/17/20 when she was transferred and had a skin tear. During an interview with S13LPN on 6/30/2020 at 2:00 p.m., he stated that he was working when the resident was transferred into her bed by S6CNA on 04/17/2020 and he filled out the incident report. He stated that S6CNA transferred the resident alone but should have had a second person because she was a 2 person assist. He stated that he did an in-service with the 4 staff who were working on the unit at that time to reinforce 2 person assistance for the resident. On 06/29/200 at 3:35 p.m., an interview was conducted with S13LPN. He stated he was working on 06/04/2020 when a CNA, who he could not remember her name, transferred the resident and scraped her leg. He stated the resident should have been a 2 person transfer. On 06/30/2020 at 3:00 p.m., an interview was conducted with S14LPN, Treatment Nurse. She stated that she was called to Resident #7's room on 06/04/2020 by a CNA (unknown) to inspect the resident's leg. She stated she could not recall the CNA's name as she was new. She stated the CNA was alone in the room and had just transferred the resident into the chair. The resident had a new LLL (Left Lower Leg) skin tear measuring 3.5 x 6.5 x 0.0 cm. She stated the nurse was then called to the room.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 observation, interview and record review, the facility failed to ensure that nurse aides are able to demonstrate competency in resident transfers (#4, #6, #8) and resident securement in the facility van for transportation (#9, #10). This deficient practice affected 5 (#4, #6, #8, #9, #10) of 10 (#1-10) sampled and random residents reviewed. Findings: Resident #4: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Annual MDS (Minimum Data Sheet) dated 6/12/2020 revealed -Functional Status: Bed mobility 3/3 (extensive assistance, 2 person physical assist); Transfer 3/3 (extensive assistance, 2 person physical assist); Toilet use 3/3 (extensive assistance, 2 person physical assist -Cognition: BIMS (Brief Interview for Mental Status) score was 09- Mobility Devices - wheelchair -Bowel and Bladder - Always incontinent. A review of the Care Plan (no date) revealed ADL (Activities of Daily Living) requires assistance. Intervention in place was that the resident was a two person assist for transfers with gait belt. The resident has needed combined level of assistance with transfers which includes extensive support provided by two persons for physical assistance. On 12/16/2019, a BSC (Bed Side Commode) was added as a new intervention. Assistance for transfers requires two persons with a gait belt. On 06/23/2020 at 11:15 AM, an observation was made of Resident #4's door. Posted on the name plate on the outside of the door were two stick figures which indicated that the resident was a two person assist for transfers. On 06/23/2020 at 11:15 AM, an interview was conducted with Resident #4 who was awake, alert and answered questions appropriately. Resident #4 stated that on the day her arm was hurt, she had called for help. The aide came and wanted to transfer her by herself. Resident #4 stated that she told the aide that she needed 2 people. Resident #4 stated that the aide said, No I can do it. I can do it. Resident #4 added that she was in the bathroom in her wheelchair and wanted to get to the recliner. The aide insisted that she could do it but dropped her and hurt her left arm. Resident #4 stated that the aide called for the nurse and they helped pick her up. On 06/30/2020 at 11:00 AM, an interview was conducted with S8LPN on the B Hall. S8LPN stated that the nurses do not do the competency checklist because the CNA'S were expected to already know how to do these tasks taking vital signs, bed making, personal hygiene, oral care, bowel and bladder, and positioning/transferring residents. On 07/01/2020 at 10:40 AM, an interview was conducted with S9LPN on Hall C. S9LPN stated that if she was in the area giving medications and walked into the resident's room while the CNA was giving care, then she observed the CNA. S9LPN stated that if she had to get up and go check on the CNA to ensure the CNA was doing things correctly, no I don't have time for that. On 06/25/2020 at 12:00 PM, an interview was conducted with S2CNA who stated that she has been working at the facility since January 2020 and she was not trained on how to use a Hoyer lift and she does not remember if she was trained on a 2 person assist. S2CNA stated that the CNA who trained her did not train her well. On 06/25/2020 at 12:20 PM, an interview was conducted with S3CNA who stated that she has been employed at the facility since 08/22/2019. S3CNA stated that the orientation training was 2 days and then she worked independently of the floor. S3CNA stated that during 1 person assist, she let the resident grab her around the neck and she grabbed them around the chest area. S3CNA stated that during 2 person assist for transfers she grabbed the resident under one arm and the other assistant grabbed the resident under the other arm. One of them grabbed the resident's pants on the side and put the resident in the chair or the bed. On 06/29/2020 at 1:35 PM, an interview was conducted with S1CNA who stated that she had been working at the facility for 2 years. S1CNA confirmed that when she transferred Resident #6 on 06/24/2020 she should have used a gait belt. S1CNA stated that she always transferred Resident #6 by having someone assist her. They supported the resident under the arms and picked her up off of the bed to transfer her to the geri chair. Resident #6 A review of the face sheet revealed that the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS revealed on 06/09/2020 an annual review was conducted which revealed that resident's cognitive skills for daily decision

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) making - severely impaired. ADL's reveal bed mobility 3/3; Transfer 3/3; Dressing 4/2; Eating 3/2 and toilet use 3/3. Ability to hear -moderate difficulty; Speech Clarity - no speech; Makes self-understood - rarely/never understood; Ability to understand others - rarely/never understands; Vision - moderately impaired. Bowel and Bladder revealed the resident - always incontinent. BIMS score was left blank. A review of the Care Plan revealed that for ADL's (Activity of Daily Living) the resident required assistance with mobility, transferring, bathing, dressing/grooming, eating, toileting, personal hygiene and oral care. On 06/24/2020 at 8:35 AM, an observation was made of Resident # 6 during a 2 person assist transfer by S1CNA and S2CNA. S1CNA sat Resident #6 up in bed and S2CNA assisted by supporting the resident's head and shoulders. The resident was leaning to her right side, her legs were not straightened, and her feet were not touching the floor. After S1CNA and S2CNA sat up straight in the bed, S1CNA grabbed the resident under the left arm. S2CNA asked S1CNA if she was not going to use a lift. S1CNA stated no, the resident could be transferred with them holding her under her arms. S2CNA then grabbed the resident under her right arm and S1CNA told S2CNA to grab the resident's pants. S1CNA and S2CNA lifted the resident off of the bed by picking her up from under her arms and S2CNA grabbed the back of her pants. The CNA's then pivoted with the resident and placed her in the geri chair. On 6/25/2020 at 11:00 AM, an interview was conducted with S10PTA, the Therapy Director, who stated that residents should never be transferred by grabbing them under the arms. S10PTA stated that she conducted the therapy part of the staff orientation. S10PTA stated she talked about proper body mechanics, the use of the gait belt, never pull on the arms or clothes and proper assistance either for 1 or 2 person assist. S10PTA stated that because Resident # 6 was dependent, she should always be transferred with a hoyer lift. S10PTA then presented a document that she provided to new employees during training entitled Two Person Manual Transfers-Recommendations Do Not support the client under the arms - you may damage his shoulders and you are at risk of taking more weight than you can safely support. On 06/25/2020 at 11:10 AM, an interview was conducted with S21PT (Physical Therapist) who stated that grabbing a resident under the arm and transferring them was not recommended because of possible injury to the axillary and arm area. On 06/25/2020 at 12:00 PM, an interview was conducted with S2CNA who stated that she had been working at the facility since January 2020 and she was not trained on the use of a hoyer lifter and did not recall if she was trained on a 2 person assist. On 06/25/2020 at 12:30 PM, an interview was conducted with S7ADM who stated that when the CNA's were hired the certification they had qualified them to perform all the tasks that were incumbent for a CNA to perform. S7ADM stated that the CNAs had to perform these tasks in order to get their certification, therefore when they were hired they were already competent to perform the work. On 06/29/2020 at 1:35 PM, an interview was conducted with S1CNA who stated that she has been working at the facility for 2 years. S1CNA confirmed that when she transferred Resident #6 on 06/24/2020 she forgot to put on the gait belt. S1CNA stated that she always transferred Resident #6 by having someone assist her. They supported the resident under the arms and picked her up off of the bed to transfer her to the geri chair. 06/30/2020 at 11:00 AM, an interview was conducted with S8LPN who worked on Hall B/C. S8LPN confirmed that the nurses are responsible for supervising the CNA's. On 06/30/2020 at 2:40 PM, an interview was conducted with S22LPN who confirmed that Resident #6 was a two person assist and that S1CNA and S2CNA should have used a gait belt when they transferred the resident on 06/24/2020 at 8:35 AM. On 07/01/2020 at 10:40 AM, an interview was conducted with S9LPN on Hall C. S9LPN stated that if she was in the area giving medications and walked into the resident's room while the CNA was giving care, then she will observe the CNA. S9LPN stated that for her to get up and go check on the CNA to ensure the CNA was doing things correctly, no I don't have time for that. On 07/01/2020 at 11:10 AM, an interview was conducted with S16DON who confirmed that the facility should have a skill and competency checklist completed and placed in the employee's personnel folder. S16DON stated that the nurses on the hall were supposed to supervise the CNA's and she did not know why some nurses said they didn't have time to properly monitor the CNA's. Resident #8: Resident #8 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of the Quarterly MDS (Minimum Data Sheet) ARD (Assessment Reference Date), 05/08/2020. Section C: Cognition revealed a BIMS (Brief Interview for Mental Status) of 12, indicating he was cognitively intact. Section G: Functional status revealed he required extensive assistance with 2 plus persons for transfers. The resident was coded as not steady, and only able to stabilize with staff assistance. A review of the Care Plan (no date) revealed ADL (Activities of Daily Living) Assistance was required - Intervention included assist with ADLs as needed including mobility, transferring . An observation was made on 06/29/2020 at 08:00 a.m. of the name plate on the outside wall of Resident #8's room. The name plate had 2 stick figures, indicating the resident required 2 people for transfers. On 06/29/2020 at 8:20 a.m., an interview was conducted with S11LPN, who was working on Hall A. She stated that the facility had no CNA (Certified Nursing Assistant) Supervisor. She stated that the CNAs reported to the nurse on the unit if there was a change in condition of a resident. She stated that she did not conduct competency evaluations or keep track of which CNAs had or needed competency evaluations for transfers or any other of their job duties. S11LPN said that she sometimes assisted CNAs with transfers, and sometimes she happened to be in a room at the same time a CNA performed her duties and assisted if needed. S11LPN was observed to have no gait belt on/with her. She stated that she believed that S1CNA and S12CNA were able to safely transfer residents. On 06/29/2020 at 8:25 a.m., an observation and interview was conducted with Resident #8 in his room. A sign on the outside wall of the room had a name plate with 2 stick figures, indicating he was a 2 person transfer. The resident was oriented to person, place and time of day. Resident #8 stated that when he was transferred by staff they sometimes had 1 CNA and sometimes had 2 CNAs. When asked if staff used a gait belt to transfer him, he stated sometimes. On 06/29/2020 at 9:00 a.m., an observation was made of S1CNA and S12CNA transferring Resident #8. S12CNA placed a gait belt loosely around the resident's torso, not around the waist. She held the belt on each side during transfer. S1CNA used her right hand to grab the resident around the upper half of the resident's right arm to lift him and placed her left hand on the back of the gait belt. When they lifted the resident the gait belt slid further up the torso to his chest. During an interview with S12CNA on 06/29/2020 at 12:50 p.m., she stated that nurses only watched her perform a skill if there was a complaint about her but she never had any problems. She stated another CNA worked with her for a few days during her orientation before she worked on her own. S12CNA was observed to have no gait belt with her. During an observation on 06/29/2020 at 12:55 p.m., Resident #8 asked S12CNA, who had no gait belt, to go to the restroom. S12CNA looked for assistance down the hall while the resident wheeled himself to the restroom. S1CNA arrived in the room at 1:00 p.m. with no gait belt. S12CNA searched the bedroom for a gait belt while S1CNA left the room to find a gait belt. S1CNA returned to the room at 1:10 p.m. and stated that she had to go to therapy to find a belt because there were none on the unit. Resident #8 was found on the toilet by S12CNA when she returned to the resident's bathroom with the gait belt and S1CNA. The resident was observed seated on the toilet, after having transferred by himself, telling S12CNA that he couldn't wait and that he didn't make it. Loose brown stool was observed on the outside of the toilet. On 6/29/2020 at 1:20 p.m., S12CNA stated that they had access to gait belts and should have one on them all the times for transfers. S12CNA stated that she was given a gait belt when she started. She stated that she kept it with her belongings and did not bring it around with her while working but that therapy also had a belt of they needed one. She stated that all of the residents were transferred by 1 or 2 persons, from their bed to a chair, wheelchair or geri-chair at some point in the day. The only exception was with a couple of residents who did not need assistance with transfers. She verified that she and S1CNA were assigned and cared for all the residents on Hall A from 6:00 a.m. to 2:00 p.m. Review of the census revealed Hall A had 22 residents On 06/29/2020 at 1:25 p.m., an interview was conducted with S1CNA. She stated that when she started at the facility, she worked alongside another CNA (not the dame one each day) for 4 or 5 days, and then she began working on her own. She stated that she was found competent to do transfers when she went to her CNA class and received a certificate before she started working. She stated that the facility did in-services on transfers. The nurse put out a memo or sign-in sheet at the desk for staff to sign that they read the in-service. She stated she did not have a competency evaluation for transfers but occasionally a nurse assisted her with transferring a resident and they never told her that she did anything wrong. S1CNA, who was observed with no gait belt with her at this time, stated and demonstrated how she always transferred a resident with 2 person assistance. She stated and demonstrated that she linked her arm, at the crease of her elbow, under the resident's upper arm on one side of the resident while the other person was on the other side of the resident, then they lifted the resident. She did not mention or demonstrate using a gait belt at this time. When asked who her supervisor was, she stated that she reported resident problems to the nurse on the hall but did not have a supervisor. On 06/30/2020 at 10:15 a.m., an interview was conducted with the Therapy Director, S10PTA (Physical Therapy Assistant). She stated that the therapy department did orientation in-services on transfer techniques. She stated that the therapy department watched some staff return demonstrate during orientation, but the nurse or nurse supervisor was responsible to conduct competency evaluations. She stated that she did not have a policy for transfer of residents but that

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MAISON DE LAFAYETTE	2707 KALISTE SALOOM ROAD LAFAYETTE, LA 70508

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) all 1 person and 2 person transfers required the use of a gait belt. She stated the CNAs were given their own gait belts to use on their residents, and that there were extra ones on the nursing unit or in therapy if they needed one. Review of S1CNA and S12CNA's personnel files revealed no competency evaluations for resident transfers. Resident #9: Review of Resident #9's Post Fall assessment dated [DATE] at 16:48 (4:38 PM) revealed: .Location: fall occurred while being transported from (local emergency room) in transportation van with driver . How/when: resident slid out of w/ch (wheelchair) while being transported . Review of witness statement signed S28CNA and dated 2/25/2020 revealed the following: When I took van out of park resident said she was slipping. Put van back in park fixed her in her wheelchair and strap her back in her seat belt. Went to leave again she said she was slipping again that time, I went inside hospital and got help .tech came pull cover from under her. I re-fixed her in chair. She said she was much better. Started leaving going down ramp, she said she was slipping again before I could come to complete stop, she fall out her chair. Call 911 got ambulance they came they came and got her while I was calling the facility. On 6/30/2020 at 4:20 PM, a telephone interview with S28CNA. She stated that she is temporarily no longer working at the facility. She stated that she was primarily a ward clerk but her jobs duties included transporting residents when no one else was available to transport. She stated she was trained by another CNA to drive the van. She recounted the day the resident fell out the chair and stated she picked Resident #9 up from the emergency room . She loaded the resident and strapped her in and as soon as she took the van out of park, the resident told her she was slipping. She then stopped and readjusted the resident in the chair. She attempted to leave again and the resident stated she was again slipping. She then asked someone from inside the emergency room to help her reposition the resident and remove a cover she was sitting on. She proceeded to progress down the ramp of the emergency room when the resident said she was sliding again. The resident fell on the floor and hit her head. S28CNA stated that the resident was strapped in properly and could not give a reason why the resident fell . She confirmed that she did not call the facility to inform them the resident was having trouble sitting up. Resident #10: Review of incident report for Resident #10 dated 2/4/2020 at 11:00 AM revealed: .Location - in the transportation van while driving to an MD appointment. Resident complained of neck pain on 2/4/2020. Resident states that the driver had to make an unplanned stop causing head to learn forward, she also stated this happened 2/3/2020 . During an interview on 6/29/2020 at12:40 PM, Resident #10 stated that she was previously transported in a gray van with 2 other residents by a CNA named S30CNA a few months ago when another residents wheelchair hit the back of hers. She stated that S30CNA was not a regular van driver but had driven before. She stated that one resident was in a seat; she was in the middle in her wheelchair and another resident was behind her in his wheelchair. She stated that the male resident's wheelchair behind her moved twice. The first time he bumped into the back of her wheelchair. The second time he came out of his chair over her back and then he fell back into his wheelchair. She stated the driver kept telling him that his wheel chair wasn't locked and that they were almost back to the facility when the S30CNA finally pulled over and strapped him properly. The next day she went to therapy because her neck was hurting. A telephone interview was conducted 6/30/2020 at 10:50 AM with S30CNA. She stated that she was an as needed driver and didn't transport that often. She stated that she was trained by the previous driver, S31CNA who periodically watched her load residents. She stated that the resident seated behind Resident #10 had his seat belt come loose. She immediately pulled over and secured it properly but resident seated behind her did not bump her wheelchair nor come out of the seat over the top of Resident #10. A review of S28CNA, S30CNA and S31CNA's personnel files failed to reveal competencies for bus, van and lift competencies as found with other driver personnel files that were reviewed. On 6/30/2020 2:08 PM, S16DON confirmed S28CNA, S30CNA, and S31CNA did not have record of competency for van driving and resident securement during transport.
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by 1. Failing to ensure adequate supervision to ensure residents needing assistance with transfers from staff were being followed for 3 (#4, #6, #7) residents; 2. Failing to ensure that nurse aides are able to demonstrate competency in resident transfers (#4, #6, #8) and resident securement in the facility van for transportation (#9, #10). 3. Failing to develop policies and procedures to ensure the safety of residents for transportation by the facility and 2 person assist transfers. This deficient practice affected 6 (#4, #6, #7, #8, #9, #10) of 10 (#1-10) sampled and random residents and has the potential to affect a census of 157 residents for who could require transportation and 54 residents who were identified as requiring two person assist for transfers. Findings: A review of S1CNA, S2CNA, S3CNA, S6CNA, and S12CNA's personnel files revealed no documentation that they were assessed for competency in a two person assist transfer. Resident #4: Review of a Post Fall Assessment Report dated 12/15/2019 at 1:10 PM, revealed that Resident #4 called for assistance on the call bell. The CNA who responded and did not seek for or wait for assistance, attempted to transfer Resident #4 from her wheelchair to the recliner by herself. Resident #4's recliner slipped backwards and the CNA dropped the resident on the floor. Resident #4 complained of left arm and right hip pain and was transported to the emergency room for evaluation and treatment. Further review of the report revealed that the facility's intervention was to reeducate staff on transfer x 2 people, dycem (Non slip material) under recliner legs, and suspension of CNA until further investigation. A review of the emergency room assessment dated [DATE] at 2:51 PM, revealed that a x-ray of the resident's left arm was obtained. The results of that x-ray on 12/15/2019 at 3:51 PM, revealed a closed [MEDICAL CONDITION] end of the left humerus. Review of another Post Fall Assessment Report dated 04/22/2020 at 12:38 PM, revealed that Resident #4 called for assistance via call bell. S3CNA responded to the call and she (S3CNA) attempted to transfer the resident by herself. Resident #4 became weak and was lowered to the bathroom floor. Resident #4 did not sustain any injuries during this incident. The facility's intervention was for the staff to please read all identifiers related to resident on the door and in chart. Resident #6: On 06/24/2020 at 8:35 AM, an observation was made of Resident # 6 during a 2 person assist transfer by S1CNA and S2CNA. S1CNA sat Resident #6 up in bed and S2CNA assisted by supporting the resident's head and shoulders. The resident was leaning to her right side, her legs were not straightened, and her feet were not touching the floor. After S1CNA and S2CNA sat up straight in the bed, S1CNA grabbed the resident under the left arm. S2CNA asked S1CNA if she was not going to use a lift. S1CNA stated no, the resident could be transferred with them holding her under her arms. S2CNA then grabbed the resident under her right arm and S1CNA told S2CNA to grab the resident's pants. S1CNA and S2CNA lifted the resident off of the bed by picking her up from under her arms and S2CNA grabbed the back of her pants. The CNA's then pivoted with the resident and placed her in the geri chair. Resident #7: During an interview with S13LPN on 6/30/2020 at 2:00 p.m., he stated that he was working when the resident was transferred into her bed by S6CNA on 04/17/2020. He stated that S6CNA transferred the resident alone but should have had a second person because she was a 2 person assist. On 06/29/200 at 3:35 p.m., an interview was conducted with S13LPN. He stated he was working on 06/04/2020 when a CNA, who he could not remember her name, transferred the resident and scraped her leg. He stated the resident should have been a 2 person transfer. On 06/30/2020 at 3:00 p.m., an interview was conducted with S14LPN, Treatment Nurse. She stated that she was called to Resident #7's room on 06/04/2020 by a CNA (unknown) to inspect the resident's leg. She stated she could not recall the CNA's name as she was new. She stated the CNA was alone in the room and had just transferred the resident into the chair. The resident had a new LLL (Left Lower Leg) skin tear measuring 3.5 x 6.5 x 0.0 cm. She stated the nurse was then called to the room. Resident #8: On 06/29/2020 at 9:00 a.m., an observation was made of S1CNA and S12CNA transferring Resident #8. S12CNA placed a gait belt loosely around the resident's torso, not around the waist. She held the belt on each side during transfer. S1CNA used her right hand to grab the resident around the upper half of the resident's right arm to lift him and placed her left hand on the back of the gait belt. When they lifted the resident the gait belt slid further up the torso to his chest. On 06/25/2020 at 12:30 PM, an interview was conducted with S7ADM who stated that when the CNA's were hired the certification they had qualified them to perform all the tasks that were incumbent for a CNA to perform. S7ADM stated that the CNAs had to perform these tasks in order to get their certification, therefore when they were hired they were already competent to perform the work. On 06/29/2020 at 8:20 a.m., an interview was conducted with

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F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) S11LPN. She stated that the facility had no CNA (Certified Nursing Assistant) Supervisor. She stated that the CNAs reported to the nurse on the unit if there was a change in condition of a resident. She stated that she did not conduct competency evaluations or keep track of which CNAs had or needed competency evaluations for transfers or any other of their job duties. S11LPN said that she sometimes assisted CNAs with transfers, and sometimes she happened to be in a room at the same time a CNA performed her duties and assisted if needed. S11LPN was observed to have no gait belt on/with her. She stated that she believed that S1CNA and S12CNA were able to safely transfer residents. On 07/01/2020 at 11:10 AM, an interview was conducted with S16DON who confirmed that the facility should have a skill and competency checklist completed and placed in the employee's personnel folder. S16DON stated that the nurses on the hall were supposed to supervise the CNA's and she did not know why some nurses said they didn't have time to properly monitor the CNA's. S16DON stated that the facility did not have any policies or procedures related to a two person assist transfer. Resident #5: Review of QI Incident Investigation for Resident #5 revealed: Occurrence: 11-19-19, Driver/CNA - (S24CNA), Facility's transportation van/driver and resident were traveling to the [MEDICAL TREATMENT] center for resident's appointment. Driver came to an unplanned stop because one vehicle had pulled out in front of her and another vehicle entered her lane and came to a complete stop. Resident slid out of her wheelchair and landed on her right foot. CNA reports resident's wheelchair was properly restrained and resident was wearing a seatbelt. Resident reports right ankle discomfort . New order per MD to send resident to ER for evaluation and treatment . emergency room results: X-ray of right ankle reveals: Suspected minimally displaced bi-malleolar fractures . Resident returned to facility with a splint to right lower leg . Resident reports: (BIMS 11) - I was in my wheelchair with my seatbelt on. I slid out of my wheelchair onto my right foot . An interview was conducted on 06/23/2020 11:34 AM with Resident #5. She was awake, alert and oriented to person and place. She recalled the van incident and stated that she slid out of her chair. She reported that the lap belt was loose and she slid out onto the floor. She stated that the wheelchair did not move. She was noted not to have any current cast or splint to the lower. Resident #5 further stated Now I'm strapped every which way. Resident #9: Review of witness statement signed S28CNA and dated 2/25/2020 revealed the following: When I took van out of park resident said she was slipping. Put van back in park fixed her in her wheelchair and strap her back in her seat belt. Went to leave again she said she was slipping again that time, I went inside hospital and got help .tech came pull cover from under her. I re-fixed her in chair. She said she was much better. Started leaving going down ramp, she said she was slipping again before I could come to complete stop, she fall out her chair. Call 911 got ambulance they came they came and got her while I was calling the facility. A review of S28CNA's personnel file revealed a hire date of 08/17/2017 and a termed date of 03/20/2020. The driver's license on file listed an expiration date of 03/20/2018. A review of S26MS's (facility trainer for resident securement in the transport van) personnel file revealed the driver's license on file had an expiration date of 2-27-2018. Resident #10: Review of incident report for Resident #10 dated 2/4/2020 at 11:00 AM revealed: .Location - in the transportation van while driving to an MD appointment. Resident complained of neck pain on 2/4/2020. Resident states that the driver had to make an unplanned stop causing head to learn forward, she also stated this happened 2/3/2020 . During an interview on 6/29/2020 at 12:40 PM, Resident #10 stated that she was previously transported in a gray van with 2 other residents by a CNA named S30CNA a few months ago when another resident's wheelchair hit the back of hers. She stated that the male resident's wheelchair behind her moved twice. The first time he bumped into the back of her wheelchair. The second time he came out of his chair over her back and then he fell back into his wheelchair. She stated the driver kept telling him that his wheel chair wasn't locked and that they were almost back to the facility when the S30CNA finally pulled over and strapped him properly. The next day she went to therapy because her neck was hurting. A review of S28CNA, S30CNA and S31CNA's personnel files failed to reveal competencies for bus, van and lift competencies as found with other driver personnel files that were reviewed. A review of S24CNA S26MS, S28CNA, S29CNA and S30CNA's (who were identified as facility van driver's) personnel files were reviewed and failed to reveal that driving histories had been conducted. On 6/30/2020 2:08 PM, S21DON confirmed S28CNA, S30CNA, and S31CNA did not have record of competency for van driving and resident securement during transport. An interview on 07/01/2020 at 1:30 PM was conducted with S7ADM, who stated that the facility did not have policies and procedures for the safe transportation of residents and operation of the facility's vans. He confirmed that driver's licenses are not kept up with. He stated that copies of driver's licenses are obtained upon hire and they do not make sure they are updated, even for the personnel who operate the facility's vehicles and transport residents. He confirmed that driving histories are not being conducted on employees who operate the facility's vehicles.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implements plans of action to correct: 1. transportation accidents involving residents and; 2. injuries related to inappropriate transfer techniques This deficient practice had the potential to affect a census of 157 residents. Findings: 1. Review of QI Incident Investigation for Resident #5 revealed: Occurrence: 11-19-19 Driver/CNA - (S24CNA) Facility's transportation van/driver and resident were traveling to the [MEDICAL TREATMENT] center for resident's appointment. Driver came to an unplanned stop because one vehicle had pulled out in front of her and another vehicle entered her lane and came to a complete stop. Resident slid out of her wheelchair and landed on her right foot. Resident did not hit her head. CNA reports resident's wheelchair was properly restrained and resident was wearing a seatbelt. Resident reports right ankle discomfort . Review of Resident #9's Post Fall assessment dated [DATE] at 16:48 (4:38 PM) revealed: .Location: fall occurred while being transported from (local emergency room) in transportation van with driver . How/when: resident slid out of w/ch (wheelchair) while being transported . 2/27/2020 - new order per NP (nurse practitioner) All to/from appointments via ambulance/stretcher due to poor limited trunk control and inability to maintain upright posture in wheelchair. Review of incident report for Resident #10 dated 2/4/2020 at 11:00 AM revealed: .Location - in the transportation van while driving to an MD appointment. Resident complained of neck pain on 2/4/2020. Resident states that the driver had to make an unplanned stop causing head to learn forward, she also stated this happened 2/3/2020 . During an interview on 6/29/2020 at12:40 PM, Resident #10 stated that she was previously transported in a gray van with 2 other residents by a CNA named S30CNA a few months ago when another residents wheelchair hit the back of hers. She stated that S30CNA was not a regular van driver but had driven before. She stated that one resident was in a seat; she was in the middle in her wheelchair and another resident was behind her in his wheelchair. She stated that the male resident's wheelchair behind her moved twice. The first time he bumped into the back of her wheelchair. The second time he came out of his chair over her back and then he fell back into his wheelchair. She stated the driver kept telling him that his wheel chair wasn't locked. She stated that they were almost back to the facility when the S30CNA finally pulled over and strapped him properly. The next day she went to therapy because her neck was hurting. A telephone interview was conducted 6/30/2020 at 10:50 AM with S30CNA. She stated that the resident seated behind Resident #10 had his seat belt come loose during transport. She immediately pulled over and secured it properly. On 7/1/2020 at 1:00 PM, an interview was conducted with S17LPN. She stated that the Quality Assurance (QA) Committee meets uarterly and as needed. She stated that there are daily QA meetings with department heads during which they discuss incidents/accidents with the departments directly involved. They make note of any repeat incidents and put a plan in place like education or additional in-services. She stated that the do visual inspections/monitoring of staff but didn't always document the monitoring. She stated that they have tried to determine what the cause of the residents coming out of their chair during transprort was but the drivers and residents stated that the belts were in place. She stated they gave in-services about safe driving after each transportation incident. She confirmed that monitoring was only done on S24CNA after Resident #5's incident and that additional monitoring should have been done on all van drivers after each transportation incident. 2. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Health Standards Incident Report revealed that on 12/15/2019 at 1:10 PM , a CNA was attempting to transfer resident from wheelchair to recliner - recliner moved - resident slid to the floor. Resident #4 complained of a 10/10 pain to left arm. Intervention - Send to the emergency room for evaluation and treatment. Dycem under recliner legs, suspension of the CNA until further investigation, In-service of staff on 2 person transfer. Review of the Witness Statement dated 12/15/2019 by the CNA who was involved in the incident. The CNA documented that she was transferring Resident #4 from the wheelchair to the recliner. When she picked her up the recliner slid backwards and Resident #4 slid to the floor. The CNA added that she was able to cross over the resident and call the nurse. Review of Post Fall assessment dated [DATE] at 12:01 PM revealed

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) that Resident #4's fall occurred in the resident's room. Resident complained of left arm and right hip pain 10/10. How/When - fell when CNA transferring. New Interventions - reeducated staff on 2 person transfer - Dycem (non-slip material) applied to feet of recliner to prevent recliner from sliding during transfer. Review of another Post Fall Assessment revealed that on 4/22/2020 at 12:38 PM the resident had a fall in the bathroom. The assessment revealed no injuries and the resident was alert, resident has full range of motion and denies pain. Intervention - have staff read all identifiers related to resident on the door and in the chart. A review of the Witness Statement dated 4/22/2020 per S3CNA revealed: S3CNA documented that the resident told her she could stand with assistance in the bathroom. S3CNA documented that the resident stated she could hold on to the rail. S3CNA documented that the resident was going down so she put her on the floor. 6/23/2020 at 11:15 AM, an interview was conducted with Resident #4 who is awake, alert and able to answer questions appropriately. Resident #4 stated that on the day her arm was hurt she had called for help. The aide came and wanted to transfer her by herself. Resident #4 stated that she told the aide that she needs 2 people. Resident #4 stated that the aide said no I can do it, I can do it. Resident #4 added that she was in the bathroom in her wheelchair and she wanted to get to the recliner. The aide insisted that she could do it but she dropped me and I hurt my left arm. Resident #4 added that the aide called for the nurse and they helped pick me up. 6/29/2020 at 8:10 AM, an interview was conducted with S18CNA who stated that she was working the day of the incident with Resident #4. S18CNA stated that S3CNA thought the resident could stand so she tried to help transfer her by herself. S18CNA added that after the incident she did not attend any in-service for reeducation on 2 person transfer 7/1/2020 at 8:45 AM, an interview was conducted with S3CNA. S3CNA stated that when the incident occurred on 4/22/2020, she thought that Resident #4 could stand and assist her during transfer. S3CNA confirmed that she did not feel like she needed to call for assistance. S3CNA stated that Resident #4 was previously on Hall C and that when she cared for Resident #4 on the Hall C, she always transferred the resident by herself. S3CNA stated the resident moved to Hall D and had been on that hall for a few days when she cared for her on 4/22/2020. S3CNA stated that she was not aware the resident was a two person assist. When S3CNA was asked about the door indicators and resident information from the kiosk (Track and document each resident's care and ADL's), S3CNA stated that the door indicators were not on the outside of the door at the time. S3CNA added that the kiosk charting was the last thing she did before her shift ended, so she would not have been aware that the resident was a 2 person assist.S3CNA stated that after the incident there was a memo that was put out for staff to read and sign. S3CNA stated that she never attended an in service about 2 person assist transfers. 7/1/2020 at 9:20, AM an interview was conducted with S20SS who was in charge of assuring the resident's door indicators were present and accurate. S20SS stated that the day Resident #4 was transferred from Hall C to Hall D her door indicators were present. 7/1/2020 at 1:14 PM, an interview was conducted with S17LPN QA (Quality Assurance) who confirmed that the facility had acknowledged that there was an issue with resident transfers. S17LPN also confirmed that the facility should have had a monitoring tool in place to ensure the proper and safe transfer of 2 person assist transfer residents.