

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195605	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Mary Anna Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Turner Street Wisner, LA 71378	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure residents were free from physical restraints imposed for the purpose of discipline or convenience for 4 (#11, #20, #24, and #29) of 5 (#11, #15, #20, #24 and #29) residents reviewed for restraints. The facility failed to 1) obtain a consent, 2) have a physician's order and 3) failed to appropriately assess residents prior to placing the bolsters on the bed. Findings: Review of the facility's Respect and Dignity Policies and Procedures dated 03/02/2023 revealed _____ Nursing Home will ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Should _____ staff decide to use a restraint, it must be the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. It is our intent at _____ for each resident to attain and maintain his/her highest practical well-being in an environment that: Prohibits the use of physical restraints for discipline or convenience; Prohibits the use of physical restraint to unnecessarily inhibit a resident's freedom of movement or activity; and limits physical restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints. _____ Nursing Home staff will document the symptoms being treated, and a physician's order for the use of the specific type of restraint will be obtained. A resident will be appropriately assessed prior to the use of any restraint. The care plan interdisciplinary team will be involved and documentation of the medical symptoms and use of the physical restraint for the least amount of time possible will be noted. Ongoing re-evaluation is necessary to be in compliance with regulatory requirements. Resident 20 Review of the medical record for resident #20 revealed an admission date of 07/05/2023. Resident #20 had diagnoses including diabetes mellitus, osteomyelitis, open angle glaucoma, gastrostomy, aphasia, metabolic encephalopathy, peripheral vascular disease, pain, embolism, and heart failure. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive skills for daily decision making, was totally dependent on staff and required two (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Event ID: Facility ID: If continuation sheet Previous Versions Obsolete 195605 Page 1 of 7		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person assistance with bed mobility and transfers. Observations of resident #20 on 01/27/2025 at 8:35 a.m., 01/27/2025 at 3:20 p.m., and on 01/28/2025 at 10:10 a.m., revealed the resident was lying in the bed with bilateral bolsters attached to the bottom half of the bed. Review of the care plan revealed resident #20 had a potential for falls due to decreased mobility and she had a roll control bolster on the bed, monitor every 2 hours with incontinent checks and turning and as needed contact. Review of the medical record revealed no documented evidence of an assessment prior to the use of roll control bolsters, no consent from the resident or the Responsible Party and there was no physician's order for the use of the roll control bolsters. An interview on 01/28/2025 at 12:00 p.m. with S1Administrator confirmed the facility failed to obtain a consent and a physician's order prior to the use of the bolsters, and they failed to assess resident #20 prior to the use of bolsters. Resident 24 Review of the medical record for resident #24 revealed an admission date of 08/30/2023. Resident #24 had diagnoses including bradycardia, lack of coordination, cognitive communication deficit, pain, Parkinson's disease, and macular degeneration. Review of the Quarterly MDS assessment dated [DATE] revealed the facility was unable to determine resident #24's Brief Interview for Mental Status (BIMS) score due to cognitive impairment. Resident #24 required extensive assistance with bed mobility and was totally dependent on staff with transfers. Observations of resident #24 on 01/27/2025 at 9:15 a.m., and 01/28/2025 at 9:00 a.m. revealed the resident was observed lying in the bed with bilateral bolsters attached to the bottom half of the bed. Review of the current care plan revealed resident #24 had the potential for falls and an intervention was noted for a roll control bolster, monitor every 2 hours with incontinent checks and turning and as needed. Review of the medical record revealed no documented evidence of an assessment prior to the use of roll control bolsters, no consent from the resident or the Responsible Party and there was no physician's order for the use of the roll control bolsters. An interview on 01/28/2025 at 12:00 p.m. with S1Administrator confirmed the facility failed to obtain a consent and a physician's order prior to the use of the bolsters, and they failed to assess resident #20 prior to the use of bolsters. Resident #11 Review of resident #11's record revealed an admission date of 08/15/2022 with diagnoses including Alzheimer's disease, wedge compression fracture of thoracic 11 and 12 vertebra, paroxysmal atrial (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fibrillation, glaucoma, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, unspecified protein calorie malnutrition, displaced fracture of base of neck of left femur, presence of left artificial hip joint, and osteoarthritis. Review of resident #11's January 2025 Physician's Orders revealed an order dated 07/21/2024 for quarter side rails on each side of bed up at all times as enabler in turning/repositioning. Review of the Significant Change/5 day MDS assessment dated [DATE] revealed a BIMS score of 99 indicating unable to determine. Further review of the MDS revealed resident had severely impaired cognitive skills for daily decision making and dependent on staff for activities of daily living. Review of resident #11's current care plan revealed a need for bed rails related to a history of falls. Observations of resident #11 on 01/27/2025 at 9:05 a.m., 01/27/2025 at 3:24 p.m., and 01/28/2025 at 8:10 a.m. revealed resident was lying in bed with bilateral bolsters attached to the bottom half of the bed. Review of the medical record revealed no documented evidence of an assessment prior to the use of roll control bolsters, no consent from the resident or the responsible party, and no physician's order for the use of bed bolsters for resident #11. An interview on 01/28/2025 at 3:55 p.m. with S1Administrator confirmed the facility failed to obtain a consent and a physician's order prior to the use of the bolsters, and they failed to assess resident #11 prior to the use of bolsters. Resident #29 Review of resident #29's record revealed an admission date of 03/14/2023 with diagnoses including pressure ulcer of sacral region stage 3, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, Alzheimer's disease, atrial fibrillation, other seizures, type 2 diabetes mellitus, and gastrostomy status, Review of resident #29's Quarterly MDS assessment dated [DATE] revealed unable to determine a BIMS score due to cognitive impairment. Further review of the MDS revealed resident dependent on staff for activities of daily living. Observations of resident #29 on 01/27/2025 at 8:50 a.m. and 01/28/2025 at 8:20 a.m. revealed resident was lying in bed with bilateral bed bolsters in place Review of the medical record revealed no documented evidence of an assessment prior to the use of roll control bolsters, no consent from the resident or the responsible party, and there was no orders for the use of the roll control bolsters. An interview on 01/28/2025 at 3:55 p.m. with S1Administrator confirmed the facility failed to obtain a consent and a physician's order prior to the use of the bolsters, and they failed to assess resident #29 prior to the use of bolsters.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was free of accident hazards as is possible by failing to ensure appropriate interventions were attempted after each fall for 1 (#11) of 1 residents sampled for falls. Findings: Review of resident #11's medical record revealed an admission date of 08/15/2022 with diagnoses including Alzheimer's disease, wedge compression fracture of Thoracic 11 and 12 vertebra, paroxysmal atrial fibrillation, glaucoma, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, unspecified protein calorie malnutrition, displaced fracture of base of neck of left femur, presence of left artificial hip joint, and osteoarthritis. Review of resident #11's January 2025 Physician's Orders revealed an order dated 07/21/2024 for quarter side rails on each side of bed up at all times as enabler in turning/repositioning. Review of resident #11's Significant Change/5 day Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview of mental status (BIMS) score of 99 indicating unable to determine. Further review of the MDS revealed resident had severely impaired cognitive skills for daily decision making and dependent on staff for activities of daily living. Review of resident #11's Incident/Accident report dated 10/12/2024 revealed resident was ambulating in the front lobby with her walker and fell. Resident reported her feet got tangled in her walker and she fell and hit her head on the floor. Review of resident #11's Incident/Accident report dated 11/12/2024 revealed resident #11 found lying on the floor in her room on right side and had a hematoma to the back of head. Review of resident #11's Incident/Accident report dated 12/15/2024 revealed resident #11 was found on the floor in her room. Resident reported she was going to the bathroom and slipped in her own urine, no complaints of pain at this time. Review of the current care plan for resident #11 revealed she had a potential for falls related to history of fall, right hip replacement, osteoarthritis, dementia with history of behavior disturbance, and depression. Further review of resident's fall care plan revealed the following interventions were implemented for the falls listed as follows: 10/12/2024 intervention- encourage/remind resident when standing to get her balance before moving her feet or her walker; 11/12/2024 intervention- remind to wear well fitted shoes; and 12/15/2024 intervention- therapy to evaluate Review of the Fall Risk Evaluations dated 11/08/2024 and 12/27/2024 revealed resident #11 at risk for falls. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/28/2025 at 3:30 p.m. with S2Director of Nursing (DON) confirmed the interventions the facility documented for these falls were not appropriate to help prevent falls for resident #11.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #20 Review of the medical record for resident #20 revealed an admission date of 07/05/2023. Resident #20 had diagnoses including diabetes mellitus, osteomyelitis, open angle glaucoma, gastrostomy, aphasia, metabolic encephalopathy, peripheral vascular disease, pain, embolism, and heart failure. Review of the January 2025 physician's orders for resident #20 revealed an order dated 07/01/2024 for quarter rails on each side of bed up at all times as enabler in turning and repositioning. Review of resident #20's quarterly minimum data [NAME] (MDS) dated [DATE] revealed the resident had severe cognitive skills for daily decision making and was totally dependent on staff and required two person assistance with bed mobility and transfers. On 01/27/2025 at 8:35 a.m., 01/27/2025 at 3:20 p.m., and on 01/28/2025 at 10:10 a.m., resident #20 was observed lying in the bed with bilateral quarter rails raised at the top of the bed. Review of the medical record revealed no documented evidence of the facility assessing the risk for entrapment prior to the installation of bed rails. An interview on 01/28/2025 at 12:00 p.m. with S1Administrator confirmed the facility failed to assess the risk for entrapment prior to the installation of bed rails for resident #20. Based on record reviews, observations, and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails prior to installation for 3 (#11, #15, and #20) of 4 (#11, #15, #20, and #29) residents reviewed for accident hazards. Findings: Review of the facility's Bed Rails and Non-Restraint Measures Policy and Procedures revised date 10/11/2024 revealed: Intent: Prior to the installation of bed rails, _____ Nursing Home will attempt to use alternatives. When alternatives are not adequate to meet the resident's needs, the resident will be assessed for the use of bed rails: which includes a review of risks including entrapment; and informed consent is obtained from the resident or if applicable, the resident representative. Resident #15 Review of resident #15's record revealed an admission date of 09/22/2021 with diagnoses including chronic systolic (congestive) heart failure, hypoxemia, moderate protein-calorie malnutrition, major depressive disorder, dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, mood disturbance, and anxiety. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2025 physician's orders for resident #15 revealed an order dated 07/01/2024 for quarter side rails on each side of bed up at all times as enabler for turning/repositioning. Review of resident #15's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive skills for daily decision making and required total assistance with activities of daily living. Observations of resident #15 on 01/27/2025 at 3:05 p.m. and 01/28/2025 at 3:45 p.m. revealed resident lying in bed with quarter bilateral bed rails in place. Review of the current care plan revealed resident #15 needed bed rails related to muscle weakness as an enabler for turning/repositioning within the bed. Review of the medical record revealed no documentation of the facility assessing the risk for entrapment prior to the installation of bed rails for resident #15. An interview on 01/28/2025 at 3:55 p.m. with S1Administrator confirmed the facility failed to assess the risk for entrapment prior to installation of bed rails on resident #15. Resident #11 Review of resident #11's medical record revealed an admission date of 08/15/2022 with diagnoses including Alzheimer's disease, wedge compression fracture of Thoracic 11 and 12 vertebra, paroxysmal atrial fibrillation, glaucoma, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, unspecified protein calorie malnutrition, displaced fracture of base of neck of left femur, presence of left artificial hip joint, and osteoarthritis. Review of resident #11's January 2025 physician's orders revealed an order dated 07/21/2024 for quarter side rails on each side of bed up at all times as enabler in turning/repositioning. Review of the Significant Change/5 day MDS assessment dated [DATE] revealed a brief interview of mental status (BIMS) score of 99 indicating unable to determine. Further review of the MDS revealed resident had severely impaired cognitive skills for daily decision making and dependent on staff for activities of daily living. Review of resident #11's current care plan revealed a need for bed rails related to a history of falls. Observations of resident #11 on 01/27/2025 at 9:05 a.m., 01/27/2025 at 3:24 p.m., and 01/28/2025 at 8:10 a.m. revealed resident was lying in bed with quarter bilateral bed rails in the up position. Review of the medical record revealed no documentation of an assessment for the risk of entrapment prior to the installation of bed rails for resident #11. An interview on 01/28/2025 at 3:55 p.m. with S1Administrator confirmed the facility failed to assess the risk for entrapment prior to the installation of bed rails on resident #11.		