

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

Printed: 06/08/2025  
Form Approved OMB  
No. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>195422   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>08/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rosewood Nursing Center  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>534 15th Street<br>Lake Charles, LA 70601 |   |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |   |
| F 0689<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354</b></p> <p>Based on interviews, observations, and record reviews, the facility failed to ensure a resident was free from accidents hazards during a mechanical lift transfer for 1 (#1) of 7 (#1, #2, #3, R1, R2, R3, and R4) sampled residents who required two-person transfer with a mechanical lift.</p> <p>This deficient practice resulted in an Immediate Jeopardy for Resident #1 on 08/08/2024 at 2:15 p.m., when S3CNA (Certified Nursing Assistant) attempted to transfer the resident from a shower bed to residents bed while utilizing the mechanical lift without assistance of another qualified staff person. Resident #1 fell from the lift sling during the transfer and landed on the floor resulting in a fractured right leg. Resident #1 was transferred to the hospital on 08/08/2024. X-ray report dated 08/08/2024 at 4:53 p.m. showed a suspected nondisplaced fracture of the distal fibula. A CT (comp tomography) scan done on 08/09/2024 at 7:43 a.m. revealed a comminuted, displaced distal femoral fracture with multiple ossific fragments and surrounding hemorrhage. Resident #1 underwent surgery; intramedullary nailing of the right femur on 08/10/2024. The resident remains in the hospital at the time of survey as a result of the fall with fracture and surgical repair.</p> <p>The facility implemented an immediate corrective action plan on 08/08/2024 which was completed prior to the State Agency's investigation. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance on 08/09/2024 at 11:00 am, thus it was determined to be a Past Noncompliance citation.</p> <p>Findings:</p> <p>A review of the facility's Mechanical Lift Policy, last reviewed by the facility in July 2024 revealed the following, in part:</p> <p>Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques.</p> <p>Staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order.</p> <p>Review of the facility's CNA Professional Orientation Guidebook revealed in part: Mechanical Lift Transfers: All mechanical lifts require two people.</p> <p>(continued on next page)</p> |  |   |

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

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>195422  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>08/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rosewood Nursing Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>534 15th Street<br>Lake Charles, LA 70601 |   |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |   |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of the medical records for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Heart Failure, Vascular Dementia, Major Depressive Disorder, and Cognitive Communication Deficit.</p> <p>Review of Resident #1's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/26/2024, revealed the following, in part:</p> <p>BIMS (Brief Interview for Mental Status) of 99 which indicated the assessment for cognition could not be complete because resident did not participate; Bed mobility- extensive assistance/2-person assist.</p> <p>Review of Resident #1's current care plan initiated 10/14/2022 revealed the following, in part: 05/23/2022 . Problem: The resident has an ADL self-care performance deficit related to cognitive and physical impairment .Approaches: The resident requires two person and mechanical aid (Hoyer lift) for transfers.</p> <p>Review of Resident #1's Fall Incident Report dated 08/08/2024 revealed the following, in part: Was called to the room by the CNA because the resident fell on the floor. CNA stated the sling pad popped Resident was left in the position that she was found in. The ambulance was called to get resident up and bring her to the ER (emergency room ).</p> <p>Review of Resident #1's hospital records revealed an x-ray report dated 08/08/2024 at 4:53 p.m. that showed a suspected non displaced fracture of the distal fibula. A CT (comp tomography) scan done on 08/09/2024 at 7:43 a.m. revealed a comminuted, displaced distal femoral fracture with multiple ossific fragments and surrounding hemorrhage. Resident #1 underwent surgery, intramedullary nailing of the right femur, on 08/10/2024.</p> <p>Review of the facility's Investigative Report revealed the following, in part: on 08/08/2024, S3CNA failed to properly follow community policy as it related to assessment and functionality of the sling and requirements of two-person assistance while utilizing Hoyer lifts resulting in resident falling from Hoyer lift and sustaining fracture. Identified staff member immediately suspended pending investigation.</p> <p>On 08/14/2024 at 3:15 pm., an interview was conducted with S4LPN (Licensed Practical Nurse). S4LPN confirmed she cared for Resident #1 on 08/08/2024. She confirmed she was aware that Resident #1 required transfers with a Hoyer lift and two person assistance. She denied ever being asked for assistance with any transfers on 08/08/2024. She stated she was made aware Resident #1 had fallen when S3CNA came into the hallway calling for help. S4LPN stated when she entered the resident's room, she noted both the shower bed and Hoyer lift were in the room and the Resident #1 was lying next to the bed on her right side with her right leg under the bed. S4LPN stated she observed Resident #1's right leg was bent in the opposite direction behind her in an unnatural alignment with a protrusion from the right thigh. She stated she suspected a fracture of the femur and chose not to move the resident until EMS arrived.</p> <p>(continued on next page)</p> |  |   |

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>195422  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>08/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rosewood Nursing Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>534 15th Street<br>Lake Charles, LA 70601 |   |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |   |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 08/15/2024 at 9:00 a.m., a phone interview was conducted with S3CNA. She confirmed she provided care to Resident #1 on 08/08/2024. S3CNA stated she had taken care of Resident #1 previously and was familiar with the type of care the resident required including that the resident required two persons for transfers with the lifter. She stated that she and another CNA (later identified as S5CNA) transferred Resident #1 from her bed to her shower bed using the Hoyer lift, brought the resident into the shower room, and gave her a shower. When done, she (S3CNA) transported Resident #1 on the shower bed back inside her room. S3CNA stated she rang the call bell to request assistance from another staff member. After waiting approximately 1 minute, Resident #1 began to cry. S3CNA stated she didn't want to make the resident wait any longer, so she proceeded to transfer the resident on her own without assistance. Resident #1 was on a lifter pad, then hooked up to the mechanical lift. S3CNA stated once Resident #1 was lifted into the air, she heard a noise which she believed was the lifter pad ripping, then the resident just fell to the floor. She further explained the resident fell on to her right side with her right leg under the bed. S3CNA stated she immediately went into the hallway and called for nursing assistance; S4LPN responded immediately. S3CNA confirmed she was aware Resident #1 required two staff members for transfers, but failed to follow the resident's care plan.</p> <p>On 08/15/2024 at 1:30 p.m., an interview was conducted with S5CNA. She stated on 08/08/2024, while walking on the hallway, she observed S3CNA attempting to transfer Resident #1 from her bed to the shower bed using the Hoyer lift without assistance. When she observed this, she entered the room and assisted S3CNA with the transfer because she was aware that Resident #1 required two persons with all transfers. S3CNA went into the shower room with the resident after the transfer while she continued on with her own tasks. S5CNA denied being asked to assist with any transfers, and also denied hearing a call bell singling for assistance.</p> <p>On 08/15/2024 at 1:45 p.m., an interview was conducted with S1ADM (Administrator). S1ADM confirmed Resident #1 had been hospitalized since 08/08/2024 as a result of the fall resulting in a leg fracture that required surgical repair on 08/10/2024. She stated that, during the investigation of the incident and interview with S3CNA, it was determined that S3CNA failed to follow Resident #1's care plan for two person assist and to assess the functionality of the sling prior to using the lift. S1ADM stated the lift sling was inspected after Resident #1's fall which was noted to have come unsewn at the seam where the hooks were attached. S1ADM denied the sling had any frayed areas. S1ADM stated they immediately inspected all slings in the facility as well as all Hoyer lifts. She stated all Hoyer lifts were in good working order with no deficits were found in any of the other slings. Then they began in-servicing all clinical staff which included: a physical demonstration, on proper use of Hoyer lifts, assessing slings for functionality, abuse/neglect, and change in condition. The facility also did an audit on all care plans to ensure each resident's transfer requirements were correct. She asserted there were no negative findings as a result of this audit. S1ADM further stated the facility had an AD HOC (impromptu) QAPI (Quality Assurance Performance Improvement) meeting on 08/08/2024 to begin investigations and initiate corrective actions and on the repeat AD HOC QAPI meeting on 08/09/2024 where they determined the deficient practice had been corrected. S1ADM reported the facility's monitoring began the following day (08/09/2024) and was ongoing. She denied any negative findings with the monitoring and stated there had been no further incidents regarding transfers, Hoyer lifts, or lifter slings. S1ADM reported she and the Director of Nursing would conducted monitoring for 90 days. Projected completion of monitoring was 09/01/2024 if no negative findings. The monitoring would be extended for an additional 60 days if any negative findings were identified.</p> <p>(continued on next page)</p> |  |   |

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>195422  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>08/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rosewood Nursing Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>534 15th Street<br>Lake Charles, LA 70601 |   |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |   |
| F 0689<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>Multiple Nurses and CNA's were interviewed about the use of the mechanical lift. All staff interviewed were knowledgeable about the facility's policy that two trained staff members should be present when lifting a resident using the mechanical lift. All staff members stated they had received multiple trainings on the proper use of mechanical lifts.</p> <p>Five random residents, who required use of a mechanical lift for transfers, were observed on 08/14/2024 and 08/15/2024 having two or more staff members present when the mechanical lift was used on them. No concerns were identified.</p> <p>The facility implemented the following actions to correct the deficient practice:</p> <p>08/08/2024- Continuous Quality Assessment and Improvement Corrective Action Plan:</p> <p>I. Immediate evaluation of all Hoyer lift and slings.</p> <p>II. Immediate reeducation of clinical staff for safe mechanical transfer procedure, lift sling evaluation and reporting, and abuse, neglect and change in condition reporting.</p> <p>III. Employee monitoring of resident transfers utilizing Hoyer lift and lift slings by administrator or designee.</p> <p>IV. Monitoring of Hoyer lift and lift slings by administrator or designee.</p> <p>V. Continued education on the use of Hoyer lifts, slings, and their usage at the time of hire, annually and as needed.</p> <p>08/09/2024- All clinical staff have received re-education; monitoring conducted and documented with ongoing trainings continued.</p> |  |   |