STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195177	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Manor Nursing & Rehab	1400 Lindberg Drive Slidell, LA 70458

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47173 Based on record review, observations and interviews, the facility failed to ensure residents had a sanitary and comfortable environment for 1 (Hall A) of 2 hallways observed. The facility failed to ensure floors were free from stains in Hall A. There were 75 licensed beds in the facility. Findings: Review of the Facility's Policy titled, Resident Rights: Safe, Clean and Comfortable Environment dated March 2023 revealed the following: Purpose: The resident has a right to a safe, clean and comfortable environment. Guidelines: 4. The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortably interior. On 08/26/2024 at 9:40 a.m., an initial walk through the facility revealed the following: Hall A's floor had multiple brown and black stains around the nurse's station and throughout hallway. On 08/27/2024 at 9:25 a.m., an interview was conducted with S6HSUP. She stated she expected the hallway floors to be mopped daily. She stated S7HSK was responsible for mopping the hallways daily. An environmental tour was conducted with S6HSUP and she confirmed the multiple areas of brown and black stains in Hall A. She confirmed the stains should have been cleaned yesterday. On 08/27/2024 at 9:50 a.m., an interview was conducted with S7HSK. He stated he was responsible for mopping all hallways and the entryway. He stated he was unable to mop both halls daily. S7HSK confirmed he worked 08/26/2024 and he did not mop Hall A and the floors were dirty. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/27/2024 at 1:15 p.m., an interview was conducted with S8RD. The above listed floor stains were reviewed. He stated the floors on Hall A were cleaned yesterday and the facility needed time to mop the floors for the day. S8RD was informed of observations made of the stains noted in Hall A from yesterday morning which remained this morning.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981 Based on record review and interviews, the facility failed to ensure there was ongoing communication and collaboration with the dialysis facility. The facility failed to ensure dialysis communication forms were filled out completely for 2 of 2 (#1 and #2) residents sampled for dialysis. Findings: Review of the Facility's Policy titled, Quality of Care: Dialysis dated 03/2023 revealed the following: Purpose: To provide residents with hemodialysis . that is consistent with professional standards of practice . Guidelines: 5. There will be ongoing communication and collaboration between the nursing home and dialysis staff for the development and implementation of the dialysis care plan. 8. The facility will assess the resident's condition and monitor for complications before and after dialysis treatments received . 9. There will be ongoing communication between the facility and the dialysis center reflected in the medical record. This communication may include .: c. Advanced Directives and Code Status . d. Nutritional/fluid management including documentation of weights, before, during and/or after dialysis 14. Facility and dialysis dieticians will coordinate the nutritional care .including identifying weight fluctuations due to fluid retention/depletion. Resident #1 Review of Resident #1's clinical record revealed an admitted [DATE] to the facility with diagnoses, which included Dependence of Renal Dialysis. Review of Resident #1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/03/2024 revealed Section O: Dialysis was checked. Review of Resident #1's current Physician's Orders revealed the following, in part: Dialysis Monday, Wednesday, Friday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Pre Dialysis Assessment & Communication forms revealed incomplete communication for dates 08/02/2024 and 08/09/2024. Further review revealed no assessment and communication forms dated 08/05/2024, 08/07/2024 and 08/12/2024. Resident #2 Review of Resident #2's clinical record revealed an admitted [DATE] to the facility with diagnoses, which included End Stage Renal Disease. Review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/18/2024 revealed Section O: Dialysis was checked. Review of Resident #2's current Physician's Orders revealed the following, in part: Dialysis Monday, Wednesday, Friday. Review of Resident #2's Pre Dialysis Assessment & Communication forms revealed incomplete communication for August 2024. Further review revealed no documentation of post dialysis weights or code status. On 08/27/2024 at 9:07 a.m., an interview was conducted with S9LPN. S9LPN stated the nurses were expected to fill out the Pre Dialysis Assessment & Communication form prior to the resident leaving for dialysis treatment. S9LPN stated the communication sheet was kept in the Electronic Health Record or in a binder. On 08/27/2024 at 12:20 p.m., an interview was conducted with S2DON. She stated Resident #1 and Resident #2 received dialysis on Mondays, Wednesdays, and Fridays. S2DON confirmed the nurses are expected to fill out the Pre Dialysis Assessment & Communication form completely prior to the resident leaving for dialysis treatment. S2DON reviewed Resident #1 and Resident #2's Pre Dialysis Assessment & Communication form and confirmed the above mentioned dates were incomplete and/or missing. S2DON confirmed continuous documentation between the dialysis center and the facility was not documented and should have been. 47173

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981 Based on record review and interviews, the facility failed to ensure a resident's laboratory tests were completed as ordered by the physician for 1 (#3) of 3 (#1, #2, and #3) sampled residents investigated. Findings: Review of Resident #3's clinical record revealed she was admitted to the facility on [DATE]. Review of Resident #3's current Physician's Orders revealed, in part: Order date 08/23/2024-CBC and CMP on Monday 08/26/2024. Further review of Resident #3's clinical record revealed no documented evidence, and the facility was unable to present any documented evidence Resident #3's CBC and CMP laboratory tests were completed as ordered by the physician on 08/26/2024. An interview was conducted on 08/27/2024 at 9:27 a.m. with S4RN. She stated S2DON just requested she obtain a CBC and a CMP on Resident #3, which was ordered to be obtained on 08/26/2024. An interview was conducted on 08/27/2024 at 9:30 a.m. with S2DON. She confirmed Resident #3 had a CBC and a CMP ordered to be obtained on 08/26/2024, and they were not.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 Based on record review and interview, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 1 (#1) of 3 (#1, #2 and #3) sampled residents reviewed for baths. Findings: Review of the Facility's Policy titled Activities for Daily Living dated August 2023 revealed the following: Guidelines: 4.d. The decision to refuse care and treatment is documented in the medical record. Review of Resident #1's clinical record revealed resident was admitted to the facility on [DATE]. Review of Resident #1's Bath/Shower Logs revealed no documentation for a bath/shower given from 08/01/2024 through 08/14/2024. On 08/27/2024 at 11:00 a.m., an interview was conducted with S5CNA. She stated she was responsible for resident baths on her shift from 7:00 a.m. - 3:00 p.m. shift. She stated she gave Resident #1 his bed baths. She stated he refused his bed bath 2 or 3 times when he was first admitted . She stated she should have documented all baths given or refused on the bath/shower log. On 08/27/2024 at 11:35 a.m., an interview was conducted with S2DON. S2DON reviewed Resident #1's bath/shower logs. She confirmed no documentation was completed on Resident #1 from 08/01/2024 through 08/14/2024 and should have been.