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	02/24/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872 Based on interviews and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for 1 (#1) of 3 (#1, #2, and #3) sampled residents, by failing to ensure Resident #1 was coded for a surgical wound. Findings: Review of Resident #1's Clinical Records revealed he was admitted to the facility on [DATE] with diagnoses, which included Cerebral Infarction. Further review revealed Resident #1 was readmitted on [DATE]. Review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/2025 revealed Resident #1 was not coded for surgical wounds in Section M: Skin Conditions, Line M1040-Other Ulcers, Wounds, and Skin Problems. Review of Resident #1's Nurse Practitioner (NP) Progress notes dated 01/24/2025 through 02/18/2025 revealed the following, in part: On 01/25/2025 at 5:40 p.m., S6NP noted under Admission History and Physical section: Cardiovascular: Left Chest Wall dressing with scant bloody drainage status post loop recorder placement. On 01/26/2025 at 3:20 p.m., S6NP noted under Physician/Practitioner Note section: Cardiovascular: Left Chest Wall dressing with scant bloody drainage status post loop recorder placement. An interview was conducted on 02/19/2025 at 4:30 p.m. with S9LPN. S9LPN stated upon completion of Resident #1's Quarterly MDS with an ARD of 01/30/2025, she reviewed the aforementioned S6NP's progress notes and overlooked the Cardiovascular section of the note, which indicated Resident #1 had a left chest wall dressing with scant bloody drainage status post loop recorder placement. S9LPN confirmed Resident #1's Quarterly MDS with an ARD of 01/30/2025 did not accurately reflect Resident #1's status by reflecting he had a surgical wound. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/24/2025 with S2DON. S2DON reviewed Resident #1's Quarterly MDS with an ARD of 01/30/2025, and confirmed the assessment did not accurately reflect Resident #1's status by reflecting he had a surgical wound and should have.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872 Based on interviews and record review, the facility failed to include a resident's medical and nursing needs for a surgical incision and loop recorder monitoring equipment with measurable objectives and timeframes for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for Care Plans. Findings: Review of the facility's policy titled, Comprehensive Care Plans dated 03/2023 revealed the following in part: Purpose: To provide each resident with a person-centered, comprehensive care plan to address the resident's medical, nursing, physical, mental and psychosocial needs. Guidelines: 1. The care plan will be comprehensive and person-centered. It will drive the type of care and services that resident receives and will describe the resident's medical, nursing, physical, mental and psychosocial needs and preferences; as well as how the facility will assist in meeting those needs and preferences. 11. The care planning process will be an on-going process. 12. Resident care needs and care plan interventions will be communicated with direct care staff Review of Resident #1's Clinical Records revealed he was admitted to the facility on [DATE] with diagnoses, which included Cerebral Infarction and Monoplegia. Further review revealed Resident #1 was readmitted on [DATE]. Review of Resident #1's After Visit Summary Discharge Instructions Orders (AVS) for local hospital admitted d 01/19/2025 through 01/24/2025 revealed the following, in part: Primary diagnosis was Acute Arterial Ischemic Stroke, Multifocal, and Multiple Vascular Territories. Further review revealed Local Hospital Facility Transfer Orders included discharge instructions for loop recorder: You may shower in 24 hours after the procedure. Allow soapy water to gently run over chest incision, not directly on incision. Do not rub or scrub incision. No bathtubs or submerging in water until site is completely healed. Keep site clean and dry at all times. Inspect site daily for tenderness, discharge, or signs of infection. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply ice pack for 24 hours. Do not remove the white adhesive strips, allow them to fall off on their own. Review of Resident #1's Nurse Practitioner (NP) Progress notes from 01/24/2025 through 02/18/2025 revealed the following, in part: 01/25/2025 at 5:40 p.m., S6NP- Admission History and Physical: HPI: Resident #1 sent to the emergency room and he was admitted for evaluation of possible Cerebral Vascular Accident (CVA). Loop recorder was placed while inpatient. Cardiovascular: Left Chest Wall dressing with scant bloody drainage status post loop recorder placement. 01/26/2025 at 3:20 p.m., S6NP- Physician/Practitioner Note: Cardiovascular: Loop recorder placed. Cardiovascular: Left Chest Wall dressing with scant bloody drainage status post loop recorder placement. Assessment/Plan: loop recorder Review of Resident #1's current Care Plan revealed no care plan problem or intervention for a surgical incision to the left chest wall and/or the loop recorder equipment. An observation was made of Resident #1 on 02/17/2025 at 4:45 p.m. Resident #1 was observed in his room and a beige medical equipment was visible on the night stand next to the bed plugged in. Resident #1 lifted his shirt and a dressing was observed on his left chest wall. The dressing was a white gauze with a small, dried, maroon drainage covered with a large clear adhesive with rolled edges and was not dated. An interview was conducted on 02/17/2025 at 4:45 p.m. with Resident #1. Resident #1 stated he was in the hospital recently for a stroke and they put in a loop recorder in his chest. Resident #1 stated the doctor at the Local Hospital told him to plug in the medical equipment for the loop recorder that was given to him at discharge to monitor his heart. Resident #1 stated the medical equipment had been in his room plugged in since his readmission on 01/24/2025. An observation was made of Resident #1 on 02/19/2025 at 9:03 a.m. Resident #1 observed in his room. He lifted his shirt and a dressing was observed on his left chest wall. The dressing was a white gauze with a small, dried, maroon drainage covered with a large clear adhesive with rolled edges. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/19/2025 at 4:30 p.m. with S9LPN. S9LPN stated she was the Care Plan nurse and Readmission nurse for Resident #1. S9LPN stated upon Resident #1's readmission on 01/24/2025, she reviewed the AVS orders and overlooked part of the orders with the title [Local Hospital] Facility Transfer Orders, which included discharge instructions for loop recorder incision care and monitoring. S9LPN stated upon further review of Resident #1's electronic health record (EHR) she reviewed the aforementioned S6NP's progress notes and overlooked the Cardiovascular section of the note, which indicated Resident #1 had a Left Chest Wall dressing with scant bloody drainage status post loop recorder placement and did not update Resident #1's Care Plan to reflect Resident #1's status. S9LPN confirmed Resident #1's Care Plan did not include medical and nursing needs for a surgical wound and/or loop recorder monitoring equipment with measurable objectives and timeframes and should have been. An interview was conducted on 02/24/2025 with S2DON. S2DON reviewed Resident #1's Care Plan from 01/24/2025 through 02/18/2025 and confirmed the Care Plan did not include medical and nursing needs for a surgical wound and/or loop recorder monitoring equipment with measurable objectives and timeframes and should have been.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872 Based on observations, interviews and record reviews, the facility failed to provide appropriate treatment and services for 1 (#1) of 3 (#1, #2, and #3) newly admitted or readmitted residents who needed physician orders for immediate care and/or follow up for surgery and for implanted devices. For 26 days, the facility failed to ensure the Admission Nurse, Charge Nurses, Wound Care Nurses, Licensed Practical Nurses and Registered Nurses: 1. Had accurately transcribed and clarified Resident #1's 01/24/2025 hospital discharge recommendations, wound care and dressing orders, cardiology follow up for surgical incision care, and monitoring equipment instructions; 2. Understood and acted as needed on their responsibilities for Resident #1's cardiac loop recorder and; 3. Assessed, monitored, documented, and treated Resident #1's surgical incision site, loop recorder, and loop recorder monitoring equipment. This deficient practice resulted in an Immediate Jeopardy situation on 01/24/2025, when Resident #1 was readmitted to the facility from the hospital after a surgical implantation of a loop recorder with monitoring equipment. Facility staff failed to accurately transcribe and clarify the resident's discharge orders and complete accurate skin assessments which resulted in Resident #1 not receiving care and treatment for the newly acquired surgical incision site or staff assistance with ensuring the monitoring equipment was functioning from 01/24/2025 through 02/20/2025. This deficient practice created a likelihood Resident #1 would suffer from post-surgical incision site complications and delayed treatment of an arrhythmia identified from the loop recording. S1ADM was notified of the Immediate Jeopardy on 02/20/2025 at 6:32 p.m. The Immediate Jeopardy was removed on 02/21/2025 at 6:45 p.m., as confirmed by onsite verification through record reviews and interviews. The facility implemented an acceptable Plan of Removal (POR) prior to survey exit. This deficient practice continued at the potential for more than minimal harm for all 86 residents residing in the facility. Findings: 1. and 2. Review of the manufacture's information and guidelines dated 08/2024 revealed the following information regarding a loop recorder, in part: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Insertable Cardiac Monitor (ICM) is implanted in patient left chest wall under the skin and records subcutaneous Electrocardiogram (ECG) data. The ICM is indicated in patients with a diagnosis of cryptogenic stroke. The ICM works continuously to capture comprehensive and actionable ECG data for up to three years. The ICM automatically-activated monitoring system included ECG data transmission from the ICM, through the patient's monitor, to the cloud network, and then made available to the doctor. The network sends alerts to the doctor of abnormal ECG data. Potential adverse events or potential complications of ICM devices include, but are not limited to, device rejection phenomena (including local tissue reaction), device migration, infection, and erosion through the skin. Review of the facility's policy titled Resident Assessments Admission Physician Order for Immediate Care dated 03/2023 revealed the following in part: Purpose: To provide each resident with necessary care and services upon admission. Policy: The facility will have physician orders for the resident's immediate care, at the time of admission. Guidelines: 1. Physician orders for immediate care may be written or verbal. 2. These orders will enable facility staff to provide essential care to the newly admitted resident 3. These orders will be consistent with the resident's physical status. 5. These orders will be in place to facilitate care for the resident until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. Review of Resident #1's Clinical Records revealed he was readmitted to the facility from the hospital on 01/24/2025 with diagnoses, which included Acute Arterial Ischemic Stroke, Multifocal, and Multiple Vascular Territories. Review of Resident #1's local hospital records dated 01/19/2025 through 01/24/2025 revealed Resident #1's hospital cardiologist implanted a loop recorder on 01/24/2025. Further review revealed the hospital cardiologist MD and NP documented the following, in part: 01/24/2025 Recommend loop recorder implantation for determination of paroxysmal atrial fibrillation or atrial arrhythmias with Cryptogenic Stroke diagnosis. Recommend outpatient follow-up for wound check in 1 week for a nurse visit and follow-up with cardiology evaluation in about 4 weeks' time. Wound care instructions: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	May remove outer large clear adhesive in 48 hrs. Encouraged to maintain the white adhesive strip in place until follow-up visit in the office. Do not remove the white adhesive strip. Patient may shower in 24 hours. Apply soap and dab the area dry at insertion site. Encouraged patient to return if this has any discharge or drainage from the incision or if any erythema, fevers or chills noted. Review of Resident #1's After Visit Summary Discharge Instructions Orders (AVS) for Local Hospital admitted d 01/19/2025 through 01/24/2025 revealed discharge instructions for loop recorder: You may shower in 24 hours after the procedure. Allow soapy water to gently run over chest incision, not directly on incision. Do not rub or scrub incision. No bathtubs or submerging in water until site is completely healed. Keep site clean and dry at all times. Inspect site daily for tenderness, discharge, or signs of infection. Apply ice pack for 24 hours. Do not remove the white adhesive strip, allow them to fall off on their own. Further review revealed no cardiologist follow up with the local hospital cardiologist who implanted the loop recorder. Review of Resident #1's hospital cardiologist letter dated 2/21/2025 revealed Resident #1 had loop recorder equipment with instructions to be plugged up beside Resident #1's bed and if power flashes please unplug and plug back in after 5 minutes. Review of Resident #1's Physician Orders from 10/31/2024 through 02/18/2025 revealed no physician's orders addressing Resident #1's surgical incision, cardiology follow up appointment, loop recorder monitoring, or equipment. Review of Resident #1's current Care Plan revealed no evidence a care plan was developed with interventions implemented for a surgical incision to the left chest wall or the loop recorder equipment. Review of Resident #1's Nursing Notes from 01/01/2025 through 02/18/2025 revealed no evidence of Resident #1's surgical incision site, cardiology follow up appointments, or the loop recorder were addressed by staff. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Nurse Practitioner Progress notes from 01/01/2025 through 02/18/2025 revealed on 01/25/2025 at 5:40 p.m., S6NP documented loop recorder was placed while inpatient. Resident #1 is discharged to the facility for continued long term care and will follow up with cardiology as scheduled. Staff to request discharge summary. Follow up with cardiology as scheduled. Review of Resident #1's Medication Administration Record and Treatment Administration Record from 01/24/2025 to 02/18/2025, 26 days, revealed no surgical incision site care or the loop recorder equipment monitoring. Review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/2025 revealed he had a Brief Interview for Mental Status (BIMS) of 15, which indicated cognitively intact. Further review revealed Resident #1 was not coded as having a surgical incision. An observation was made and interview conducted with Resident #1 on 02/17/2025 at 4:45 p.m. A beige piece of medical equipment was visible in the resident's room on the night stand next to the bed and plugged into the wall. Resident #1 lifted his shirt and a white gauze with a small amount of dried maroon colored drainage covered with a large clear adhesive bandage was noted to the left chest wall. There was no date noted on the dressing. Resident #1 stated he was in the hospital recently for a stroke and a loop recorder was put in his chest. Resident #1 stated the doctor at the local hospital told him to plug in the medical equipment for the loop recorder to monitor his heart. Resident #1 stated the medical equipment had been in his room plugged in since his readmission on 01/24/2025. The resident stated the dressing was applied at the hospital and the facility staff had not removed the dressing since his readmission on 01/24/2025. He stated the facility staff had not spoken to him about or addressed the surgical incision, loop recorder, or the equipment used to monitor his heart rate since he was readmitted to the facility. An observation was made of Resident #1 on 02/19/2025 at 9:03 a.m. Resident #1 lifted his shirt and a dressing was observed on his left chest wall. The dressing was a white gauze with a small amount of dried maroon drainage covered with a clear adhesive bandage was noted to the left chest wall. A telephone interview was conducted on 02/20/2025 at 12:33 p.m. with S10LPN. S10LPN stated she was responsible for providing the facility with resident's hospital documentation. S10LPN stated she provided the facility with Resident #1's hospital records from 01/20/2025 through 01/22/2025, but did not send the records from 01/23/2025 through 01/24/2025. S10LPN stated she sent the hospital AVS orders via email on 01/24/2025 to S2DON, S11ADON and S9LPN for review, which included the loop recorder discharge instructions. S10LPN stated S2DON, S11DON and S9LPN should have reviewed the AVS orders to ensure further information was not needed. She stated the note from the hospital case manager stated Resident #1's hospital nurse gave report on 01/24/2025 at 4:16 p.m. to the facility nurse so she did not provide the facility with the paperwork from the 23rd or 24th. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 02/19/2025 at 4:30 p.m. with S9LPN. S9LPN stated she would assist with completion of resident admission and readmission order entry. She stated the admissions or readmission process was, S10LPN would send an email to dietary, S11ADON, S2DON and herself, which included the AVS orders from the hospital, which they review and follow as orders and instructions from the hospital for residents' care. S9LPN stated from the email received she will print out the AVS and the residents' current physician orders. She stated she will use the residents' current physician order to compare against the AVS and enter new orders or discontinue orders according to the AVS. S9LPN confirmed she did not review part of the AVS titled Local Hospital Facility Transfer Orders, which included the discharge instructions regarding loop recorder incision care. S9LPN confirmed since she failed to review the discharge instructions in the entirety, no orders were entered for Resident #1's loop recorder incision care. After review of Resident's NP Progress Notes, S9LPN stated she did see the S6NP's progress notes on 01/25/2025 during MDS assessment completion, but overlooked the note where loop recorder was placed and the left chest wall incision in the NP's Progress Notes and only looked at the S6NP's plan at the bottom of the note. S9LPN stated the floor nurse who would be receiving Resident #1 for readmission would have received report from the hospital nurse before the resident came to the facility and S9LPN would give a copy of AVS to the admission nurse. S9LPN stated she would have given the copy to S3LPN because he worked on Fridays. S9LPN reviewed Resident #1's electronic health record (EHR) and confirmed Resident #1 did not receive treatment or monitoring for the surgical incision upon readmission to the facility on [DATE] to present. S9LPN confirmed she did not contact the physician to clarify whether incision orders were needed or not. S9LPN stated she was not sure of who the cardiologist was or who had been monitoring the loop recorder. S9LPN confirmed Resident #1 did not have a cardiologist follow up appointment scheduled and should have A telephone interview was conducted on 02/19/2025 at 12:00 p.m. with S3LPN. S3LPN stated he worked on 01/24/2025 and 01/25/2025 and was responsible for Resident #1's readmission to the facility. S3LPN stated the admission or readmission process for the admission nurse to receive report from the local hospital. S3LPN stated the local hospital will fax an AVS packet over to the facility and those orders from the AVS are entered into the physician orders by S11ADON or whoever is available. S3LPN stated he was responsible to review the AVS orders against the current Physician orders as a check and balance that the AVS orders are entered correctly. S3LPN stated he reviewed Resident #1's AVS paperwork from the hospital on readmission and did not recall discharge loop recorder incision instructions. S3LPN confirmed he did see a new dressing on Resident #1, during readmission and during weekly skin assessments, but he did not assess or remove the dressing. S3LPN stated he assumed wound care was taking care of the incision and dressing. S3LPN confirmed he did not call the physician for dressing or incision order clarifications or notify S2DON or wound care of the new incision. S3LPN stated when residents are admitted or readmitted a full body and skin assessment should be completed by the nurse to assess the skin for wounds, developing wounds or any issues with the resident's skin and document in the residents' EHR. S3LPN confirmed there were no orders or care implemented for Resident #1's surgical incision or monitoring of the loop recorder equipment from 01/24/2025 through 02/17/2025. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview was conducted on 02/19/2025 at 12:34 p.m. with S5LPN. S5LPN stated she cared for Resident #1 on the night shift of 01/24/2025. S5LPN stated she did review the discharge summary instructions for Resident #1, but failed to see discharge instructions for a surgical incision and loop recorder. S5LPN stated the process for the admitting nurse during a resident readmission from the hospital would be to complete a head to toe assessment, which included a full skin assessment and document the assessment in the nursing notes. S5LPN stated during the skin assessment the nurse would check for open areas, bruising, sores and any changes of the skin. S5LPN stated staff receive a copy of a resident's discharge summary instructions for review and a copy is kept at the nurses' station for reference. S5LPN stated she did not receive report of Resident #1 having any new skin wound or incision from S3LPN on the night of 01/24/2025. S5LPN confirmed since she did not receive report of the new incision she had not changed the dressing, completed any monitoring or cared for Resident #1's incision. S5LPN stated Resident #1 did notify her the hospital performed a surgical procedure to insert a device, but she did not report it or investigate further. S5LPN confirmed there were no orders to care for Resident #1's incision or equipment at the bedside. A telephone interview was conducted on 02/20/2025 at 10:46 a.m. with S6NP. S6NP stated she was aware Resident #1 was readmitted to the facility from the local hospital status post loop recorder placement. She stated she requested the nurse, who she could not recall, on 01/25/2025 to contact the hospital and request the AVS orders. S6NP confirmed Resident #1 did not receive care for his left chest wall dressing at the loop recorder insertion site, which caused a likelihood for Resident #1 to develop an infection. S6NP stated Resident #1's incision should have been treated or monitored, and was not. An interview was conducted on 02/19/2025 at 10:59 a.m. with S4LPN. S4LPN stated she provided care to Resident #1 from 01/24/2025 through 02/19/2025. S4LPN stated she did not receive report from staff or see any documentation in the EHR stating Resident #1 had a surgical wound or monitoring equipment. S4LPN stated after Resident #1 was readmitted on [DATE] he informed her he had a dressing, but she was unsure of the date. S4LPN stated she assumed someone was taking care of the dressing, and she did not further investigate the issue. S4LPN stated she observed the dressing to Resident #1's left chest wall. S4LPN confirmed she did not remove the dressing or assess the incision site. S4LPN stated she did not recall reporting the dressing to the wound care nurse, S2DON, or MD/NP. S4LPN stated if she reported the dressing and clarified wound care orders she would have documented this in the nursing notes. S4LPN stated she observed the dressing to Resident #1's left chest wall, but did not provide treatment because she did not have orders. S4LPN stated Resident #1 informed her of the monitoring for the cardiologist, but she did not see any equipment. S4LPN said she did not notify anyone of the dressing, the information about the monitoring equipment, or contact the physician to obtain clarification for treatment. A telephone interview was conducted on 02/20/2025 at 1:01 p.m. with S13WCN2. S13WCN2 stated she was responsible for providing resident wound care from 01/24/2025 through mid-February 2025. S13WCN2 confirmed staff did not report a surgical incision or dressing for Resident #1 nor had she provided any wound care to Resident #1 from 01/24/2025 to 02/17/2025. An interview was conducted on 02/19/2025 at 11:11 a.m. with S8WCN1. S8WCN1 stated she S8WCN1 stated Resident #1 had no orders for surgical incision care. S8WCN1 confirmed she did not provide any wound care to Resident #1 from her hire date in February 2025 to 02/17/2025. (continued on next page)

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	195177	A. Building B. Wing	02/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview was conducted on 02/19/2025 at 9:48 a.m. with S7NP. S7NP confirmed he would expect the nurses to follow the AVS orders received from the hospital. S7NP stated he would expect the nurses to notify the facility's wound care nurse practitioner and wound care nurse, if there were no orders for a wound or incision. He stated he expected the nurse to monitor, as ordered, the incision and immediately report to him and the wound care nurse practitioner any signs and symptoms of decline in the incision, not healing properly and any other issues with the resident and/or incision. An interview was conducted on 02/20/2025 at 10:30 a.m. with S2DON. S2DON stated the admission and readmission process started with S10LPN who emailed the AVS instructions on 01/24/2025. S2DON stated upon Resident #1's readmission the facility received Resident #1's AVS orders via email from S10LPN. S2DON confirmed the email included the document titled local hospital facility transfer orders, which included the loop recorder incision discharge instructions. S2DON confirmed S9LPN was responsible for reviewing Resident #1's AVS and entering orders for resident care. S2DON stated S9LPN should have reviewed the AVS orders in its entirety and entered the loop recorder incision instructions into the EHR and did not. S2DON confirmed staff should have clarified orders with a physician when Resident #1 verbally notified staff of the incision and staff made observations of the incision. S2DON reviewed Resident #1's EHR and verified the resident did not receive care for loop recorder incision, from 01/24/2025 to 02/18/2025, or the subsequent monitoring equipment from 01/24/2025 through 02/20/2025, when the medical director was contacted for instructions. S2DON confirmed the cardiologist was not contacted until 02/19/2025. S2DON stated for Resident #1's readmitted d 01/24/2025 there was no admission evaluation or nursing note and there should have been. After review of Resident #1's EHR, S2DON confirmed there was no documentation regarding Resident #1's incision dressing, treatment, assessment, or monitoring. S2DON stated the progress notes are only monitored by the clinical administrative staff, if they have an adverse event or new orders and not necessarily on a readmission and then the clinical administrative staff will give a brief synapses during the morning meetings to catch up on the resident status as needed. She stated she did not receive report in the morning meetings about a surgical incision, loop recorder monitoring equipment. S2DON confirmed stated she was not aware and had not seen a device/equipment at Resident #1's bedside since readmission. A telephone interview was conducted on 02/24/2025 at 3:46 p.m. with the hospital cardiologist office nurse. She stated the first time they were contacted by the facility was on 02/21/2025, regarding a follow up appointment and requested the loop recorder equipment and incision instructions. She stated she expected the facility to call within a few days of readmission for a cardiologist follow up for an incision check and loop recorder monitoring equipment instructions and did not. After review of AVS orders and hospital medical records regarding loop recorder discharge instructions and follow up, she stated she would have expected the facility to follow the orders. She confirmed the adhesive dressing should have been removed at least 48 hours after the loop recorder was placed and a follow up for skin check by the cardiologist nurse or the nurse at the facility. She confirmed in order for the nurse to assess the incision the large clear adhesive dressing should have been removed to assess the incision, which is a little more than an inch long with white adhesive strips, for redness and drainage at least a week status post loop recorder placement. She stated if Resident #1 had symptoms of atrial fibrillation, they would be alerted and would call the facility to notify them the Resident #1 needed to be seen by the cardiologist. 3. Review of the facility's policy titled, Skin and Wound Management Guidelines undated, revealed the following, in part: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Guidelines: Admission/Readmission 1. Staff nurse a. Complete the NSG Admission/Readmission Evaluation including a careful evaluation of the skin with thorough and descriptive documentation of any alteration in skin integrity. c. Provide detailed documentation of any alteration in skin integrity in the Progress Notes. d. Obtain and enter treatment order for any identified skin issues. e. Enter into the (TAR), including the following: i. monitoring each shift for presence and condition of dressing, if a dressing is used; ii. daily monitoring for signs of infection or drainage; iii. dressing changes as ordered. 2. Wound Care Nurse a. Review admissions/readmissions and conduct a thorough assessment and documentation of admission, on any wound being monitored. Review of Resident #1's local hospital records dated 01/19/2025 through 01/24/2025 revealed Resident #1's Hospital Cardiologist implanted a loop recorder on 01/24/2025. Review of Resident #1's Physician Orders from 10/31/2024 through 02/18/2025 revealed on 11/01/2024, an order was implemented for Weekly Skin Check - Document results on Weekly Skin Observation Assessment every day shift every 7 days. Review of Resident #1's Skin & Wound-Total Body Skin Assessments dated 01/31/2025, 02/07/2025, and 02/14/2025 revealed normal skin assessments with no new wounds or surgical incisions documented. Further revealed there was no assessment dated [DATE]. Review of Resident #1's Wound Care Evaluations from 10/31/2024 to current revealed no documentation for left chest wall surgical incision treatment, assessment and/or monitoring and no other wounds. Review of Resident #1's Nursing Notes from 01/01/2025 through 02/18/2025 revealed no evidence of Resident #1's surgical incision site or the loop recorder monitoring equipment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview was conducted on 02/19/2025 at 12:00 p.m. with S3LPN. S3LPN stated he worked on 01/24/2025 and 01/25/2025 and was responsible for Resident #1's readmission to the facility. S3LPN stated when he completed the weekly skin body audits on 01/31/2025, 02/07/2025 and 02/14/2025, he did not document Resident #1's surgical incision. S3LPN stated a new wound or new dressing should have on the aforementioned dates should have been documented new wound and MD/NP notified. S3LPN stated the wound care nurse should be notified of the new wound to request an assessment and treatment of the new wound or dressing and was not. S3LPN confirmed he did see a new dressing on Resident #1, during readmission and on the weekly skin assessments. S3LPN confirmed a readmission skin assessment should have been completed and had not been. S3LPN confirmed he completed a weekly skin assessment for the resident on 01/31/2025, 02/07/2025 and 02/14/2025 and did not document the surgical incision or dressing. S3LPN confirmed there were no orders for assessment, monitoring, or treatment implemented for Resident #1's surgical incision or monitoring equipment from 01/24/2025 through 02/17/2025. A telephone interview was conducted on 02/20/2025 at 10:46 a.m. with S6NP. S6NP stated she was aware Resident #1 was readmitted to the facility from the local hospital status post loop recorder placement. S6NP confirmed Resident #1 did not receive care for his left chest wall dressing at the loop recorder insertion site, which caused a likelihood for Resident #1 to develop an infection. S6NP stated Resident #1's incision should have been treated or monitored, and was not. An interview was conducted on 02/19/2025 at 10:59 a.m. with S4LPN. S4LPN stated she provided care to Resident #1 on her shifts from 01/24/2025 through 02/19/2025 S4LPN stated she did not receive report or see any documentation in the EHR stating Resident #1 had a surgical wound or monitoring equipment. S4LPN stated she observed the dressing to Resident #1's left chest wall, but did not provide treatment because she did not have orders. S4LPN said she did not notify anyone of the dressing or contact the MD/NP for orders. A telephone interview was conducted on 02/20/2025 at 1:01 p.m. with S13WCN2. S13WCN2 stated she was responsible for providing resident wound care from 01/24/2025 through mid-February 2025. S13WCN2 confirmed staff did not report a surgical incision or dressing for Resident #1 from 01/24/2025 to 02/17/2025. An interview was conducted on 02/19/2025 at 11:11 a.m. with S8WCN1. S8WCN1 stated Resident #1 had no orders for surgical incision care. S8WCN1 confirmed staff did not report a surgical incision for Resident #1 from her hire date in February 2025 to 02/17/2025. A telephone interview was conducted on 02/19/2025 at 9:48 a.m. with S7NP. S7NP confirmed he would expect the nurses to follow the AVS orders received from the hospital. S7NP stated he would expect the nurses to notify the facility's wound care nurse practitioner and wound care nurse, if there were no orders for a wound or incision. He stated he expected the nurse to monitor, as ordered, the incision and immediately report to him and the wound care nurse practitioner any signs and symptoms of decline in the incision, not healing properly and any other issues with the resident and/or incision. An interview was conducted 02/20/2025 at 10:30 a.m. with S2DON. S2DON confirmed the nurse was expected to conduct a head to toe skin assessment and document accurate findings when a resident was readmitted to the facility and weekly. S2DON confirmed any nurse that observed a skin dressing on a resident without documentation or orders should contact the physician to clarify what treatment is needed. S2DON reviewed Resident #1's EHR and verified there was no documentation noting Resident #1 had a skin incision or monitoring equipment assessment, monitoring or treatment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 02/21/2025 at 1:00 p.m. with S1ADM. S1ADM stated the nursing staff had not completed nursing care assessment and monitoring for Resident #1's surgical incision per facility policy and procedure, which could have caused complications with his surgical incision. The facility implemented the following plan of removal to correct the deficient practice: Corrective Action 1) Orders reviewed and order clarification obtained on 02/20/2025 from PCP for loop recorder monitoring and maintenance to start after all staff providing care has been completed. 2) Full body skin assessment of Resident #1 completed on 02/19/2025. 3) An order was obtained to monitor Resident #1's left chest wall incision site every shift for tenderness and signs of infection starting 02/19/2025. Identification of others at risk l) All newly admitted or readmitted residents with surgical incisions or medical devices had the potential to be affected. Systemic Changes l) DON/designee will ensure all nursing staff (including agency) receive education on admission assessment, verifying, clarifying and accurately transcribing admission orders, as well as training on proper completion of skin assessments and body audits. This training was started on 02/19/2025 and completed 02/21/2025. All future incoming employees and agency workers will be trained prior to being allowed to provide any treatment. 2) The admitting nurse will call the PCP to hospital discharge orders and obtain clarification as needed. Once orders are verified the admission nurse will accurately transcribe new orders into the EHR and a second nurse will confirm orders for accuracy, to start on 02/21/2025. 3) Clinical administrative staff will review all newly admitted residents discharge orders, admission orders, and admission assessments to ensure accuracy and completion during morning clinical meeting daily starting on 02/21/2025. Monitoring 1) DON/designee to complete random audits of newly admitted /readmitted residents discharge orders, admission orders and admission assessments for completion and accuracy weekly x 4 weeks then monthly x 2 months. 2) Audit trends will be reported to facility QAPI for review and further recommendations. 3) The facility asserts the likelihood for serious harm to any recipient no longer exists as of 02/21/2025. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Throughout the survey from 02/20/2025 to 02/21/2025, observations, interviews, and record review revealed the above listed actions were implemented. Random staff interviews revealed the above education for staff was completed and monitoring by S2DON was started as mentioned above in the POR.

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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** 48872 Based on interviews and record review the facility failed to ensure resident records were maintained and accurate in accordance with accepted professional standards and practices for 1 (#1) of 5 (#1, #2, #3, #4, and #5) sampled residents' records reviewed. The facility failed to ensure staff: 1. Accurately completed readmission assessment for Resident #1; 2. Maintained documented blood pressure readings with blood pressure medication administration for Resident #1; and 3. Accurately documented weekly skin assessments for Resident #1. Findings: Review of facility's policy titled Administration Resident Records-Identifiable Information, dated 02/2023 revealed the following, in part: Policy: The facility will maintain a complete, accurate, readily accessible and systematically organized medical record, in accordance with accepted professional standards and practices, for each resident. Guidelines: 1. The medical record will reflect a resident's progress toward achieving their person-centered plan of care objective goals and the improvement and maintenance of their clinical and functional status. 2. The medical record will reflect the resident's condition and the care and services provided across disciplines to facilitate communication among the interdisciplinary team. 4. The medical record will contain: b. A record of the resident's assessments; e. nurse progress notes; Review of Resident #1's Clinical Records revealed he was readmitted to the facility from the hospital on 01/24/2025 with diagnoses, which included Acute Arterial Ischemic Stroke and Hypertension 1. Review of Resident #1's Re-Admission Evaluation dated 01/24/2025 revealed no readmission assessment documentation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Nursing Notes dated 01/24/2025 revealed no readmission assessment note. A telephone interview was conducted on 02/19/2025 at 12:00 p.m. with S3LPN. S3LPN stated he readmitted Resident #1 to the facility on [DATE]. S3LPN stated upon Resident #1's readmission, a complete and accurate physical and skin assessment should have been documented in the Electronic Health Record (EHR) and was not. An interview was conducted on 02/20/2025 at 10:30 a.m. with S2DON. S2DON confirmed when a readmission assessment was performed, she expected nursing staff to conduct a head to toe physical and skin assessment and document accurate findings in an readmission evaluation and/or nursing notes. S2DON reviewed Resident #1's Electronic Health Records (EHR) and confirmed there was no readmission evaluation or nursing notes regarding the readmission assessment and should have been. 2. Review of Resident #1's current Physician Orders revealed the following, in part: Start date: 01/25/2025. Lisinopril tablet 10 milligram, give 1 tablet by mouth one time a day related to essential (primary) hypertension, hold if blood pressure less than 110/60 and notify Nurse Practitioner (NP). Review of Resident #1's Medical Administrative Record (MAR) from 01/25/2025 to 02/17/2025 revealed no documented blood pressure readings. Review of Resident #1's vital sign records from 01/25/2025 through 02/17/2025 revealed no documented blood pressure readings. A telephone interview was conducted on 02/18/2025 at 11:02 a.m. with S3LPN. S3LPN confirmed in Resident #1's EHR from 01/25/2025 to 02/17/2025 there were no blood pressure readings documented in conjunction with Lisinopril medication administration and there should have been. An interview was conducted on 02/18/2025 at 4:15 p.m. with S4LPN. S4LPN stated when she took care of Resident #1 on her shifts from 01/25/2025 to 02/17/2025, she documented the blood pressure results on her personal nursing flowsheets and could not readily produce these documents because they were discarded in the shredder. After review of Resident #1's EHR from 01/25/2025 to 02/17/2025, she confirmed there were no blood pressure readings documented in conjunction with Lisinopril medication administration and there should have been. An interview was conducted on 02/18/2025 at 3:45 p.m. with S2DON. S2DON stated nursing staff have personal nursing flowsheets to document residents' vital signs, but were not part of residents' EHR. After review of Resident #1's EHR from 01/25/2025 through 02/17/2025, S2DON confirmed there were no blood pressure readings documented in conjuction with Lisinopril medication administration and should have been. 3. Review of Resident #1's local hospital records admission, 01/19/2025, through discharge, 01/24/2025, revealed an implanted loop recorder was implanted on the left chest wall on 01/24/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's current Physician Orders revealed on 11/01/2024, an order was implemented for Weekly Skin Check - Document results on Weekly Skin Observation Assessment every day shift every 7 days. Review of Resident #1's weekly Skin Observation assessment dated [DATE], 02/07/2025, and 02/14/2025 revealed normal skin assessments with no new wounds or surgical incisions documented. Review of Resident #1's Nursing Notes from 01/24/2025 through 02/18/2025 revealed no documentation of Resident #1's surgical incision site. An interview was conducted on 02/19/2025 at 12:00 p.m. with S3LPN. S3LPN confirmed he observed a new dressing on Resident #1 and did not accurately document the new wound or incision on the 01/31/2025 weekly skin observation assessment and should have. An interview was conducted on 02/20/2025 at 10:30 a.m. with S2DON. S2DON confirmed nursing staff was expected to conduct a head to toe skin assessment and document accurate findings when a weekly skin assessment was performed as ordered. S2DON confirmed when nursing staff observed a new wound or incision it should be accurately documented on the weekly skin observation assessment. S2DON confirmed Resident #1 had a new incision on the left chest wall from a loop recorder implantation on 01/24/2025. S2DON reviewed Resident #1's weekly skin observation assessment dated [DATE] and verified there was no documentation of a new incision and should have been.