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	07/01/2026

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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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure staff:Provided residents with a clean, comfortable and homelike environment for 6 of 6 (Hall 1, Hall 2, Hall 3, Hall 4, Hall 5, and Hall 6) hallway floors; Provided a clean, comfortable and homelike environment for resident's room floor for 1 (#3) of 4 sampled residents reviewed for environmental concerns; andMaintained a resident's mattress in a sanitary manner and good condition for 1 (#3) of 4 sampled residents reviewed for environmental concerns. Findings: Review of the facility's policy dated 03/2026 and titled Resident Rights Safe, Clean and Comfortable Environment revealed the following, in part:The resident has a right to a safe, clean and comfortable environment. The facility will provide a safe, clean and comfortable environment.The facility will provide housekeeping and maintenance service necessary to maintain a sanitary, orderly and comfortable interior.The facility will provide a bed in good condition.1.An observation was made on 06/29/2026 at 10:00 a.m., during a facility tour. The floors on Hall 1, Hall 2, Hall 3, Hall 4, Hall 5, and Hall 6 had multiple dry brown, black, yellow, and tan spots and multiple scuff marks scattered throughout the hallway's floors.An observation was made on 06/30/2026 at 3:00 p.m. of the floors on Hall 1, Hall 2, Hall 3, Hall 4, Hall 5, and Hall 6. There were multiple dry, brown, black, yellow, and tan spots and scuff marks scattered throughout the aforementioned hallway's floors.An interview and observation of the facility was conducted on 07/01/2026 at 5:45 p.m. with S11HKS. During the facility tour, S11HKS confirmed there were multiple dry, brown, black, yellow, and tan spots and scuff marks scattered throughout the floors on Hall 1, Hall 2, Hall 3, Hall 4, Hall 5, and Hall 6. S11HKS confirmed the hallway floors were not a clean environment for the residents and should have been.An interview and observation of the facility was conducted on 07/01/2026 at 6:00 p.m. with S1ADM. During the facility tour, S1ADM confirmed there were multiple dry, brown, black, yellow, and tan spots and scuff marks scattered throughout the floors on Hall 1, Hall 2, Hall 3, Hall 4, Hall 5, and Hall 6. S1ADM confirmed the floors were not clean and there were spots which should not have been on the floors. S1ADM further confirmed she expected staff to have mopped and cleaned the hallway floors on a routine basis at least once a day and respond to spots as needed.2.Resident #3Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Cerebral Palsy. Review of the quarterly MDS with an ARD of 04/22/2026 revealed Resident #3 had a BIMS of 00, which indicated she was severely cognitively impaired.An observation was made on 06/29/2026 at 3:25 p.m. of Resident #3's Room A. There was a large, dry, tan substance located on the floor in between the right side of the bed and the fall mat, and under the IV pole. Located on Resident #3's fall mat was another large, dry, tan substance. An observation was made on 07/01/2026 at 8:25 a.m. of Resident #3's Room A. There was a large, dry, tan substance located on the floor in between the right side of the bed and the fall mat, and under the IV pole. Located on the fall mat there was another large, dry, tan substance. An interview was conducted on 07/01/2026 at 5:45 p.m. with S11HKS. S11HKS confirmed the above observation of the two large, dry, tan substances on the floor and on the fall mat in Resident #3's Room A. S11HKS stated the substances should have been cleaned in a timely manner (continued on next page)

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	but was not.An interview and observation was conducted on 07/01/2026 at 9:00 a.m. with S1ADM. S1ADM confirmed there was a dry, tan substance on the fall mat and on the floor next the bed, which should have been cleaned up. She further confirmed she expected staff to have responded to and cleaned spills in Resident #3's room as needed.3.Review of facility's policy dated 03/2024 and titled Bed Maintenance and Inspections revealed the following, in part:Mattress inspections will be conducted upon each item entering the facility and then placed on a regularly scheduled inspection and maintenance cycle. An observation was conducted on 07/01/2026 at 8:25 a.m., of a navy blue mattress with no linen in Resident #3's Room A. The center of the mattress had a large, faded, light-blue circular discoloration, marked by multiple scattered yellow, light-green, and brown spots. A few additional brown spots are scattered across the rest of the mattress surface. The mattress had a strong foul odor and 11 small bugs were flying around the discolored spots on the mattress. The middle of the mattress curved inward and created a shallow bowl-like appearance. An interview and observation was conducted on 07/01/2026 at 8:26 a.m. in Room A with S12CNA. S12CNA confirmed the mattress was faded in the middle from where Resident #3 laid. S12CNA also confirmed the mattress had green spots in the middle, and there were small bugs flying above the mattress. S12CNA stated he removed the linen off Resident #3's mattress at 8:00 a.m. today, and he did not report the status of the mattress to anyone. He confirmed Resident #3's mattress condition was not sanitary, clean, or homelike and it should have been.An interview and observation was conducted on 07/01/2026 at 8:33 a.m. S4ADON. S4ADON entered Room A and stated she had not been made aware of Resident #3's mattress condition. She confirmed Resident #3's current mattress condition was not sanitary, clean, or homelike and it should be replaced. An interview and observation was conducted on 07/01/2026 at 9:00 a.m. with S1ADM. S1ADM entered Room A and confirmed Resident #3's mattress was not clean and there were small flying insects hovering above the mattress. S1ADM further confirmed Resident #3's mattress should have been replaced because the foam in the middle of the mattress was compressed. An interview was conducted on 07/01/2026 at 9:36 a.m. with S5IPSDC. S5IPSDC stated she went to Room A and observed Resident #3's mattress condition and confirmed the mattress smelled like old urine and the mattress needed to be replaced. S5IPSDC stated she expected the CNA's to report to the nurse if a residents' mattresses was not sanitary, unclean, uncomfortable, or not in good condition. An interview was conducted on 07/01/2026 at 10:17 a.m. with S14MD. S14MD stated he and S15MA were responsible for ordering and installing new mattresses for residents. S14MD stated if there was a request for a new mattress he expected staff to notify him or S15MA verbally or logged in the maintenance binder immediately. He stated staff had not reported to him or logged in the maintenance binder an issue with Resident #3's mattress condition until after surveyor's observation on today.An interview was conducted on 07/01/2026 at 10:40 a.m. with S15MA. S15MA stated, if there was a request for a new mattress for a resident, he expected staff to notify him or S14MA immediately. S15MA stated staff had not reported to him an issue with Resident #3's mattress condition, until after surveyor's observation on today.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident received ADL care in accordance with professional standards of practice and the comprehensive person-centered care plan for Resident 1 (#4) of 4 residents reviewed for ADL care.Findings: Review of the facility's policy dated 03/2026 and titled Quality of Life Activities of Daily Living/ Maintain Abilities revealed the following, in part:Facility provides necessary care and services to support the resident's needs. Review of Resident #4's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Generalized Muscle Weakness, Lack of Coordination, and Difficulty in Walking. Review of Resident #4's current MDS revealed she had a BIMS of 14, which indicated she was cognitively intact. Review of Resident #4's most recent Care Plan revealed the following, in part:Problem: Self-care Deficit Approaches: Toileting- totally dependent An interview was conducted on 06/30/2026 at 5:00 p.m. with Resident #4. She stated she notified a CNA she needed her soiled brief to be changed. She stated she had to sit in her soiled brief for 4 hours until she was changed by staff. She stated 4 hours was too long for her to wait to be changed. An interview was conducted on 06/30/2026 at 11:18 a.m. with S16LPN. S16LPN stated she reported Resident #4's ADL care needs to S17CNA on 06/13/2026 and informed her of Residents increase in bladder urgency requiring more frequent brief changes. S16LPN stated when she returned to work on 06/14/2026, Resident #4's brief was observed to be soiled and bed sheets were saturated with urine. An interview was conducted on 07/01/2026 at 2:18 p.m. with S17CNA. S17CNA stated she was Resident #4's assigned aide 3 weeks ago. S17CNA stated Resident #4 pressed the call light and voiced needing to be changed. S17CNA stated she forgot to return to Resident #4's room to change her because she got busy providing care to other Residents and had to respond to other call light needs. S17CNA stated Resident #4 was not changed for more than 2 hours. S17CNA stated Resident #4 should have been changed in a timely manner and was not. An interview was conducted on 07/01/2026 at 6:15p.m.with S2IDON. S2IDON stated she expected CNAs to round every 2 hours to provide incontinence care to residents. She confirmed it was not acceptable for a resident to have to wait more than 2 hours to be changed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interviews and record review the facility failed to provide the necessary treatment and services, consistent with professional standards, to promote healing and prevent the development of new pressure ulcers by failing to ensure resident's wound care was implemented as ordered for 3 (#R1, #R2, and #R3) of 8 residents reviewed for wound care management.Findings: #R1Review of Resident #R1's clinical record revealed an admission date of 08/21/2024 with diagnoses which included the following in part, Peripheral Vascular Disease, Atopic Dermatitis and Inflammatory Disorders of Scrotum. Review of Resident #R1's current physician orders revealed in part, the following:Start Date: 04/24/2025- MedCentris to evaluate and treatStart Date: 03/20/2026- Calcium Alginate-Silver External Pad 4-Apply to left groin topically every day shift every Monday, Wednesday, Friday for Abscess. Clean wound bed with wound cleaner, apply silver alginate and cover with Optilock absorbent padStart Date: 06/23/2026- Wound care steps-1-evalaute patients back and skin tears 2- cleanse wound site 3- Apply Mepilex- One time a day Review of Resident #R1's current care plan revealed in part, the following:Focus: Risk for skin breakdown r/t impaired mobility, history of wounds, dry skin Intervention/Tasks: Administer treatments as ordered and monitor for effectiveness. Notify MD for worsening or stalled wounds.Focus: R1 has a stage 3 pressure ulcer to the left gluteus Intervention/Tasks: Wound/Skin care per Physician orderFocus: The resident has MASD to sacrum and spine Review of Resident #R1's June 2026 Medication Administration Record (MAR) revealed the following:06/26/2026-assigned nurse- S8LPN, no documented evidence wound care performedOn 07/01/2026 at 11:15 a.m., an interview was conducted with S8LPN. She reviewed Resident #R1's June 2026 MAR and confirmed she was Resident #R1's assigned nurse on 06/26/2026. S8LPN confirmed Resident #R1's wound care on 06/26/2026 was not performed because she had not been provided any education on wound care management by provider. S8LPN stated she did not feel comfortable performing wound care as she feared she would lose her nursing license if she performed inadequate wound care to residents. #R2Review of Resident #R2's clinical record revealed an admission date of 09/11/2018 with diagnoses which included the following in part, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Type II Diabetes Mellitus. Review of Resident #R2's current physician orders revealed in part, the following:Start Date: 05/02/2025- MedCentris Evaluate and TreatStart Date: 05/28/2026-Collagen Matrix-Silver External Sheet 2- Apply to right buttock topically every day shift Monday, Tuesday, Thursday for Pressure 2.Clean wound bed with wound cleanser , apply silver collagen to wound bed and cover with silicone foam border. Review of Resident #R2's current care plan revealed in part, the following:Focus: Resident #R2 has a Stage 2 pressure ulcer to right gluteus r/t impaired mobility and incontinenceIntervention/Tasks: Apply wound treatment/dressing per provider orders Review of Resident #R2's June 2026 MAR revealed the following:06/04/2026 -assigned nurse- S6LPN, no documented evidence wound care performed06/11/2026-assigned nurse-S8LPN, no documented evidence wound care performed06/16/2026-assigned nurse-S6LPN, no documented evidence wound care performed06/25/2026-assigned nurse-S8LPN, no documented evidence wound care performed #R3Review of Resident #R3's clinical record revealed an admission date of 09/03/2021 with diagnoses which included the following in part, Cellulitis, Xerosis Cutis, and Rash with Other Nonspecific Skin Eruption. Review of Resident #R3's current physician orders revealed in part, the following:Start Date: 05/05/2026- Cleanse Left posterior thigh with wound cleanser, apply silver collagen to wound bed, gentian violet to peri-wound and cover with silicone foam border every day shift every Monday, Tuesday, Thursday for skin tear abrasion. Review of Resident #R3's current care plan revealed in part, the following:Focus: Resident #R3 has an abrasion to left posterior thighFocus: Resident #R3 has potential for pressure ulcer development r/t impaired mobility, incontinence, history of skin irritation Intervention/Tasks: Administer treatments as ordered and monitor for effectiveness Review of Resident #R3's June 2026 MAR revealed the following:06/04/2026 -assigned nurse- (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	S6LPN, no documented evidence wound care performed06/11/2026-assigned nurse-S8LPN, no documented evidence wound care performed06/16/2026-assigned nurse-S6LPN, no documented evidence wound care performed06/25/2026-assigned nurse-S8LPN, no documented evidence wound care performed On 07/01/2026 at 11:15 a.m., an interview was conducted with S8LPN. She reviewed Resident #2's and #R3's June 2026 MAR and confirmed she was Resident #R2's and #R3's assigned nurse on 06/11/2026 and 06/25/2026. S8LPN confirmed Resident #R2's and #R3's wound care on 06/11/2026 and 06/25/2026 was not performed because she had not been provided any education on wound care management by provider. S8LPN stated she did not feel comfortable performing wound care as she feared she would lose her nursing license if she performed inadequate wound care to residents. On 07/01/2026 at 12:15 p.m. a telephone interview was conducted with S6LPN. S6LPN confirmed she was Resident #R2's and #R3's assigned nurse on 06/04/2026 and 06/16/2026. S6LPN stated on 06/04/2026 she was unaware wound care was to be performed by floor nurse. S6LPN stated on 06/16/2026 due to the high acuity of her assigned hall, she was unable to complete daily wound care task for Resident #R2 and #R3 and reported this to oncoming shift and placed on 24 hour report sheet. S6LPN stated a blank on the Medication Administration Record meant the task wasn't completed or signed off on. On 07/01/2026 at 12:50 p.m., an interview was conducted with S3ADON. She reviewed the aforementioned June 2026 (MAR) for Resident #R1, #R2 and #R3. S3ADON stated a blank on the MAR indicated a task was not completed and signed off on. S3ADON stated if a task wasn't documented or signed off it was considered not done. S3ADON stated she expected her nursing staff to sign off on task when completed.On 07/01/2026 at 1:30 p.m., an interview was conducted with S2IDON. She reviewed the aforementioned June 2026 MAR for Resident #R1, #R2 and #R3. S2IDON stated a blank on the MAR indicated a task was not completed and signed off on. S2IDON stated if a task wasn't documented or signed off it was considered not done. S2IDON confirmed all residents should be provided the necessary treatment and services, consistent with professional standards, to promote healing and prevent the development of new pressure ulcers.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interviews the facility failed to ensure 4 (S7LPN, S8LPN, S9LPN and S10LPN) of 4 LPNs reviewed for wound care had the competencies and skill sets to provide wound care to residents. Findings: On 06/30/2026 at 9:30 a.m., an interview was conducted with S10LPN. S10LPN stated he provided wound care to his assigned Residents who required wound care management services. S10LPN stated the provider had not assessed his competencies or provided training prior to assigning residents with wound care. On 07/01/2026 at 11:15 a.m., an interview was conducted with S8LPN. She stated she had limited clinical experience due to being a recent graduate. She denied having any certifications or educational background in wound care management. She stated she did not feel comfortable providing wound care without the proper education and training. She stated the provider had not assessed her competencies or provided training prior to assigning her to complete wound care management for residents. She voiced concern that if she provided wound care incorrectly and had an adverse outcome she could lose her nursing license. On 07/01/2026 at 4:40 p.m., an interview was conducted with S7LPN. S7LPN stated she provided wound care to her assigned Residents who required wound care management services. She denied having any certifications or educational background in wound care management. S7LPN stated the provider had not assessed her competencies or provided training prior to assigning her to complete wound care management for residents. On 07/01/2026 at 5:45 p.m., an interview was conducted with S9LPN. S9LPN stated she provided wound care to her assigned Residents who required wound care management services. She denied having any certifications or educational background in wound care management. S9LPN stated the provider had not assessed her competencies or provided training prior to assigning her to complete wound care management for residents. S9LPN stated she didn't feel comfortable providing wound care to residents due to lack of education and training in wound management procedure and protocols. On 07/01/2026 at 11:10 a.m., an interview was conducted with S5IPSDC. She stated wound care responsibilities had recently been assigned to the floor nurses after the facility eliminated the wound care nurse position. She confirmed S7LPN, S8LPN, S9LPN and S10LPN were floor nurses that would be required to perform wound care. S5IPSDC stated the provider had not assessed competencies or provided training in wound care management for S7LPN, S8LPN, S9LPN and S10LPN. On 07/01/2026 at 4:10 p.m., an interview was conducted with S2IDON. She stated nursing staff were not provided education or trainings in wound care management prior to being assigned the task of performing daily wound care to assigned residents. S2IDON confirmed the provider had no competency assessments or evaluations for S7LPN, S8LPN, S9LPN and S10LPN to provide wound care management for residents.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident was free of significant medication errors by not providing medication administration in accordance with accepted professional nursing standards for 1 (#1) of 4 residents' MARs reviewed.Findings: Review of the facility's undated policy titled Job Description Licensed Practical Nurse revealed the following, in part:Pharmacy knowledge:Demonstrate a knowledge of drug reactions and sensitivities and nursing interventions. Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included, in part, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Further review revealed Resident #1's allergies included Amoxicillin. Review of Resident #1's current Physician Orders, as of 06/29/2026, revealed the following antibiotic:Start date 06/28/2026. Amoxicillin-Pot Clavulanate tab 875-125mg, 1 tab via PEG tube every 12 hours for dental infection for 7 days. Discontinued-06/30/2026.Further Review revealed the following antibiotic was added to Resident #1's medication regimen:Start Date 06/30/2026. Cephalexin Suspension Reconstituted 250 mg/5ml Give 10 ml via PEG-tube every 6 hours for infection for 7 Days. Review of Resident #1's MAR dated June 2026 revealed Amoxicillin-Pot Clavulanate tab 875-125mg antibiotic medication administered on the following dates and times:06/28/2026 at 8:00 a.m. and 8:00 p.m.; and06/29/2026 at 8:00 a.m. Review of Resident #1's Nurses Notes revealed the following, in part: Date-06/29/2026-Author- S7LPN- Resident was started on Amoxicillin 875- 125 for DX Tooth Abscess. Resident noted to have itching allergy reaction to this medication, NP was made aware of this and medication discontinued and new order for Keflex put in place for Tooth abscess. Resident's RP.called and notified . Resident had no adverse reactions throughout shift from medication. No itching or swelling or other adverse reactions noted. Resident also made aware of medication change. Respirations even and unlabored. No s/s of any respiratory distress noted. Resident remained in stable condition throughout shift . An interview was conducted on 06/30/2026 at 11:18 a.m. with S16LPN. S16LPN stated, on 06/28/2026, she gave the first Amoxicillin-Pot Clavulanate dose to Resident #1. S16LPN stated she acquired the first two doses of Amoxicillin-Pot Clavulanate out of the facility's emergency kit because the next pharmacy delivery would be Monday afternoon. S16LPN stated she did not call the doctor before she administered the Amoxicillin-Pot Clavulanate for Resident #1. She further confirmed she should have looked at Resident #1's allergies before Amoxicillin-Pot Clavulanate was administered to Resident #1 and did not. An interview was conducted on 07/01/2026 at 4:30 p.m. with S7LPN. S7LPN stated, on 06/29/2026 at 6:00 a.m., she gave Amoxicillin-Pot Clavulanate to Resident #1. S7LPN stated on 06/29/2026 the pharmacy called her and notified her of the Amoxicillin-Pot Clavulanate allergy. S7LPN stated she called the on call provider for order clarification. She stated Resident #1 had an itching reaction to the Amoxicillin-Pot Clavulanate medication. S7LPN confirmed she did not look at Resident #1's allergies before she administered the Amoxicillin-Pot Clavulanate medication, and she should have. An interview was conducted on 07/01/2026 at 1:03 p.m. with S2IDON. S2IDON confirmed she expected nursing staff to review residents' allergies before administering medication and review the electronic health record system allergy alerts to identify any discrepancies. S2IDON further confirmed when an allergy to an ordered medication is identified, she expected the nurse to call the ordering provider to clarify if the prescribed medication should be given or discontinued and to document the notification in the nurses notes.