

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Lakeshore Manor Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>Based on interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 2 (#52 and #80) residents out of a total of 21 sampled residents. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Resident #52 was coded correctly for PASRR (Pre-admission Screening and Resident Review); and 2. Resident #80 was coded correctly for discharge. <p>Findings:</p> <p>Resident #52</p> <p>Review of Resident #52's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #52's OBH-Level II Evaluation Summary & Determination Notice dated 04/22/2024 revealed under recommendations: The individual has a serious mental illness and is recommended nursing home admission.</p> <p>Review of Resident #52's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/04/2024 revealed Section A1500 PASRR: Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, was coded as 0. No.</p> <p>Section A1510 Level II PASRR conditions was blank.</p> <p>Resident #80</p> <p>Review of Resident #80's Clinical Record revealed he was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Review of Resident #80's Discharge MDS with an ARD of 05/17/2024 revealed Section A2105 Discharge Status: Short Term General Hospital.</p> <p>Review of Resident #80's Physician Orders dated 05/17/2024 included the following:</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
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Discharge home. Continue medications as ordered. Follow up with infectious disease and Primary Care Provider. Order Home health</p> <p>Review of Resident #80's Nurse's Note dated 05/17/2024 at 2:57 p.m. revealed the following, in part: Resident set to discharge this afternoon, discharge orders put in system by Nurse Practitioner. Resident will be followed and discharged with order for home health. Resident was in wheelchair and was rolled out with sister. Resident left the building. Signed, S7LPN</p> <p>On 07/09/2024 at 10:18 a.m., an interview was conducted with S5MDS. She stated she was responsible for completing resident's MDS assessments. She reviewed Resident #52's PASRR Level II dated 04/22/2024 indicating he had a serious mental illness. She reviewed Resident #52's Annual MDS with an ARD of 06/04/2024. She confirmed Section A1500 was not coded as yes and should have been. She stated Resident #80 was discharged home. She reviewed the nurse's notes and verified he was discharged home in May 2024. She reviewed Resident #80's Discharge MDS, Section A2105. She confirmed Resident #80 was coded as being discharged to the hospital and should have been coded as being discharged home.</p> <p>On 07/09/2024 at 11:52 a.m., an interview was conducted with S2DON. She reviewed the aforementioned findings and confirmed MDS assessments should be coded correctly.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912</p> <p>Based on record reviews and interviews, the facility failed implement a comprehensive person centered care plan to meet a resident's needs for 1 (#73) of 18 sampled residents reviewed in final sample. The facility failed to ensure Resident #73's laboratory results were faxed to his physician.</p> <p>Findings:</p> <p>Review of Resident #73's Clinical Record revealed he was admitted on [DATE] with diagnoses which included Malignant Neoplasm of Colon, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, and Secondary Malignant Neoplasm of Unspecified Lung.</p> <p>Review of Resident #73's current Physician Orders revealed, in part:</p> <p>05/21/2024-CBC once weekly, CMP once weekly, Iron and TIBC every 4 weeks, Ferritin every 4 weeks, CEA every 4 weeks, fax results to oncologist's office.</p> <p>Review of Residents #73's current Care plan, revealed the following:</p> <p>Onset: 04/29/2024</p> <p>Problem: The resident is receiving chemotherapy related to cancer</p> <p>Intervention: Obtain and monitor lab/ diagnostic work as ordered. Report results to MD and follow up as indicated.</p> <p>On 07/08/2024 at 12:04 p.m., a phone interview was conducted with Charge Nurse at Resident #73's oncologist office. She stated the protocol was for the facility to fax lab results prior to appointments so the physician could evaluate the lab results. She stated the facility was not faxing lab results as ordered.</p> <p>On 07/08/2024 at 3:00 p.m., an interview was conducted with S11LPN. She reviewed Resident #73's orders and confirmed Resident #73 was to have weekly and monthly labs drawn and results faxed to oncologist's office. S11LPN stated she was not sure who was responsible for faxing Resident #73's lab results as ordered.</p> <p>On 07/08/2024 at 2:06 p.m., an interview was conducted with S2DON. She stated the floor nurses were capable of faxing Resident#73's lab results to his oncologist's office, but no one person had the sole responsibility to do so. S2DON stated S10ADON was responsible for ensuring Resident #73's lab results were being faxed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/09/2024 at 10:11a.m., an interview was conducted with S10ADON. He stated he does not over see if staff faxed Resident #73's lab results to oncologist's office. S10ADON stated he usually gets a call from the oncologist's office requesting the lab results be sent over. He stated he only faxed the lab results if the oncologist's office called the facility requesting the results. S10ADON confirmed he expected staff to follow physician's orders and the lab results should have been faxed.</p> <p>On 07/09/2024 at 10:32 a.m., an interview was conducted with S1ADM. She confirmed she expected staff to follow all physician's orders.</p> <p>On 07/09/2024 at 1:04 p.m., an interview was conducted with S12NP. He stated he would expect staff to fax lab results to oncologist weekly and every 4 weeks as ordered. S12NP confirmed he expected to staff to follow all physician's orders.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>Based on record review and interviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice by failing to ensure a resident attended their scheduled follow up appointment for 1 (#74) of 2 (#73 and #74) residents reviewed for medical appointments.</p> <p>Findings:</p> <p>Review of Resident #74's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Non-ST Elevation Myocardial Infarction.</p> <p>Review of Resident #74's Admission MDS with an ARD of 05/06/2024 revealed a BIMS of 15, which indicated he was cognitively intact.</p> <p>Review of Resident #74's Hospital Discharge Orders dated 05/01/2024 revealed the following, in part:</p> <p>Discharge to Skilled Nursing Facility</p> <p>Post Op appointment on 05/21/2024 at 1:15 p.m. with cardiothoracic surgery clinic.</p> <p>Review of Resident #74's Physician Orders dated May 2024-June 2024 revealed the following, in part:</p> <p>06/11/2024-Follow up with surgeon at cardiothoracic surgery clinic.</p> <p>Review of Resident #74's Nurse's Notes dated May 2024-June 2024 revealed no evidence he attended the scheduled follow up appointment with the cardiothoracic surgeon on 05/21/2024 or 05/28/2024. Further review revealed he was admitted to a local hospital from 05/27/2024-05/29/2024.</p> <p>Review of the facility's Emergency Transfer Log revealed Resident #74 was transferred to a local hospital on 05/27/2024 and returned to the facility on [DATE].</p> <p>On 07/01/24 at 9:55 a.m., an interview was conducted with Resident #74. He stated he had a double bypass in April 2024. He stated he had not seen the cardiologist who performed his surgery for a follow up appointment.</p> <p>On 07/08/2024 at 11:47 a.m., an interview was conducted with S6WC. She stated she was responsible for scheduling resident's appointments. She stated Resident #74 had an appointment scheduled on 05/21/2024 to follow up with the cardiothoracic surgeon but he went to the hospital so she reschedule it for 05/28/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/08/2024 at 1:06 p.m., an interview was conducted with the Registered Nurse at the cardiothoracic surgeon's office. She stated Resident #74 had a follow up appointment scheduled on 05/21/2024 with the surgeon, but it was cancelled. She stated a new appointment was scheduled for 05/28/2024 and Resident #74 did not show up. She stated no further follow up appointments were scheduled for the resident.</p> <p>On 07/08/2024 at 2:08 p.m., an interview was conducted with S6WC. She reviewed the facility's Emergency Transfer Log dated May 2024 and verified Resident #74 was out of the facility on 05/28/2024 at the hospital, and was not in the hospital on 05/21/2024. She stated she did not know why she rescheduled his appointment from 05/21/2024 to 05/28/2024. She stated when a resident missed a follow up appointment due to being hospitalized, she rescheduled it when the resident returned to the facility. She stated she should have rescheduled the follow up appointment after Resident #74 returned from the hospital and did not. She reviewed the physician order placed on 06/11/2024 to make a follow up appointment with the cardiothoracic surgeon. She stated she was unaware of the order. She reviewed her appointment book and confirmed she did not schedule an appointment for Resident #74 to see the cardiothoracic surgeon after the order was placed on 06/11/2024.</p> <p>On 07/08/2024 at 2:25 p.m., an interview was conducted with S2DON. She stated S6WC was responsible for making resident's medical appointments. She reviewed Resident #74's discharge papers from the hospital dated 05/01/2024 and verified he had a post-operative appointment scheduled on 05/21/2024. She was notified the appointment was rescheduled to 05/28/2024. She reviewed the facility's May 2024 Emergency Transfer Log and verified Resident #74 was at the hospital on 05/28/2024. She confirmed a follow up surgical appointment should have been made when Resident #74 returned from the hospital. She was notified of the physician order placed on 06/11/2024 to make Resident #74 a follow up appointment with the cardiothoracic surgeon. She confirmed the appointment should have been made when the order was placed.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>46981</p> <p>Based on observation, interviews, and record review, the facility failed to ensure nurse staffing data was posted daily in a prominent location readily accessible to residents and visitors. This deficient practice had the potential to affect any of the 80 residents residing in the facility.</p> <p>Findings:</p> <p>Review of the facility's policy dated 03/2023 and titled Posted Nurse Staffing Information revealed in part, the following:</p> <p>Policy: At the beginning of each shift, on a daily basis, the facility will post:</p> <ol style="list-style-type: none"> 1. The facility name 2. The current date 3. The total number and the actual hours worked 4. Resident census <p>Guidelines:</p> <ol style="list-style-type: none"> 1. The information posted will be up to date and current. <p>An observation was made on 07/01/2024 at 10:00 a.m. of the facility. No staffing data sheets observed.</p> <p>An interview was conducted on 07/01/2024 at 10:05 a.m. with S16HR. She stated she was responsible for posting staffing data sheets. She stated the last daily staffing data sheet completed was 06/27/2024.</p> <p>An interview was conducted on 07/01/2024 at 10:06 a.m. with S1ADM. She stated the last daily staffing data sheet completed was 06/27/2024.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>46981</p> <p>Based on record review, observations, and interviews, the facility failed to provide pharmaceutical services, including procedures that assure the dispensing and administering of all drugs and biologicals, to meet the needs of each resident. The facility failed to ensure insulin pen needles were primed prior to administration of insulin per manufactures guidelines for 2 (#17 and #42) of 3 (#17, #42, and #48) residents observed for insulin administration.</p> <p>Findings:</p> <p>Review of the facility's policy titled Pharmacy Services Medication Administration dated 03/2023, revealed the following, in part:</p> <p>2. Medications will be prepared and administered in accordance with:</p> <p>b. Manufacturer's specifications.</p> <p>Review of the insulin lispro's manufacturer insert revealed the following, in part:</p> <p>Preparing your Pen:</p> <p>Step 4: Push the capped needle straight onto the pen and twist the needle on until it is tight.</p> <p>Priming your Pen: Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.</p> <p>Step 6: To prime your pen, turn the dose knob to select 2 units.</p> <p>Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top.</p> <p>Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly.</p> <p>Review of the insulin aspart's manufacturer insert revealed the following, in part:</p> <p>Preparing your pen:</p> <p>B. Attaching the needle:</p> <p>Giving the airshot before each injection:</p> <p>Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. Turn the dose selector to select 2 units.</p> <p>F. Hold your pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.</p> <p>G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0.</p> <p>Resident #17</p> <p>Review of Resident #17's current Physician Orders revealed, in part, an order for insulin lispro subcutaneous solution pen-injector 100 unit/mL, inject 19 units subcutaneously before meals.</p> <p>On 07/02/2024 at 11:30 a.m., an observation was made of S9LPN preparing and administering Resident #17's insulin lispro. S9LPN dialed up 19 units of insulin lispro. S9LPN did not prime the insulin pen needle prior to administering insulin to Resident #17.</p> <p>On 07/02/2024 at 11:35 a.m., an interview was conducted with S9LPN. S9LPN confirmed she did not prime the insulin pen needle prior to dialing the insulin dose. S9LPN stated priming the insulin pen needle was not required.</p> <p>Resident #42</p> <p>Review of Resident #42's current Physician Orders revealed, in part, an order for insulin aspart solution 100 unit/mL subcutaneous per sliding scale before meals and an order for insulin aspart solution 100 unit/mL, inject 3 units subcutaneously every 4 hours.</p> <p>On 07/09/2024 at 11:20 a.m., an observation was made of S15LPN preparing and administering Resident #42's insulin aspart. S15LPN dialed up 5 units of insulin aspart. S15LPN did not prime the insulin pen needle prior to administering insulin to Resident #42.</p> <p>On 07/09/2024 at 11:22 a.m., an interview was conducted with S15LPN. S15LPN stated Resident #42 required a total of 5 units of insulin due to sliding scale and scheduled insulin. S15LPN confirmed she did not prime the insulin pen needle prior to dialing the insulin dose. S15LPN stated priming the insulin pen needle was not required.</p> <p>On 07/09/2024 at 12:02 p.m., an interview was conducted with S2DON. She reviewed both insulin pen needle manufactures inserts and confirmed both insulin pen needles required a priming of 2 units of insulin into the needle prior to administering the appropriate amount of insulin.</p> <p>47173</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912</p> <p>Based on record review, observations, and interviews, the facility failed to ensure drugs were stored and labeled properly in accordance with current accepted professional principles. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Insulin pens containing multiple doses of insulin were clearly labeled with resident's name and other identifiers to verify the correct pen was used on the correct resident and an open date in 1(Med Cart C) of 3 medication carts (Med Cart A, B, and C) reviewed; 2. Multi-dose vial medications were discarded within 28 days of opening on 2 (Med Carts B and Med Cart C) of 3 medication carts (Med Cart A, B, and C) reviewed; 3. Insulin pens containing multiple doses of insulin were clearly labeled with resident's name, other identifiers, and an open date in 1(Med room [ROOM NUMBER]) of 1 medication room's refrigerator reviewed; and 4. Med Cart B was clean and free of loose pills in 1(Med Cart B) of 3 medication carts (Med Cart A, B, and C) reviewed. <p>Findings:</p> <p>Review of the facility's policy titled Labeling and Storage of Drugs and Biologicals, dated ,d+[DATE] revealed, in part, the following:</p> <p>Policy: Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>Guidelines:</p> <ol style="list-style-type: none"> 4. Medication labeling and biologicals dispensed by the pharmacy must be consistent with applicable federal and state requirements and currently accepted pharmaceutical principles and practices. 8. If a multi-dose vial has been opened or accessed (e.g., needle punctured), the vial should be dated and discarded within 28 days. <ol style="list-style-type: none"> 1. <p>On [DATE] at 11:00 a.m., an observation was made of Med Cart C with S9LPN, which revealed the following:</p> <p>2-Novolog Flex Pens were opened and unlabeled.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1-Lantus insulin pen was opened and unlabeled.</p> <p>On [DATE] at 11:01 a.m., an interview was conducted with S9LPN. She stated some insulin pens come with labels and some do not. S9LPN confirmed all insulin pens should be labeled by pharmacy, dated when opened, and were not.</p> <p>2.</p> <p>On [DATE] at 11:00 a.m., an observation was made of Med Cart C with S9LPN, which revealed the following:</p> <p>1-vial of Lispro insulin was opened with an open date of [DATE].</p> <p>On [DATE] at 11:01 a.m., an interview was conducted with S9LPN. She confirmed insulin multi-dose vials expired 28 days after opening, and this vial should have been discarded.</p> <p>On [DATE] at 11:10 a.m., an observation was made of Review of Med Cart B with S8LPN, which revealed the following:</p> <p>1-vial of Lantus insulin was opened and with an open date of [DATE].</p> <p>On [DATE] at 11:11 a.m., an interview was conducted with S8LPN. She confirmed insulin multi-dose vials expired 28 days after opening, and this vial should have been discarded.</p> <p>3.</p> <p>On [DATE] at 10:30 a.m., an observation was made of Med room [ROOM NUMBER] with S10ADON, which revealed the following:</p> <p>1-Novolog Flex Pen opened, unlabeled, and undated.</p> <p>On [DATE] at 10:45 a.m., an interview was conducted with S10ADON. He confirmed insulin multi-dose vials expired 28 days after opening. He confirmed insulin pens should have a label and an open date. S10ADON confirmed the Novolog Flex Pen should have had a label and an open date, and it did not.</p> <p>4.</p> <p>On [DATE] at 11:10 a.m., an observation was made of Review of Med Cart B with S8LPN, which revealed the following:</p> <p>1-Oblong blue colored capsule loose in cart.</p> <p>1-Round peach colored tablet loose in cart.</p> <p>On [DATE] at 11:11 a.m., an interview was conducted with S8LPN. She confirmed both medications were loose in cart and should not have been.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lakeshore Manor Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 1:34 p.m., an interview was conducted with S2DON. She stated that multi-dose vials expired 28 days after opening. She confirmed the vials of insulin should have been removed. She stated insulin pens should be labeled with the resident's name. S2DON confirmed there should not be any loose pills on the medication carts.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>Based on record review, observation, and interviews the facility failed to provide food that accommodated the resident's food preference for 1 (#26) of 2 (#26 and #73) of residents reviewed for food accommodations/preference.</p> <p>Findings:</p> <p>Review of Resident #26's clinical record revealed he was admitted to the facility on [DATE].</p> <p>Review of Resident #26's Quarterly Minimum Data Set with an Assessment Reference Date of 04/30/2024 revealed a BIMS of 15, which indicated he was cognitively intact.</p> <p>On 07/01/2024 at 9:29 a.m., an interview was conducted with Resident #26. Resident #26 stated an employee spoke with him a few weeks ago about food preferences. He stated he could not recall the name of the employee. Resident #26 stated he requested chef salads every Monday, Wednesday, and Friday for supper and had not received them.</p> <p>On 07/01/2024 at 4:55 p.m., an observation was made of Resident #26's supper tray. Resident #26 was served chicken tenders and French fries. An observation was made of Resident #26's supper meal ticket dated Monday, July 1, 2024. It read, Prefers: No preferences.</p> <p>On 07/02/2024 at 8:42 a.m., an interview was conducted with S4RDM. She confirmed Resident #26 food preference was chef salads every Monday, Wednesday, and Friday. S4RDM was presented with the observation of Residents #26 supper tray and meal ticket on 07/01/2024. She confirmed Resident #26 should have received a chef salad on 07/01/2024 and he did not.</p> <p>On 07/08/2024 at 3:43 p.m., an interview was conducted with S1ADM. She stated when the dietary manager assessed the residents quarterly for food preferences, they should enter the information into the system so it transferred to their meal ticket. She was notified of the aforementioned findings. She confirmed if a resident had a food preference, the dietary manager should have transferred the information to the meal ticket so kitchen staff could have accommodated the preference. She confirmed Resident #26 should have received a chef salad on 07/01/2024.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a resident received the correct food portions and snacks as ordered by a physician for 1 (#73) of 18 sampled residents reviewed in final sample.</p> <p>Findings:</p> <p>Review of Resident #73's Clinical Record revealed he was admitted on [DATE] with diagnoses which included Malignant Neoplasm of Colon, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, and Secondary Malignant Neoplasm of Unspecified Lung.</p> <p>Review of the current Physician Orders revealed, in part:</p> <p>Start date 04/19/2024-Regular / NAS diet, regular texture, thin consistency, recommend snacks BID between meals for weight stability. Double portions with all meals for increased kilocalorie and protein.</p> <p>Review of the most recent Care Plan revealed, in part:</p> <p>Onset: 04/13/2024</p> <p>Problem: NAS Regular Diet-At risk for weight loss related to diagnosis of cancer</p> <p>Intervention: Provide, serve diet as ordered.</p> <p>Review of the facility's Diet Type Report dated 07/08/2024 revealed, in part:</p> <p>Resident #73, Regular/NAS Diet, regular texture, additional directions: recommend snacks BID between meals for weight stability. Double portions with all meals for increased kilocalorie and protein.</p> <p>On 07/02/2024 at 8:05 a.m., an observation was made of Resident #73's breakfast tray. The tray did not contain double portions.</p> <p>Review of Resident #73's dietary slip dated 07/02/2024 read regular portion.</p> <p>On 07/08/2024 at 10:52 a.m., an interview was conducted with Resident #73. He stated he did not receive snacks twice a day.</p> <p>On 07/08/2024 at 3:00 p.m., an interview was conducted with S11LPN. She stated S10ADON was responsible for dietary orders. S11LPN stated she was not aware Resident #73 had an order for BID snacks between meals, and Resident #73 had not received them and should have.</p> <p>On 07/09/2024 at 10:08 a.m., an interview was conducted with S13CNA. She stated Resident #73 received regular portions. She stated Resident #73 did not receive BID snacks.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/08/2024 at 10:15 a.m., a telephone interview was conducted with S14RD. She stated nutritional interventions are communicated to the staff via a discussion with the NP, DON, or ADON. She stated she sent recommendations at the end of the day via spread sheet to MDS, DON, ADON, and ADM. She stated her last visit for Resident #73 was on 06/28/2024, and she recommended BID snacks between meals and double portion meals. S14RD confirmed she would expect the dietary slip to read double portions as ordered and for the resident to receive BID snacks.</p> <p>On 07/08/2024 at 1:56 p.m., an interview was conducted with S4RDM. She stated any changes to dietary recommendations should be documented in the electronic system by the nurses. S4RDM reviewed Resident #73's dietary orders and stated S14RD made changes to Resident #73's diet on 06/28/2024 which included snacks BID between meals for weight stability and double portions with all meals for increased kilocalorie and protein. S4RDM reviewed Resident #73's dietary slip and confirmed the dietary slip read regular portion and should have read double portions. S4RDM stated kitchen staff were responsible for supplying BID snacks between meals and had not been.</p> <p>On 07/08/2024 at 2:06 p.m., an interview was conducted with S2DON. She stated the protocol for dietary recommendations was for S14RD to make the recommendations, the recommendations were then reviewed by MD/NP, and S10ADON was then responsible for inputting orders into the computer and communicating changes with the dietary department.</p> <p>On 07/08/2024 at 2:31 p.m., an interview was conducted with S10ADON. He stated the protocol for dietary recommendations was S14RD emailed the recommendations, the NP acknowledged in agreement with the recommendations, and he was then responsible for inputting orders into the computer and communicating changes with the dietary department.</p> <p>On 07/09/2024 at 1:04 p.m., an interview was conducted with S12NP. He stated the protocol when S14RD made dietary recommendations was for the orders to be changed in the computer and changes communicated with the dietary department. S12NP confirmed he expected staff to follow the dietary recommendations and physician's order.</p> <p>On 07/09/2024 at 10:32 a.m., an interview was conducted with S1ADM. She stated she expected staff to follow all physician's orders. S1ADM confirmed she expected staff to follow all therapeutic diet orders.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981</p> <p>Based on observations, interviews, and record review, the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies for 1 of 1 (Med room [ROOM NUMBER]) medication storage room and 2 (Med Cart B and Med Cart C) of 3 (Med Cart A, Med Cart B, and Med Cart C) medication carts reviewed for medication storage.</p> <p>This had the potential to affect the 19 residents who received insulin in the facility.</p> <p>Findings:</p> <p>Review of facility's Plan of Action/Continuous Quality Improvement, dated [DATE], revealed, in part, the following:</p> <p>Problem Area Identified: Medication storage.</p> <p>Actions: S2DON or designee to audit medication storage rooms and medication carts once weekly for 8 weeks, then monthly thereafter.</p> <p>Review of the facility's Medication Storage Room and Medication Cart Audit Logs, dated [DATE] revealed no audit was conducted on [DATE].</p> <p>An observation made on [DATE] at 11:00 a.m. of Med Cart C with S9LPN revealed the following:</p> <p>2-Novolog Flex Pens opened, unlabeled, and undated.</p> <p>1-Lantus insulin pen opened, unlabeled, and undated.</p> <p>An interview was conducted on [DATE] at 11:01 a.m. with S9LPN. She confirmed multi-dose insulin pens expired 28 days after opening, and the aforementioned pens should have been discarded.</p> <p>An observation made on [DATE] at 11:10 a.m. of Med Cart B with S8LPN revealed the following:</p> <p>1-vial of Lantus insulin opened, with an open date of [DATE].</p> <p>An interview was conducted on [DATE] at 11:11 a.m. with S8LPN. She confirmed multi-dose insulin vials expired 28 days after opening, and the aforementioned vial should have been discarded.</p> <p>An observation made on [DATE] at 10:30 a.m. of Med room [ROOM NUMBER] with S10ADON revealed the following:</p> <p>1-Novolog Flex Pen opened, unlabeled, and undated.</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on [DATE] at 10:45 a.m. with S10ADON. He confirmed multi-dose insulin vials expired 28 days after opening. He confirmed insulin pens should have a label and an open date. S10ADON confirmed the aforementioned Novolog Flex Pen should have been labeled and dated, and was not.</p> <p>An interview was conducted on [DATE] at 12:47 p.m. with S2DON. She stated medication storage was being audited once a week on Sundays for 8 weeks, then monthly thereafter. She confirmed the audit for [DATE] was missed resulting in expired and unlabeled insulin being available for resident use in medication carts and in the medication storage room. She confirmed their QA/QAPI system had not been effective.</p> <p>An interview was conducted on [DATE] at 12:48 p.m. with S1ADM. She stated medication storage was being audited once a week on Sundays for 8 weeks, then monthly thereafter. She confirmed the audit for [DATE] was missed resulting in expired and unlabeled insulin being available for resident use in medication carts and in the medication storage room.</p>