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	01/12/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44615 Based on observations, interviews, and record review the facility failed to ensure a resident received services with reasonable accommodation of needs as evidenced by the facility failing to have a call pad within reach for 1 (#53) of 23 sampled residents reviewed in the final sample. Findings: Review of facility's policy titled Physical Environment Resident Call System revealed, in part, the following: Purpose: To provide residents with a means to directly contact caregivers from their room. Guidelines: 3. The call system will be accessible to residents while in bed or other sleeping accommodations within the resident room, and to a resident when lying on the floor. Review of Resident #53's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction with Right-Sided Hemiplegia. Review of Resident #53's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/06/2024 indicated resident had a Brief Interview of Mental Status (BIMS) of 11, which indicated resident is moderate cognitively intact. Further review revealed, Resident #53 required total dependence with transfers, repositioning and activities of daily living (ADLs). Section B (ability to understand), usually understands. Review of Resident #53's current Care Plan revealed the following, in part: Problem: Requires assistance with adl's due to Cerebrovascular Accident (CVA) with hemiplegia Interventions: Bed Mobility: is totally dependent on staff for repositioning and turning in bed, Ensure call light within reach. Focus: Resident #53 able to move left hand and able to use call light when asked. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation/interview was made on 01/06/2025 at 10:50 a.m. of Resident #53 lying in bed. The call assist pad was on bed at upper left shoulder area and out of Resident #53's reach. Resident #53 stated she could not reach the call pad. Resident #53 stated she is able to use the call pad when it is within her reach. Resident #53 immediately reached for the call pad and her eyes widened. Resident #53 pressed call pad with her left hand at this time to demonstrate she knew how to use the call pad. An observation was made on 01/06/2025 at 02:18 p.m. of call assist pad hanging down, off of left side of bed edge, toward floor. Resident # 53 unable to reach call pad. An observation was made on 01/07/2025 at 10:14 a.m. of Resident #53 lying in bed. The call pad was behind Resident #53's head, toward top of bed, and not within resident's reach. Resident #53 stated she did not know where her call pad was. An interview/observation was conducted on 01/07/2025 at 10:15 a.m. with S14CNA when she entered into Resident #53's room. S14CNA stated Resident #53 required call pad and was able to activate for assistance. She further stated call pad had to be placed in reachable position, which was mid chest area so she could reach it with her left hand. S14CNA verified that call pad was not left in proper position for Resident #53. S14CNA verified call pad cord was wrapped around bed rail and call pad should not have been at top of bed near Resident's head. An observation was made on 01/08/2025 at 1:30 p.m. of Resident # 53 supine in bed and call pad hanging down on left side of bed, not within reach. An interview was conducted with S2DON on 01/08/25 1:40 p.m. She stated that all Residents should have call pad or button within reach at all times. S2DON and Surveyor then entered into Resident #53's room and observed her soft touch call pad was not within Resident's reach. S2DON asked Resident #53 where she liked her call pad placed and Resident #53 touched her mid chest area. S2DON confirmed that the call pad was not within Resident #53's reach and it 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50093 Based on interviews and record reviews, the facility failed to protect a resident's right to be free from sexual and psychosocial abuse for 1(#33) of 12 (#13, #14, #24, #31, #33, #61, #74, #77, #190, #191, #192, and #193) residents reviewed for sexual and psychosocial abuse. The facility failed to ensure Resident #33 was not sexually abused by S5MAIN. This deficient practice resulted in an Immediate Jeopardy (IJ) situation for Resident #33, a cognitively impaired blind resident, on 01/08/2025, when it was discovered that during the Christmas/New Year Holiday Season, S8CNA witnessed S5MAIN sitting on Resident #33's bed, rubbing the resident's shoulder, and kissed her on the cheek. S8CNA failed to report the sexual abuse and S5MAIN continued to work in the facility until 01/02/2025 at 5:00 p.m. On 01/05/2025, #R1 reported S5MAIN sat down next to Resident #33 on her bed, rubbed Resident #33's back and arm, kissed her cheek and neck and said he wanted to see her beautiful cat again. As a result of the investigation, despite there not being a significant decline in mental or physical functioning for Resident #33, it could be determined the reasonable person would have experienced severe psychosocial harm as a result of the sexual abuse, since a reasonable person would not expect to be treated in this manner in their own home or a health care facility. S1ADMIN was notified of the Immediate Jeopardy situation on 01/10/2025 at 6:09 p.m. The Immediate Jeopardy situation was removed on 01/12/2025 at 2:15 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The deficient practice continued at the potential for more than minimal harm for the remaining 92 residents residing in the facility. Findings: Review of the facility policy titled Abuse, with a revision date of 05/15/2023, revealed the following, in part: Intent: To promote a safe environment for residents, visitors, and employees through prompt and appropriate response and follow up to abuse allegations and events. Definitions: Sexual Abuse: Non-consensual sexual contact of any type with a resident. Responsibilities of Facilities and Covered Individuals 2. The facility will immediately protect the resident from further potential abuse while the investigation is in progress. This includes: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Removing employee/s from duty when an allegation has been made until the investigation has been completed and a determination has been made. c. Implementing increased supervision as necessary for alleged perpetrator and alleged victim. d. Conducting interviews with other residents and staff. e. Monitoring the alleged victim and intervening as appropriate, for indications of physical injury, pain, or psychosocial distress. Review of Resident #33's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following cerebral infarction affecting the left non-dominant side, Unspecified Dementia, Difficulty in Walking, Cognitive Communication Deficit and Legal Blindness. Review of Resident #33's Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 08/01/2024 revealed Resident #33 had a Brief Interview for Mental Status (BIMS) of 08, which indicated the resident had moderate cognitive impairment. Review of Resident #33's current Care Plan revealed the resident was blind, cognitively impaired with a BIMS of 8, and required assistance with ADLS to include transfer assistance and a wheelchair for mobility. On 01/06/2025 review of the facility's self-reported incident dated 01/05/2025 at 9:59 p.m. revealed: Resident Victim: Resident #33 Accused: S5MAIN Accused Allegations: Sexual Abuse Incident Description: #R1 told S6CNA that she saw S5MAIN kissing her roommate (Resident #33) on the forehead and the cheek. She says that she overheard S5MAIN tell Resident #33 he could see her cat when she was walking naked in the hallway. Review of #R1's witness statement revealed the following, in part: On 01/03/2025, Friday, at approximately 4:30 p.m., S5MAIN sat on Resident #33's bed, began to rub her back and arm and began peck kissing her left cheek. S5MAIN whispered to Resident #33. He told her how beautiful she was, and he had seen her cat (vagina) the other day when she was running down the hall. He told Resident #33 that her cat was special. I spoke up and told him he needed to get out then closed my curtain because was disgusting and unacceptable. Before he left the room he told Resident #33 he would bring her more coffee. Review of S20LPN's witness statement dated 01/05/2025 at 9:00 p.m. and 9:15 p.m. revealed the following, in part: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Performed complete head to toe body audit on Resident #33. No markings, scratching, soreness noted. No pain or discomfort. Resident #33 does not recall anything. Review of S5MAIN witness statement dated 01/06/2025 revealed the following, in part: I don't really remember, but I was having a conversation about my and Resident 33's meeting when she was in the hall outside of her room with her cat hanging out. Her words not mine. Just kind of introducing her to her new roommate describing what a special Resident #33 was. I then gave Resident #33 a kiss on her head. I think she wasn't feel well that day and I had no coffee to get her. On 01/07/2024 at 9:00 a.m., an interview was conducted with S1ADMIN. S1ADMIN stated on 01/05/2025, #R1 reported to S6CNA that she had witnessed S5MAIN kissing Resident #33. #R1 reported S5MAIN was heard telling Resident #33 he had seen her cat when she was walking naked. Review of S5MAIN's personnel file revealed he began working in the facility on 09/30/2024. On 01/07/2024 at 9:54 a.m. an interview was conducted with Resident #33. Resident #33 stated she could not see. The resident was oriented to person, but was unable to answer questions due to cognitive impairment. During the interview, Resident #33 repeatedly stated she liked and wanted coffee. Resident #33 was unable to recall if anyone had kissed or touched her inappropriately. On 01/07/2025 at 10:20 a.m. an interview was conducted with #R1. #R1 reported Resident #33 was her roommate. #R1 said Resident #33 could not see, had dementia and did not always know what was going on, and always wanted coffee. #R1 stated approximately a week ago, she was in her room in bed when S5MAIN came into the room with a handheld drill. #R1 stated Resident #33 was asleep in bed. The resident stated S5MAIN walked over to Resident #33's bed, tried to wake her up by whispering to her and rubbing her back and arm. #R1 stated S5MAIN kissed Resident #33's left cheek. She stated S5MAIN woke Resident #33 up and asked her if she wanted coffee, then left the room and returned with a cup of coffee that he gave to Resident #33. She stated S5MAIN sat down next to Resident #33 on her bed, began to rub Resident #33's back and arm, and again kissed her on the cheek and the neck. #R1 stated other staff members witnessed S5MAIN sitting on Resident #33's bed. #R1 stated she heard S5MAIN tell Resident #33 he wanted to see her beautiful cat again, and that he had seen her beautiful cat while she was naked in the hall. #R1 stated Resident #33 seemed to be in shock and asked S5MAIN to move over and said to S5MAIN he shouldn't be sitting on her bed. She said Resident #33 told S5MAIN to give her some space. #R1 said S5MAIN told Resident #33 he was going to come back later. She stated she was scared to report the incident and waited until one of the CNA's she trusted returned to work. #R1 said she reported the incident to S6CNA with another staff member present on 01/05/2025. #R1 said after she reported it the other staff member stated another one. Review of #R1's MDS with an ARD of 12/26/2024 revealed the resident was admitted to the facility on [DATE] and had a BIMS of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 01/07/2025 at 12:01 p.m. with S6CNA. She stated on 01/05/2025, #R1 reported to her that approximately a week ago, she was in her room in bed when S5MAIN came into the room. She stated #R1 reported S5MAIN walked over to Resident #33's bed, leaned over Resident #33, rubbed her arm and back, kissed her, and asked her if she wanted coffee. S6CNA stated #R1 reported she heard S5MAIN tell Resident #33 he had seen her cat meaning vagina. S6CNA stated she told S4LPN about what #R1 reported. S4LPN responded that she should have reported what S5MAIN had done to her sooner because if she had S5MAIN would not have been able to do this to Resident #33. S6CNA explained S5MAIN was suspended last week for pulling S4LPN's pants down without consent while on duty. S6CNA stated after speaking with S4LPN, she reported the incident to S3RN. A telephone interview was conducted on 01/07/2025 at 12:32 p.m. with S5MAIN. S5MAIN stated Resident #33 liked coffee and he would sometimes bring her some in her room and at other times would go visit her in her room. S5MAIN said he went into Resident #33's room sometime around Christmas, to tell her merry Christmas. He also stated he went into the Residents room recently to welcome #R1 to the facility. He stated the last time he went into the room, Resident #33's roommate was awake and in the room. He confirmed he sat on the residents' bed while she was in it and kissed the resident on the forehead and again on her cheek. He said he thought it was appropriate to kiss Resident #33 because they had developed a close relationship. S5MAIN stated he told #R1 that he had seen her in the hallway when she was only wearing a shirt. He stated Resident #33 asked him if he had never seen a cat before. S5MAIN stated after speaking with the resident he kissed her again on the forehead and the cheek. S5MAIN stated he was suspended from the facility on 01/02/2025 and refused to speak about why. On 01/07/2025 at 1:30 p.m., an interview was conducted with S4LPN. S4LPN said on 12/10/2024, S5MAIN followed her into her office, S5MAIN closed and locked the office door, advanced towards her from behind, pulled her pants down and touched her inappropriately with his hand on her buttocks. She stated she did not report the incident to anyone at the facility because she was scared. S4LPN said on 01/01/2025, S5MAIN came into her office again and said I know there isn't anybody here today and I want to look at your hole in what she perceived as a sexually suggestive tone, raising his eyebrow, and leaning towards her. He began to tell her what he wanted to do to her hole which made her feel uncomfortable and scared so she ran out of the room. She said after she ran out of the room, she reported both the 12/10/2024 and 01/01/2025 incidents with S5MAIN to S2DON on 01/01/2025. She said S2DON began monitoring S5MAIN to make sure nothing else happened to staff or residents. S4LPN stated on 01/02/2025, S1ADMIN was notified of the 12/10/2024 and 01/01/2025 incidents, and S5MAIN was suspended. S4LPN stated she should have reported the 12/10/2024 incident immediately to S2DON and S1ADMIN, but did not. Throughout the interview, S4LPN was observed to become tearful and stated S5MAIN would not have been able to hurt Resident #33 if she had told S2DON or S1ADMIN what happened on 12/10/2024. S4LPN stated she received abuse training within the last 90 days, but not after 01/01/2025. An interview was conducted on 01/07/2025 at 3:56 p.m. with S7CNA. He stated a few weeks ago, S4LPN reported to him that S5MAIN made a physical sexual advance towards her. S7CNA also stated that S8CNA recently told him she saw S5MAIN sitting on Resident #33's bed, talking to her and making inappropriate sexual statements. S7CNA stated on 01/05/2025, #R1 told him she had witnessed S5MAIN sitting on Resident #33's bed, talking to her and making inappropriate sexual statements. S7CNA stated it was not appropriate for S5MAIN to sit on Resident #33's bed and make inappropriate sexual comments to the resident. He stated other employees said S5MAIN exhibited weird behaviors, but he did not know what that meant. S7CNA said he never reported anything to his supervisor or the administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 01/08/2025 at 1:13 p.m. with Resident #33's sister. She stated Resident #33 had dementia and was not cognitively intact. She stated she was notified of an incident involving Resident #33 and a worker at the facility on 01/05/2025. She stated an employee of the facility told her a male worker kissed Resident #33 on her jaw and inappropriately touched/stroked her back and arm with his hands. She stated Resident #33 would not want an unknown male kissing and touching her. She stated, if Resident #33 had all her cognitive abilities, the resident would have suffered serious psychosocial harm from the male staff kissing and touching her while in her bed. She stated Resident #33 wouldn't want that person near her and would have been fearful. On 01/08/2024 at 2:24 p.m., an interview was conducted with S18LPN. She stated she was familiar with Resident #33. She stated Resident #33 was confused at baseline and would have different levels of confusion at different times. On 01/08/2024 at 2:28p.m., an interview was conducted with S19LPN. She stated she was familiar with Resident #33. She stated Resident #33 was confused at baseline and would have different levels of confusion at different times. On 01/08/2025 at 2:40 p.m., and interview was conducted with S8CNA. She stated at some time between Christmas and New Year's Day she was checking on the residents and saw S5MAIN in Resident #33's room. She stated she saw S5MAIN bring Resident #33 a cup of coffee. She stated S5MAIN sat on Resident #33's bed, talked to her, rubbed the resident's shoulder with his hand, and then kissed her on the cheek. S8CNA stated she could not hear what S5MAIN was saying. S8CNA stated #R1 was in the room. S8CNA stated she thought it was strange that someone from the maintenance department was that chummy with a resident. She stated she had seen S5MAIN in Resident #33's room before, but she had not seen him sitting on the bed before. She stated the observation made her feel uncomfortable and she thought it was inappropriate. She stated she did not report the incident to administration and thought she would have if it happened again. She stated she did communicate what she saw with another CNA. She confirmed she was trained on abuse prior to the incident and confirmed she should have reported what she saw because it was sexual abuse. An interview was conducted on 01/10/2025 at 1:36 p.m. with S2DON. S2DON said on 01/01/2025, S4LPN accused S5MAIN of sexual assaulting her. She stated after S4LPN reported the accusation of sexual assault, she began visually monitoring S5MAIN to make sure nothing happened to any of the staff or residents. S2DON stated S5MAIN's behavior was somewhat weird and quirky, and after a few hours of monitoring him, she told him he could leave for the day. She stated she did not monitor to see if S5MAIN actually left the facility. She stated on 01/02/2025, she reported the allegation to the administrator and S5MAIN was removed from the facility. S2DON said Resident #33 had a BIMS of 8 and had cognitive impairment. S2DON stated on 01/05/2025, around 6:00 p.m., S3RN reported #R1 had witnessed S5MAIN in her room with Resident #33. #R1 reported S5MAIN kissed Resident #33's forehead and cheek, rubbed Resident #33's arm and back, and made sexually inappropriate comments to Resident #33. S2DON stated she immediately contacted S1ADMIN and the Regional Director of Clinical. She reported, after S3RN reported S5MAIN had allegedly sexually abused Resident #33, the facility began an investigation to include interviewing #R1 and S20LPN completed a body audit on Resident #33. She stated Resident #33 was interviewed and unable to state if someone had sexually abused her, but the DON said due to Resident #33's cognitive impairment, she would not take her word. She stated the police were not notified. S2DON stated she did not know any of the facility staff had witnessed the incident and confirmed the staff that witnessed it should have immediately reported it so Resident #33 could have been protected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 01/10/2025 at 2:30 p.m. with S1ADMIN. S1ADMIN said Resident #33 had dementia. S1ADMIN stated on 01/05/2025, around 7:00 p.m., S2DON told him #R1 reported she witnessed S5MAIN kiss Resident #33 on the forehead and heard S5MAIN make an inappropriate comment to Resident #33 about her cat. S1ADMIN stated he notified the Regional Administration and the facility began an investigation to include interviewing all cognitive female residents. S1ADMIN stated S5MAIN told him a few weeks ago he had seen Resident #33 naked in the hallway. S5MAIN explained he was in #R1 and Resident #33's room recently and spoke to them about seeing Resident #33 naked. He stated S5MAIN said after he spoke to the residents he left the room and kissed Resident #33 on her forehead while leaving. S1ADMIN stated S5MAIN was suspended from work on 01/02/2025 and left the facility sometime in the late afternoon or early evening. S1ADMIN stated he was not aware an employee had witnessed the incident between S5MAIN and Resident #33 and had not reported it. S1ADMIN stated he had not reported the incident to police because he did not think it involved inappropriate touching. Review of the Individual Employee Time Card revealed on 01/02/2024 S5MAIN clocked in to work at 8:30 a. m. and out at 5:00 p.m. Review of Both S5MAIN and S8CNA's Individual Employee Time Cards revealed the employees were both in the facility on the following dates and times. 12/31 from 3:09 p.m. too 5:15 p.m. 1/1 from 3:09 p.m. to 5:27 p.m. 01/02 from 3:18 p.m. 5:00 p.m. Plan of Removal The surveyor confirmed the following had been initiated and/or implemented prior to exit: Corrective Action: 1. The accused has not worked in the building since 01/02/2025 and is currently on indefinite suspension pending further review. 2. Resident #33 was evaluated by Nurse Practitioner [NAME] on 01/08/2025 with no findings. 3. DON/Designee has in-serviced all employees and agency staff prior to the beginning of their shift on abuse, noting sexual and verbal, and the proper reporting procedure and how to identify abuse and signs of abuse. Employees gave verbal returned demonstrations of types of abuse, signs and proper reporting procedures. 4. Social Services/Designee performed a psychosocial evaluation on Resident #33 on 01/10/2025 with no findings. 5. DON/Designee has consulted with outside psych services 01/11/2025 to evaluate Resident #33 for psychosocial harm and is scheduled 01/13/2025. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. From these evaluations, if any concerns are identified, the facility will develop a plan of care to address any concerns, trauma, etc. that might be identified. 7. DON/Designee has put daily monitors in place on 01/10/2025 for each shift for Resident #33 that staff will ask resident does she feel safe in the facility with no psycho-social harm exhibited. 8. The administrator/Designee has reported the alleged violation of abuse to the police on 01/10/2025. Identification of others at risk: 1. DON/Designee has interviewed interviewable residents on 01/10/2025 to determine if they have experienced sexual/verbal abuse, and if they feel safe in the facility with no findings. 2. DON/Designee has observed non interviewable residents on 01/11/2025 for non-verbal psycho-social signs of sexual/verbal abuse with no findings. Systemic Changes: 1. DON/Designee has in-serviced all employees and agency personnel starting on 01/10/2025 and will educate all employees and agency staff prior to the beginning of their shift on abuse, noting sexual and verbal, and the proper reporting procedure and how to identify abuse and signs of abuse. Employees gave verbal returned demonstration of types of abuse, signs and proper reporting procedures. Monitoring: 1. Audits have been conducted and are ongoing by DON or designee on 10 residents questioning if they have experienced sexual/verbal abuse, and if they feel safe in the facility weekly x's 4 weeks, then monthly x's 2 months. 2. Audits have been conducted and are ongoing by DON or designee on 10 non interviewable residents to observe for any non-verbal signs of physical/sexual/verbal weekly x's 4 weeks, then monthly x's 2 months. 3. DON/Designee has conducted and is ongoing interview audits of 5 staff members from various shifts and departments to ensure that there has not been observations of inappropriate behavior between staff members and residents in the past 30 days with cognitively intact or cognitively impaired residents. 4. Audit trends will be reported to facility QAPI for review and further recommendations.

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	01/12/2025

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50093 Based on interviews and record reviews, the facility failed to ensure allegations of sexual abuse were reported immediately to the facility's administrator and to law enforcement authorities in an appropriate timeframe for 1 (#33) of 12 (#13, #14, #24, #31, #33, #61, #74, #77, #190, #191, #192, and #193) residents reviewed for sexual abuse. The facility failed to ensure: 1. Staff immediately reported allegations of sexual abuse to the administrator; and 2. The Administrator reported allegations of sexual abuse to local law enforcement This deficient practice resulted in an Immediate Jeopardy (IJ) situation for Resident #33, a cognitively impaired blind resident, on 01/08/2025, when it was discovered that during the Christmas/New Year Holiday Season, S8CNA witnessed S5MAIN sitting on Resident #33's bed, rubbing the resident's shoulder, and kissed her on the cheek. S8CNA failed to report the sexual abuse and S5MAIN continued to work in the facility until 01/02/2025 at 5:00 p.m. On 01/05/2025, #R1 reported to S6CNA S5MAIN sat down next to Resident #33 on her bed, rubbed Resident #33's back and arm, kissed her cheek and neck and said he wanted to see her beautiful cat again. Administration was made aware of the incident on 01/05/2025 and failed to report the allegations of sexual abuse to local law enforcement. As a result of the investigation, despite there not being a significant decline in mental or physical functioning for Resident #33, it could be determined the reasonable person would have experienced severe psychosocial harm as a result of the sexual abuse, since a reasonable person would not expect to be treated in this manner in their own home or a health care facility. S1ADMIN was notified of the Immediate Jeopardy situation on 01/10/2025 at 6:09 p.m. The Immediate Jeopardy situation was removed on 01/12/2025 at 2:15 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The deficient practice continued at the potential for more than minimal harm for the remaining 92 residents residing in the facility. Findings: Cross Reference F600 Review of the facility policy titled Abuse, with a revision date of 05/15/2023, revealed the following, in part: Definitions: Sexual Abuse: Non-consensual sexual contact of any type with a resident. Responsibilities of Facilities and Covered Individuals (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Reporting responsibilities for reasonable suspicion of a crime in accordance with State law: e. Sexual abuse Response to Allegations and Suspicions 1. Allegations may be verbal or in writing and will be reported to the administrator of the facility and other officials as required. Review of Resident #33's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following cerebral infarction affecting the left non-dominant side, Unspecified Dementia, Difficulty in Walking, Cognitive Communication Deficit and Legal Blindness. Review of Resident #33's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/01/2024 revealed Resident #33 had a Brief Interview for Mental Status (BIMS) of 08, which indicated the resident had moderate cognitive impairment. On 01/06/2025 review of the facility's self-reported incident dated 01/05/2025 at 09:59 p.m. revealed: Resident Victim: Resident #33 Accused: S5MAIN Accused Allegations: Sexual Abuse Protective Actions: Suspended Pending Outcome Incident Description: #R1 told S6CNA that she saw S5MAIN kissing her roommate (Resident #33) on the forehead and the cheek. She says that she overheard S5MAIN tell Resident #33 he could see her cat when she was walking naked in the hallway. An interview was conducted on 01/08/2025 at 1:13 p.m. with Resident #33's sister. She stated Resident #33 had dementia and was not cognitively intact. She stated she was notified of an incident involving Resident #33 and a worker at the facility on 01/05/2025. She stated an employee of the facility told her a male worker kissed Resident #33 on her jaw and inappropriately touched/stroked her back and arm with his hands. She stated Resident #33 would not want an unknown male kissing and touching her. She stated, if Resident #33 had all her cognitive abilities, the resident would have suffered serious psychosocial harm from the male staff kissing and touching her while in her bed. She stated Resident #33 wouldn't want that person near her and would have been fearful. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 01/07/2024 at 10:20 a.m. with #R1. #R1 stated approximately a week ago, she was in her room in bed when S5MAIN came into the room, walked over to Resident #33's bed, tried to wake her up by whispering to her and rubbing her back and arm. #R1 stated S5MAIN kissed Resident #33's left cheek, sat down next to Resident #33 on her bed, began to rub Resident #33's back and arm, and again kissed her on the cheek and the neck. #R1 stated other staff members witnessed S5MAIN sitting on Resident #33's bed. #R1 stated she heard S5MAIN tell Resident #33 he wanted to see her beautiful cat again, and that he had seen her beautiful cat while she was naked in the hall. #R1 said she reported the incident to S6CNA a few days after she witnessed it. She stated when she reported it to S6CNA on 01/05/2025 another staff member was present on 01/05/2025. Review of #R1's MDS with an ARD of 12/26/2024 revealed the resident was admitted to the facility on [DATE] and had a BIMS of 15, which indicated the resident was cognitively intact. An interview was conducted on 01/08/2025 at 2:40 p.m. with S8CNA. She stated at some time between Christmas and New Year's Day, she was checking on the residents shortly after she reported for her shift after 3:00 p.m. and saw S5MAIN in Resident #33's room. She stated S5MAIN sat on Resident #33's bed, talked to her, rubbed the resident's shoulder with his hand, and then kissed her on the cheek. She stated the observation made her feel uncomfortable and she thought it was inappropriate. She stated she did not report the incident to administration and stated she would have if it happened again. She stated she did communicate what she saw with S6CNA and S7CNA. She confirmed she should have reported what she saw because it was sexual abuse. An interview was conducted on 01/07/2025 at 3:56 p.m. with S7CNA. S7CNA stated S8CNA recently told him she saw S5MAIN sitting on Resident #33's bed, talking to her and making inappropriate sexual statements. S7CNA stated on 01/05/2025, #R1 told him she had witnessed S5MAIN sitting on Resident #33's bed, talking to her and making inappropriate sexual statements. S7CNA said he never reported this to his supervisor or the administrator. An interview was conducted on 01/07/2025 at 12:01 p.m. with S6CNA. She stated on 01/05/2025, #R1 reported to her that approximately a week ago, S5MAIN came into the room, walked over to Resident #33's bed, leaned over Resident #33, rubbed her arm and back, kissed her, and asked her if she wanted coffee. S6CNA stated #R1 reported she heard S5MAIN tell Resident #33 he had seen her cat meaning vagina. S6CNA stated she reported #R1's allegations to S4LPN and S3RN. An interview was conducted on 01/10/2025 at 1:36 p.m. with S2DON. S2DON said Resident #33 had a BIMS of 8 and had cognitive impairment. S2DON stated on 01/05/2025, around 6:00 p.m., S3RN reported #R1 had witnessed S5MAIN in her room with Resident #33. #R1 reported S5MAIN kissed Resident #33's forehead and cheek, rubbed Resident #33's arm and back, and made sexually inappropriate comments to Resident #33. S2DON stated she immediately contacted S1ADMIN and the Regional Director of Clinical. S2DON stated she was not aware a staff member had witnessed the incident and confirmed the staff that witnessed it should have immediately reported it so Resident #33 could have been protected. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 01/10/2025 at 2:30 p.m. with S1ADMIN. S1ADMIN said Resident #33 had dementia. S1ADMIN stated on 01/05/2025, around 7:00 p.m., S2DON told him #R1 reported she witnessed S5MAIN kiss Resident #33 on the forehead and heard S5MAIN make an inappropriate comment to Resident #33 about her cat. S1ADMIN stated S5MAIN told him a few weeks ago after he spoke to the residents he left the room and kissed Resident #33 on her forehead while leaving. S1ADMIN stated he was not aware an employee had witnessed the incident between S5MAIN and Resident #33 and had not reported it. S1ADMIN stated he had not reported the incident to police. Plan of Removal The surveyor confirmed the following had been initiated and/or implemented prior to exit: Corrective Action: 1. The accused has not worked in the building since 01/02/2025 and is currently on indefinite suspension pending further review. 2. Resident #33 was evaluated by the Nurse Practitioner on 01/08/2025. 3. DON/Designee has in-serviced all employees and agency staff prior to the beginning of their shift on abuse, noting sexual and verbal, and the proper reporting procedure and how to identify abuse and signs of abuse. Employees gave verbal returned demonstrations of types of abuse, signs and proper reporting procedures. 4. Social Services/Designee performed a psychosocial evaluation on Resident #33 on 01/10/2025. 5. DON/Designee has consulted with outside psych services 01/11/2025 to evaluate Resident #33 for psychosocial harm and is scheduled 01/13/2025. 6. From these evaluations, if any concerns are identified, the facility will develop a plan of care to address any concerns, trauma, etc. that might be identified. 7. DON/Designee has put daily monitors in place on 01/10/2025 for each shift for Resident #33 that staff will ask resident does she feel safe in the facility with no psycho-social harm exhibited. 8. The administrator/Designee has reported the alleged violation of abuse to the police on 01/10/2025. Identification of others at risk: 1. DON/Designee has interviewed interviewable residents on 01/10/2025 to determine if they have experienced sexual/verbal abuse, and if they feel safe in the facility with no findings. 2. DON/Designee has observed non interviewable residents on 01/11/2025 for non-verbal psycho-social signs of sexual/verbal abuse with no findings. Systemic Changes: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. DON/Designee has in-serviced all employees and agency personnel starting on 01/10/2025 and will educate all employees and agency staff prior to the beginning of their shift on abuse, noting sexual and verbal, and the proper reporting procedure and how to identify abuse and signs of abuse. Employees gave verbal returned demonstration of types of abuse, signs and proper reporting procedures. Monitoring: 1. Audits have been conducted and are ongoing by DON or designee on 10 residents questioning if they have experienced sexual/verbal abuse, and if they feel safe in the facility weekly x's 4 weeks, then monthly x's 2 months. 2. Audits have been conducted and are ongoing by DON or designee on 10 non interviewable residents to observe for any non-verbal signs of physical/sexual/verbal weekly x's 4 weeks, then monthly x's 2 months. 3. DON/Designee has conducted and is ongoing interview audits of 5 staff members from various shifts and departments to ensure that there has not been observations of inappropriate behavior between staff members and residents in the past 30 days with cognitively intact or cognitively impaired residents. 4. Audit trends will be reported to facility QAPI for review and further recommendations.

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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** 47173 Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident's status for 1(#52) of 23 residents reviewed for MDS. Findings: Review of the clinical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses, which included Dementia, Difficulty Walking, Dysarthria following Cerebrovascular Accident, Other lack of Coordination, Depression and Failure to Thrive. Review of Resident #52's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/2024 revealed in part, the following: Section P: Restraints: Chair prevents rising -used less than daily. On 01/09/2025 at 2:50 p.m., an interview was conducted with S17PTA. She stated she was familiar with Resident #52. She stated he had become weaker and could not sit up independently in a wheelchair for a period of time. She stated he lacked trunk control and a Geri chair would be used for safety and support. On 01/09/2025 at 1:45 p.m., an interview was conducted with S8MDS. She stated Resident #52 used a Geri chair when out of bed for support and safety due to lack of trunk control. S8MDS reviewed Resident #52's Quarterly MDS with an ARD of 10/24/2024 and stated the MDS was coded for, Chair prevents rising- used less than daily. S8MDS confirmed Resident #52's Geri chair was not used as a restraint and the MDS was coded in error. On 01/09/2025 at 1:55 p.m., an interview was conducted with S2DON. She stated Resident #52 used a Geri chair for support and safety due to poor trunk control and not a restraint. She confirmed the MDS should not have been coded as a restraint.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 Based on record review and interviews the facility failed to ensure resident's plan of care was revised for the use of a geri chair for 1 (#52) of 23 sampled residents reviewed for care plans. Findings: Review of the clinical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses, which included Dementia, Difficulty Walking, Dysarthria following CVA, Other lack of Coordination, Depression and Failure to Thrive. Review of Resident #52's most recent Care Plan revealed no documentation related to resident using a geri chair. On 01/07/2024 at 10:10 a.m., an interview was conducted with S10CNA. She stated Resident #52 used a geri chair. On 01/09/2025 at 10:35 a.m., an interview was conducted with S11CNA. She stated Resident #52 used a geri chair. On 01/09/2025 at 4:00 p.m., an interview was conducted with S9CNA. He stated he started working at the facility in August 2024. He stated Resident #52 had always used a geri chair when he got out of bed. He stated he had never seen Resident #53 use a regular wheelchair. On 01/09/2025 at 1:45 p.m., an interview was conducted with S8MDS. She stated she was responsible for MDS assessments and Care Plans. She stated Resident #52 used a geri chair when he got out of bed for support and safety due to lack of trunk control. She reviewed the current care plan and confirmed Resident #52 was not care planned for using a geri chair. On 01/09/2025 at 1:55 p.m., an interview was conducted with S2DON. She stated Resident #52 used a geri chair for support/safety due to poor trunk control. She stated she was not aware a resident needed to be care planned for a geri chair but she would update the care plan now.

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	195177	A. Building B. Wing	01/12/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50093 Based on record review, observations, and interviews, the facility failed to store food in accordance with professional standards for food service safety. The facility failed to ensure: 1. Staff properly sealed, labeled, and dated food after opening; and 2. Staff removed expired items available for consumption. Findings: Review of the facility's policy titled Refrigerated Storage dated ,d+[DATE], revealed the following, in part: Intent: To provide guidance related to safe storage of refrigerated foods. Guidelines: 10. Refrigerated foods should be properly covered, labeled, and dated. 11. Leftover food or unused portions of packaged foods should be covered, labeled, and dated. 15. Items leftover from tray line, such as poured milk or juice, will be labeled, and dated and used for the next meal. Such items will be discarded at the end of the day. On [DATE] at 8:52 a.m., an observation of Refrigerator A made with S16DM revealed the following: 1. ,d+[DATE] full, gallon of 2% reduced fat milk with an expiration date of [DATE]; 2. Two gallons of 2% reduced fat milk with an expiration date of [DATE]; 3. Five small containers of fruit, unlabeled and undated; and 4. ,d+[DATE] full, large container of jelly, unlabeled and undated. On [DATE] at 9:11 a.m., an observation of Refrigerator B made with S17DM revealed the following: 1. One loaf of bread, unlabeled and undated; 2. ,d+[DATE] used loaf of bread, unlabeled and undated; (continued on next page)

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	195177	A. Building B. Wing	01/12/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. ,d+[DATE] used loaf of bread, unlabeled and undated; 4. ,d+[DATE] used, ,d+[DATE] pound of grated parmesan cheese, unsealed, open to air; 5. Five pound bag of feta cheese, unsealed, open to air; and 6. ,d+[DATE] used, 16 ounce block of margarine, unsealed, open to air, and undated. On [DATE] at 9:17 a.m., an interview was conducted with S17DM. She confirmed the above mentioned findings. S17DM confirmed stored foods should be properly labeled, dated, and sealed once opened. S17DM confirmed expired items should have been removed and not be available for consumption. On [DATE] at 2:32 p.m., an interview was conducted with S1ADMIN. He stated all stored food should be labeled, dated, and sealed, once opened. S1ADMIN confirmed food with an expired dated should be removed and not be available for consumption.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872 Based on observations, interviews, and record review, the facility failed to implement and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure: 1. Staff properly utilized Enhanced Barrier Precaution (EBP) Personal Protective Equipment (PPE) during care for 2 of 2 (#53 and #57) residents observed for EBP; 2. The facility's infection control and prevention policy was reviewed annually. This had the potential to effect all 92 residents in the facility. Findings: 1. Review of the facility's policy revised 03/26/2024, titled Infection Prevention and Control Transmission-Based Precautions Enhanced Barrier Precautions revealed the following, in part: Policy: Enhanced barrier precautions are an infection control intervention used to reduce transmission of Central Disease Center (CDC) targeted multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities. Gown and gloves are worn by personnel during high-contact care activities for residents with chronic wounds or indwelling medical devices. Resident #53 Review of Resident #53's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #53's current Physician Orders revealed the following, in part: Start date- 06/19/2024. Percutaneous Endoscopic Gastrostomy (PEG) site care every day. Start date- 04/22/2024. Place on enhanced barrier precautions. Resident #57 Review of Resident #57's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Left Leg Wound. Review of Resident #57's current Physician Orders revealed the following, in part: (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Start date- 04/22/2024. Place resident on enhanced barrier precautions related to left leg wound. An observation was made on 01/07/2025 at 2:15 p.m. of Resident #53 and Resident #57's door to their shared room. A sign was noted on the door that read EBP which included instructions to wear gown and gloves during high contact activity. A simultaneous observation was made on 01/07/2025 at 2:15 p.m. of S14LPN providing assistance to both Resident #53 and #57 in their shared room. S14LPN applied a clean gown and gloves and entered the residents' room. Resident #57 requested S14LPN's assistance to be repositioned. S14LPN's gown came in contact with Resident #57 and Resident #57's linen which S14LPN used to reposition her upright in the geriatric chair. Between assisting Resident #57 and #53, S14LPN did not change her gown. With the dirty gown, S14LPN administered Resident #53's medications through the PEG Tube. After S14LPN completed medication administration for Resident #53, she removed the soiled gown and gloves. Without donning clean PPE, S14LPN repositioned Resident #57 in her geriatric chair as mentioned above. An interview was conducted on 01/07/2025 at 2:18 p.m. with S14LPN. S14LPN stated Resident #53 was on EBP because of the PEG tube. She stated Resident #57 had an open wound, but was not on EBP and did not require gown and glove use with care. S14LPN confirmed the above observations of her providing care to Resident #53 and Resident #57. S14LPN stated she should have changed her gown after she repositioned Resident #57 and before administering medication to Resident #53. An interview was conducted on 01/08/2025 at 8:35 a.m. with S2DON. S2DON confirmed Resident #53 had a PEG tube and was on EBP. S2DON confirmed Resident #57 had a wound and was on EBP. S2DON confirmed a gown and gloves should be worn when a resident on EBP was repositioned. S2DON stated she expected the nurse to change her gown after Resident #57 was repositioned and before Resident #53 was administered medication by PEG tube. She stated she expected the nurse to apply a gown and glove before repositioning Resident #57. 2. Review of the facility's policy titled Infection Prevention and Control Program had a published date of 11/2017 and a revision date of 06/08/2022. Review of the facility's documentation for annual review of the above policy revealed no evidence of annual review. An interview was conducted on 01/08/2025 at 4:50 p.m. with S1ADMIN. S1ADMIN stated he did not know the last time the facility's Infection Prevention and Control policy was reviewed and could not provide documentation of an annual review having been conducted.