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	12/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure an effective system was in place for staff to identify residents assessed as unsafe smokers and to provide supervision and interventions during smoking for 1 (#50) of 3 residents reviewed for smoking. Review of the facility's policy, Physical Environment- Facility with Independent and Supervised Smokers, revised 03/2025, revealed the following in part:Purpose: To provide a safe environment for residents.Guidelines:Smoking blankets or aprons will be furnished for residents who are assessed to require a smoking blanket or apron.Residents who are independent smokers are instructed not to share smoking paraphernalia with other residents or staff.Residents who are deemed unsafe to smoke independently will be supervised by staff members while smoking.Review of Resident #50's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included the following: Cerebral Infarction due to Embolism of Left Middle Cerebral Artery, Aphasia following Cerebral Infarction, Dysphagia following Cerebral Infarction, and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side. Review of Resident #50's Quarterly MDS with an ARD of 11/04/2025 revealed Resident #50 was assessed by the facility to have a BIMS of 6, which indicated the resident was severely cognitively impaired. Further review revealed he self-propelled himself independently in his wheelchair.Review of Resident #50's Clinical Record revealed, in part, the following practitioner note dated 05/05/2025:Seen today per staff request. Patient burned his clothing with cigarette. He did not burn his skin. ExaminationConstitutional: No apparent distress. Alert and oriented times 2. Delayed speech. Limited ability to communicate.Musculoskeletal: Right hemiparesisNeurological: Right upper extremity paralysis, Right lower extremity weakness, delayed speechReview of Resident #50's current Care Plan revealed the following, in part: Focus: The resident is a smoker. Interventions:The resident requires a smoking apron while smoking. Date Initiated: 05/07/2025.The resident requires supervision while smoking. Date Initiated: 05/07/2025. Review of Resident #50's Smoking Screen, dated 08/18/2025, revealed the following, in part:Does the resident smoke? Yes.How many times does the resident smoke per day? 2-5 timesThe resident has cognitive loss. Yes. The resident has a history of hiding their smoking materials or activities from the staff. Yes.The resident has a history of noncompliance with the facilities smoking policy. Yes. The resident has a history of smoking in non-designated smoking areas. Yes. The resident is unable to use a fire extinguisher to extinguish a fire as a result of smoking. Yes. The resident uses medications that could cause drowsiness. Yes.Can the resident light his/her own cigarette/activate electronic cigarette? No.Adaptive equipment needed: The resident requires a smoking apron while smoking.Interventions and Determinations: The resident requires SUPERVISION while smoking.Review of Resident #50's Smoking Screen, dated 11/18/2025, revealed the following, in part: Does the resident smoke? Yes.How many times does the resident smoke per day? 5-10 times.The resident has cognitive loss. Yes.The resident has dexterity problem(s). Yes.The resident has a history of hiding their smoking materials or activities from the staff. Yes.The resident has a history of noncompliance with the facilities smoking policy. Yes. The resident has a history of (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195177	A. Building B. Wing	12/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking in non-designated smoking areas. Yes. The resident is unable to retrieve a cigarette if it were dropped. Yes. The resident is unable to use a fire extinguisher to extinguish a fire as a result of smoking. Yes.On 12/09/2025 at 11:17 a.m., an observation was made of Resident #50 seated in his wheelchair in the facility's designated smoking area. Resident #50 was observed leaning forward with his upper body noticeably tilted to the right side of the wheelchair. Resident #50 held a partially smoked cigarette in his left hand. Resident #50 propelled his wheelchair with his feet toward another resident, who then lit Resident #50's cigarette. After the cigarette was lit, Resident #50 was observed loosely holding the lit cigarette in his left hand. Resident #50 was not observed wearing a smoking apron and no staff member was present to supervise the resident while he was smoking.On 12/09/2025 at 11:20 a.m., an interview was attempted with Resident #50. Resident #50 did not hold eye contact or make verbal responses. Resident #50 vocalized a sound. Due to Resident #50's inability to communicate the interview was discontinued. On 12/09/2025 at 11:25 a.m., an interview was conducted with S5ADON. S5ADON confirmed Resident #50 was currently in the smoking area and not being supervised by facility staff and was not wearing a smoking apron. S5ADON stated Resident #50 was not a smoker. S5ADON stated there was no designated staff member assigned to supervise unsafe smokers, but S11AC could see the smoking area from the activity room. On 12/09/2025 at 11:27 a.m., an interview was conducted with S11AC. S11AC stated she was not responsible for the supervision of the designated smoking area and was unaware of what residents needed supervision while smoking. On 12/09/2025 at 11:46 a.m., an interview was conducted with S12LPN. S12LPN stated Resident #50 resided on Hall A and she was assigned to care for the resident. S12LPN did not know if Resident #50 was an unsafe smoker that required supervision while smoking and a smoking apron. S12LPN stated if Resident #50 required supervision she would periodically go to the designated smoking area to check on him, but was not sure when the last time this happened. S12LPN stated there was not a list of unsafe smokers requiring supervision on Hall A. S12LPN stated there was no designated smoking times and any resident can smoke at any time. S12LPN confirmed Resident #50 was care planned to need a smoking apron and supervision while smoking.On 12/09/2025 at 12:14 p.m., an interview was conducted with S8CNA. S8CNA stated she did not know Resident #50 was an unsafe smoker that required supervision while smoking and a smoking apron. S8CNA stated she did not know where to find if a resident was considered a safe or unsafe smoker or any smoking interventions. S8CNA stated she had seen Resident #50 smoke shortly before Thanksgiving. S8CNA stated she did not know if there were any other residents in her assignment needing a smoking apron or staff supervision while smoking. S8CNA stated there was no list on Hall A that indicated who was unsafe or safe to smoke.On 12/09/2025 at 12:26 p.m., an observation was conducted of the Hall B nurse station with S15LPN. S15LPN retrieved a smoker list from a binder behind the desk. S15LPN stated the list only contained residents for Hall B. S15LPN stated the list did not indicate whether each smoker on the list was deemed safe or unsafe, only that the resident smoked.On 12/09/2025 at 12:30 p.m., an interview was conducted with S21CNA. S21CNA stated the facility did not have designated smoking times and residents could go outside to the courtyard to smoke whenever they like. S21CNA stated she did not know how to identify which residents required supervision or a smoking apron and did not know who was responsible to supervise unsafe smokers. S21CNA demonstrated the view of the electronic chart for her assigned residents. She was unable to locate whether a resident was unsafe or safe to smoke in the electronic chart.On 12/09/2025 at 12:35 p.m., an interview was conducted with S20LPN. She stated the facility did not have designated smoking times and residents could go outside to the courtyard to smoke whenever they wanted to. She stated she did not know how to identify which residents required supervision or a smoking apron and did not know who was responsible to supervise unsafe smokers. S20LPN stated she was familiar with Resident #50 and did not know the resident was an unsafe smoker who required supervision while smoking and a smoking apron.On 12/09/2025 at 12:40 p.m., an interview was conducted with S19CNA. She stated the facility did not have designated smoking times and residents could go outside (continued on next page)

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	12/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the courtyard to smoke whenever they would like to. She stated she did not know how to identify which residents required supervision or a smoking apron and did not know who was responsible to supervise unsafe smokers. S19CNA demonstrated she was unable to locate whether a resident was unsafe or safe to smoke in the electronic chart. S19CNA stated she had cared for Resident #50 and did not know the resident was an unsafe smoker who required supervision while smoking and a smoking apron.On 12/09/2025 at 12:40 p.m., an interview was conducted with S15LPN. She stated the facility did not have designated smoking times and residents could go outside to the courtyard to smoke whenever they would like to. She stated she did not know how to identify which residents required supervision or a smoking apron and did not know who was responsible to supervise unsafe smokers. S15LPN stated she was familiar with Resident #50 and did not know the resident was an unsafe smoker who required supervision while smoking and a smoking apron.On 12/09/2025 at 12:45 p.m., an interview was conducted with S14LPN. She stated the facility did not have designated smoking times and residents could go outside to the courtyard to smoke whenever they wanted to. She stated she did not know how to identify which residents required supervision or a smoking apron and did not know who was responsible to supervise unsafe smokers. S14LPN stated she was familiar with Resident #50 and did not know the resident was an unsafe smoker who required supervision while smoking and a smoking apron.On 12/09/2025 at 12:50 p.m., an interview was conducted with S18CNA. She stated the facility did not have designated smoking times and residents could go outside to the courtyard to smoke whenever they would like to. She stated she did not know how to identify which residents required supervision or a smoking apron and did not know who was responsible to supervise unsafe smokers. S18CNA stated she had cared for Resident #50 and did not know the resident was an unsafe smoker who required supervision while smoking and a smoking apron.On 12/10/2025 at 2:03 p.m., an interview was conducted with S25NP. S25NP stated she provided care for Resident #50. S25NP stated Resident #50 had a Cerebral Infarction and suffered from right sided extremity impairment, muscle weakness, and communication deficits. S25NP stated if Resident #50 was assessed to require a smoking apron and staff supervision during smoking, she expected the facility to provide that care at all times. On 12/09/2025 at 1:27 p.m., an interview was conducted with S2DON. S2DON stated every resident was assessed for smoking upon admission to the facility. She stated the assessment was completed by the nurse receiving the resident. She stated if the nurse selected the resident was not a smoker, then the assessment was complete. She stated if the nurse selected the resident was a smoker, then more questions populated in regards to cognition, mobility/dexterity, medications, and needed interventions. She stated the assessment did not score a resident but, rather, the nurse completing the assessment had to unselect any interventions the nurse deemed not needed. S2DON stated the electronic health record system then automatically created the smoking care plan based upon the nurse's smoking assessment. She stated a smoking assessment populated for completion in the electronic health record upon admit, readmit, quarterly, annually, and could be triggered as needed due to any incident. S2DON stated a nurse should know a resident's smoking status and interventions by reviewing the resident's care plan. She further stated there should be a smoker list at each of the facility's two nurses' stations; however, she confirmed those lists did not indicate a resident's safe smoking status or required interventions and CNAs did not have access to those lists. S2DON stated a CNA should know a resident's smoking status and interventions by reviewing the electronic chart. She stated smoking status and required interventions to be communicated from shift to shift through nurse-to-nurse and CNA-to-CNA report. S2DON stated there was no staff designated to supervising unsafe smokers. She stated the designated smoking area was an open courtyard accessible to any resident. She confirmed there was no designated smoking times for residents. S2DON reviewed Resident #50's care plan and confirmed Resident #50 required the use of a smoking apron and staff supervision while smoking. S2DON stated Resident #50 was the only smoker in the facility that required a smoking apron or supervision while smoking. On 12/10/2025 at 2:00 p.m., an interview conducted with S1ADM revealed the facility identified five (continued on next page)

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	12/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	additional unsafe smokers since yesterday that required supervision/smoking apron through their facility wide assessment. S1ADM stated Resident #50 was assessed and a new smoking evaluation completed. He stated the facility completed a new facility wide smoking assessment on all residents, a new position of a safe smoking monitor was added to daily staffing to supervise the smokers, smoking binders were implemented to assist staff in identifying smokers, residents identified as smokers signed agreements that included expectations of safe smoking, and a resident council meeting was conducted to announce the smoking times and process on 12/10/2025. S1ADM explained the smoking binder would include resident's smoking supervision status and interventions. He stated facility leadership began educating staff on the role expectations of the smoking monitor, the new smoking binders, and the smoking policy on 12/09/2025.

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	12/10/2025

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 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. Based on observations, interviews, and policy review, the facility failed to store food under sanitary conditions by failing to ensure food was properly dated, labeled, and sealed in the walk-in refrigerator and freezer. This deficient practice had the potential to affect 72 residents who ate from the facility's kitchen.Findings: Review of the facility's policy dated 03/2023 and titled, Food Safety, revealed the following, in part:9. Refrigerated foods:f. Food, including leftovers, will be labeled and dated in the refrigerator. On 12/08/2025 at 8:14 a.m., an initial tour was conducted of the facility's kitchen with S4CK. The following observations were made with S4CK: Walk-in refrigerator:1 metal pan of mustard greens covered with plastic wrap with no date or label; and 3 pork loins with no date or label. Walk-in freezer: 1 metal pan of green beans with no date or label; 1 clear bag of hamburger patties, not sealed, open to air, with no open date. On 12/08/2025 at 8:22 a.m., an interview was conducted with S4CK. She confirmed the above observations. S4CK confirmed the refrigerator and freezer items should have been labeled, dated, and sealed and were not. On 12/08/2025 at 8:37 a.m., an interview was conducted with S3DM. She was informed of the above observations. S3DM confirmed all foods should have been sealed, dated, and labeled. S3DM confirmed 72 residents ate out of the kitchen. On 12/09/2025 at 12:16 p.m., an interview was conducted with S1ADM. He was notified of the above observations of the facility's refrigerator and freezer. S1ADM confirmed all foods should have been labeled, sealed, and dated.

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	12/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and interviews, the facility failed to ensure the residents had a safe, clean, comfortable homelike environment by failing to maintain a clean environment 1 (#74) of 24 sampled residents. Findings: Review of Resident #74's clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #74's MDS with an ARD of 11/11/2025 revealed the facility assessed him to have a BIMS of 15, which indicated he was cognitively intact. On 12/08/2025 at 9:05 a.m., an interview was conducted with Resident #74. Resident #74 stated his toilet was clogged with feces and toilet paper. He stated it had been clogged for at least 3 days. Resident #74 stated he could not use the toilet in his room and had to use a restroom at the end of his hall. He stated he reported the clogged toilet to a CNA 2 days ago and nothing had been done. On 12/08/2025 at 9:10 a.m., an observation was conducted of Resident #74's restroom. The toilet was observed with multiple layers of feces and toilet paper. The feces in the toilet was dry with very little water in the bottom of the bowl. On 12/08/2025 at 3:25 p.m., an observation was conducted of Resident #74's toilet, it remained clogged with multiple piles of feces and toilet paper. On 12/09/2025 at 9:30 a.m., an interview was conducted with S6HKS. S6HKS stated she was made aware of the clogged toilet on 12/08/2025 at 3:40 p.m. S6HKS stated housekeeping staff is responsible for cleaning each room daily. S6HKS stated each resident's entire bathroom should be cleaned once a day and as needed. S6HKS stated at 7:00 a.m. daily rounds are completed in each resident room, including restroom. S6HKS stated she expected the issue to be discovered when daily rounds were completed or when housekeeping staff was cleaning the bathroom and it was not. On 12/09/2025 at 11:00 a.m., an interview was conducted with S1ADM. S1ADM stated he would expect housekeeping staff to identity a clogged toilet on their daily rounds, and report it to maintenance and they did not.

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	12/10/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents with an identified mental health diagnosis were referred for a Pre-admission Screening and Resident Review (PASARR) Level II evaluation as required for 1 of 1 (#12) resident reviewed for PASARR.Review of Resident #12's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Hemiplegia and Hemiparesis. Further review revealed an additional medical diagnosis of Unspecified Psychosis with an onset date of 09/30/2019.Review of Resident #12's PASARR Level I dated 09/27/2019 revealed no mental health diagnoses were selected. Further review revealed no review for a Level II evaluation and determination had been submitted for Resident #12 to include his diagnosis of Unspecified Psychosis.An interview was conducted on 12/09/2025 at 2:30 p.m. with S9SS. She reviewed Resident #12's PASARR pre-admission Level I and resident review dated 09/27/2019. She confirmed Resident #12 had a diagnosis of Unspecified Psychosis upon admission and was not accurately screened. She confirmed Resident #12 should have had a new resident review conducted but did not.An interview was conducted on 12/10/2025 at 4:00 p.m. with S2DON. She reviewed Resident #12's PASARR pre-admission Level I and resident review dated 09/27/2019. She confirmed Resident #12 had a diagnosis of Unspecified Psychosis upon admission.

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	12/10/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure interventions for smoking were implemented as identified on the care plan for 1 (#50) of 3 residents reviewed for smoking.Review of the facility's policy, Physical Environment- Facility with Independent and Supervised Smokers, revised 03/2025, revealed the following in part:Purpose: To provide a safe environment for residents.Guidelines:Smoking blankets or aprons will be furnished for residents who are assessed to require a smoking blanket or apron.Residents who are deemed unsafe to smoke independently will be supervised by staff members while smoking. Review of Resident #50's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included the following: Cerebral Infarction due to Embolism of Left Middle Cerebral Artery, Aphasia following Cerebral Infarction, Dysphagia following Cerebral Infarction, and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side. Review of Resident #50's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/04/2025 revealed Resident #50 was assessed by the facility to have a Brief Interview Mental Status (BIMS) of 6, which indicated the resident was severely cognitively impaired.Review of Resident #50's current Care Plan revealed the following, in part: Focus: The resident is a smoker.Interventions:The resident requires a smoking apron while smoking.The resident requires supervision while smoking.On 12/09/2025 at 11:17 a.m., an observation was made of Resident #50 smoking in the designated smoking area without supervision or a smoking apron.On 12/09/2025 at 11:25 a.m., an interview was conducted with S5ADON. S5ADON confirmed Resident #50 was in the smoking area and not being supervised by facility staff and was not wearing a smoking apron. On 12/09/2025 at 11:46 a.m., an interview was conducted with S12LPN. S12LPN stated she was unaware Resident #50 was outside smoking. S12LPN stated she had not yet reviewed Resident #50's care plan this shift. S12LPN did not recall if Resident #50 needed supervision or a smoking apron.On 12/09/2025 at 12:14 p.m. an interview was conducted with S8CNA. S8CNA stated she was unaware Resident #50 was outside smoking. S8CNA stated she was unaware if Resident #50 was an unsafe smoker. S8CNA stated she was unaware of where to find smoking interventions for Resident #50.On 12/09/2025 at 1:27 p.m., an interview was conducted with S2DON. S2DON stated she expected all nursing staff to implement the interventions stated on residents' care plans. S2DON reviewed Resident #50's care plan and confirmed Resident #50 required the use of a smoking apron and staff supervision while smoking. S2DON further confirmed Resident #50's care plan interventions were not implemented while smoking and should have been.

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	12/10/2025

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 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** Based on record review, observation and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection for 1 (#2) of 3 resident's observed for perineal care. The facility failed to ensure staff performed hand hygiene and proper glove use for Resident #2 during perineal care.Review of the facility's policy titled, Perineal Care with a revision date of 03/2025, revealed the following, in part:Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote: cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Policy explanation and compliance guideline: 6.) Perform hand hygiene and put on gloves.10.). Change gloves if soiled and continue with perineal care. Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis of Personal History of Urinary Tract Infections with Gram-Negative Sepsis and Irritable Bowel Syndrome. Review of the facility's Infection Log revealed Resident #2 was treated for a Urinary Tract Infection with Sepsis on 10/06/2025. 0n 12/09/2025 at 12:00p.m., an observation was made of S8CNA performing peri care for Resident #2. S8CNA failed to perform hand hygiene prior to donning a clean pair of gloves. Resident #2 was observed to be soiled of urine and feces. S8CNA removed and disposed of the soiled adult brief. S8CNA failed to remove the soiled gloves and perform proper hand hygiene. S8CNA then continued to apply a clean adult brief, and adjust Resident #2's bed linen.S8CNA handed Resident #2 the call light and television remote before removing the soiled gloves. S8CNA removed soiled gloves without performing hand hygiene prior to exiting Resident #2's room. On 12/09/2025 at 12:18p.m., an interview was conducted with S8CNA. S8CNA stated she was unaware she should change gloves and perform hand hygiene during the dirty to clean peri care transition process. S8CNA confirmed she did not change gloves or perform hand hygiene before entering and prior to exiting Resident #2's room. 0n 12/10/2025 at 10:25a.m., an interview was conducted with S7ICN. S7ICN confirmed proper hand hygiene should be performed prior to direct contact with residents as well as between dirty to clean process of peri care. S7ICN stated after proper handwashing she would expect staff to don a clean pair of gloves before proceeding with direct care. On 12/10/2025 at 10:35a.m., an interview was conducted with S2DON. S2DON confirmed proper hand hygiene should be performed prior to direct contact with residents as well as between dirty to clean process of peri care. S2DON stated after proper handwashing she would expect staff to don a clean pair of gloves before proceeding with direct care.