

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Ormond Nursing and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Plantation Road Destrehan, LA 70047	
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 - Few	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 reviews, the facility failed to ensure a resident that had a risk of aspiration was supervised during meals for 1(Resident #31) of 1 sampled residents investigated for accidents hazards. Findings:Review of Resident #31's clinical record revealed, in part, Resident #31 was admitted to the facility on [DATE]. Further review revealed Resident #31's diagnoses included, myasthenia gravis (chronic autoimmune disease that causes weakness in the muscles you control voluntarily) generalized muscle weakness, gait impairment (difficulty walking), reduce mobility, and cognitive communication deficit (inability to focus, remember, organize thoughts, or follow conversations). Review of Resident #31's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/2026 revealed, in part, Resident #31 had a Brief Interview for Mental Status (BIMS) of 11, which indicated he was moderately impaired but is able to express wants and understands clearly. Further review revealed Resident #31 required supervision or assistance during eating, and was dependent upon staff for chair/bed transfers. Review of Resident #31's speech therapy treatment plan dated 06/08/2026 revealed, in part, Resident #31's treatment diagnoses included, aphasia (neurological language disorder that impairs a person's ability to communicate); and dysphagia (difficulty swallowing). Review of Resident #31's physician orders dated 06/08/2026 revealed, in part, an order for speech therapy to evaluate and treat Resident #31 three times per week for dysphagia. In an interview on 07/20/2026 at 8:20AM, Resident #31 indicated he should be placed upright in a chair for every meal to keep him from choking. Observation on 07/20/2026 at 8:22AM revealed Resident #31 was sitting in bed eating breakfast, unsupervised by staff. Further observation revealed signage posted above Resident #31's bed indicated Resident #31 was to be in a chair for meals due to the risk of aspiration. In an interview on 07/21/2026 at 8:33AM, S10Certified Nursing Assistance (CNA) indicated staff is required to assist Resident #31 out of bed, into a chair for meals. S10CNA further indicated Resident #31 was not out of bed for breakfast and should have been. In an interview on 07/21/2026 at 8:36AM, S9Licensed Practical Nurse (LPN) indicated she was unaware of whether staff was required to assist Resident #31 to a chair in an upright position for all meals. S9LPN then indicated after she reviewed Resident #31's medical records and observed the signage posted on Resident #31's wall. S9LPN acknowledged Resident #31 was at risk for aspiration, and staff should have assisted him to an upright position in a chair for meals. In an interview on 07/21/2026 at 8:40AM, Resident #31 indicated he should be placed upright in a chair for every meal but no one ever gets him up for breakfast. Observation on 07/21/2026 at 8:45AM revealed Resident #31 was coughing while eating breakfast in bed, and there was no staff supervision. In an interview on 07/21/2026 at 9:09AM, S4Speech Therapist (ST) indicated signage was posted by the therapy department to inform staff that during Resident #31's meals he required supervision from staff and he (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 195221	Facility ID: 195221 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be assisted to an upright position in a chair. In an interview on 07/21/2026 at 2:09PM, S2Director of Nursing (DON) indicated she was unaware of the above mentioned requirements for Resident #31's meals by speech therapy. S2DON further indicated Resident #31 should have been receiving meals in the dining room under staff supervision. In an interview on 07/21/2026 at 2:10PM, S3Assistant Director of Nursing (ADON) indicated she was unaware of the above mentioned requirements for Resident #31's meals by speech therapy. S3ADON further indicated Resident #31 should have been receiving meals in the dining room under staff supervision. In an interview on 07/22/2026 at 1:20PM, S8Corporate Nurse indicated she was unaware of the above mentioned requirements for Resident #31's meals by speech therapy. S8Corporate Nurse confirmed Resident #31 should have been receiving meals in the dining room under staff supervision.		

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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. Based on observation, interviews, and record reviews, the facility failed to ensure a resident with an increased risk for multidrug-resistant organisms (MDRO's) had Enhanced Barrier Precautions (EBP) implemented for 1(Resident #8) of 2 residents observed for wound care. Review of the facility's EBP policy and procedure, dated 01/2023 and revised 03/2024 revealed, in part, EBP are an infection control intervention designed to reduce transmission of MDRO's in nursing homes. EBP involve gown and glove use during high-contact resident care activities for residents at increased risk of MDRO acquisition (e.g., residents with wounds). EBP expand the use of gown and gloves beyond anticipated blood and body fluid exposure. EBP focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDRO's to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Review of Resident #8's medical record revealed, in part, Resident #8 had a diagnosis of a stage 4 pressure ulcer to the left heel. Review of Resident #8's July 2026 physician orders revealed, in part, cleanse Resident #8's left heel stage 4 pressure ulcer with normal saline, pat dry, apply collagen to wound bed, and cover with a Mediplex dressing three times per week and prn (as needed) every day shift every Monday, Wednesday, and Friday until resolved related to pressure induced deep tissue damage to the left heel. Observation on 07/21/2026 10:39AM revealed S7Treatment Nurse performed wound care to Resident #8's left heel stage 4 pressure ulcer without wearing a gown. Further observation revealed there was no signage on or near Resident #8's room door indicating she required EBP. In an interview on 07/21/2026 at 1:41PM, S7Treatment Nurse indicated she did not wear a gown when she performed Resident #8's wound care because EBP were not implemented for Resident #8. In an interview on 07/21/2026 at 1:58PM, S6Infection Control Nurse confirmed that EBP had not been implemented for Resident #8 and should have been for Resident #8's left heel pressure ulcer. In an interview on 07/21/2026 at 1:59PM, S2Director of Nursing confirmed that EBP had not been implemented for Resident #8 and should have been as required.		