

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2025
NAME OF PROVIDER OR SUPPLIER  Jefferson Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2200 Jefferson Hwy Jefferson, LA 70121	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure a dependent resident was provided assistance with dressing/changing clothes for 1(Resident #3) of 3 sampled residents reviewed for activities of daily living needs. Findings: Review of Resident #3's Electronic Medical Record (EMR) revealed, in part, Resident #3 was admitted to the facility on [DATE]. Further review revealed Resident #3 had a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/01/2025 revealed, in part, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #3 was cognitively intact. Further review revealed Resident #3 required substantial/maximal assistance with upper and lower body dressing. Observation on 12/01/2025 at 9:15AM revealed Resident #3 was lying in bed wearing a hospital gown with a red stain noted to left upper corner of Resident #3's chest. Observation on 12/02/2025 at 9:35AM revealed Resident #3 was sleeping in her bed, wearing a hospital gown with the red stain noted to left upper corner of Resident #3's chest. Observation on 12/03/2025 at 8:58AM revealed Resident #3 was lying in her bed wearing a hospital gown with the red stain noted to left upper corner of Resident #3's chest In an interview on 12/03/2025 at 9:00AM, Resident #3 indicated no staff member had changed her clothes and Resident #3 had been wearing the same hospital gown since 12/01/2025. Resident #3 further indicated she was not changed yesterday and wanted her clothes to have been changed. In an interview on 12/03/2025 at 12:03PM, S13Certified Nursing Assistant indicated she gave Resident #3 a bed bath on 12/02/2025 and then dressed Resident #3 in the same hospital gown she had on prior to her bath. In an interview on 12/03/2025 at 12:09 PM, S2Corporate Nurse acknowledged a resident's clothes should have been changed daily and a resident should not have been dressed in the clothes they were wearing prior to a bath, after the resident received a bath.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure staff were competent in mechanical lift operational procedures for 9(S5Certified Nursing Assistant [CNA] Supervisor, S7CNA, S8CNA, S9CNA, S15CNA, S16CNA, S17CNA, S18CNA, S19CNA) of 14 staff members investigated for staff competency with the operation of the facility's mechanical lift. Findings: Review of the facility's Transferring a Resident policy/procedure, dated 07/02/2019, revealed, in part, staff were to follow the manufacturer's guidelines for mechanical lift transfer procedures. Review of the facility's mechanical lift Operating Manual, dated 03/2007, revealed, in part, the mechanical lift transfer procedure (from a bed) specified that the caster brakes of the mechanical lift should be left unlocked when a resident was raised from the bed during transfer. Further review revealed, leaving the mechanical lift caster brakes unlocked would allow the mechanical lift to walk forward to center itself over the resident's center of gravity as it was raised. Further review revealed, this procedure increased the stability of the mechanical lift. In an interview on 12/02/2025 at 9:51AM, S5CNA Supervisor indicated when using the facility's mechanical lift to transfer a resident from a bed, it was the facility's procedure to lock the brakes of the mechanical lift when the resident was raised using the mechanical lift, and to lock the brakes of the mechanical lift when resident was lowered using the mechanical lift. Observation on 12/02/2025 at 9:54AM revealed, after placing Resident #R5 in the mechanical lift sling and hooking the mechanical lift sling to the mechanical lift using its loops, S15CNA walked up to the mechanical lift and locked both of the mechanical lift's caster brakes. Further observation revealed S9CNA continued the procedure of transferring Resident #R5 with the mechanical lift and raised Resident #R5 approximately 2-3 inches off of the bed without unlocking the mechanical lift's caster brakes. In an interview on 12/02/2025 at 10:00AM, S15CNA indicated the caster brakes of the mechanical lift should have been locked when raising a resident from a bed or letting a resident back down using the mechanical lift. In an interview on 12/02/2025 at 10:15AM, S16CNA indicated when transferring a resident from a bed, she would lock the brakes of the mechanical lift while lifting a resident out of the bed with the mechanical lift, unlock the brakes to move the mechanical lift, and then lock the brakes when placing a resident lowering the resident back down into a chair using the mechanical lift. In an interview on 12/02/2025 at 10:24AM, S17CNA indicated she would lock the caster brakes of the mechanical lift when raising a resident off of the bed. In an interview on 12/02/2025 at 10:26AM, S18CNA indicated the mechanical lift's brakes should be down and locked when residents are lifted up from a bed using the mechanical lift, unlocked when the rolling the mechanical lift, and then relocked when lowering a resident back down in the bed or chair. In an interview on 12/02/2025 at 10:33AM, S9CNA confirmed S15CNA locked the caster brakes of the mechanical lift during the above mentioned observation of Resident #R5's transfer. In a telephone interview on 12/02/2025 at 12:26PM, S8CNA indicated she would lock the brakes of the mechanical lift when she lifted a resident up from a bed using a mechanical lift. In an interview on 12/02/2025 at 12:32PM S19CNA indicated the brakes of the mechanical lift were to be locked when lifting a resident up from a bed and lowering a resident down into the bed or chair using the mechanical lift. In an interview on 12/02/2025 at 1:46PM, S4CNA Supervisor indicated 9CNA and S15CNA should not have locked the caster brakes of the mechanical lift when transferring Resident #R5. S4CNA Supervisor further indicated the caster brake locks should not be locked when a resident was raised from the bed using the mechanical lift. In an interview on 12/04/2025 at 1:04PM, S2Corporate Nurse indicated the CNAs using the facility's mechanical lifts should be competent in the procedure on the proper usage of the facility's mechanical lift per the manufacturer's guidelines.</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interviews and record reviews, the provider failed to ensure the accuracy of resident's records for 6 (Resident #2, Resident #3, Resident #R6, Resident #R7, Resident #R8, Resident #R9) of 9 residents reviewed for accurate records. Findings: Review of Resident #2's December 2025 Task Log documentation report revealed, in part, on 12/03/2025 at 11:55AM, S15CNA documented on Resident's #2 performance regarding bed mobility, toilet use, bowel elimination, that Resident #2 was turned and positioned, and that Resident #2 had eaten 51-75% of the 8:00AM meal. Further review revealed on 12/03/2025 at 11:56AM, S15CNA documented on Resident #2's performance regarding bladder elimination. Review of Resident #3's December 2025 Task Log documentation report revealed, in part, documentation a bed bath was completed for Resident #3 by S10CNA on 12/02/2025. Review of Resident #R6's December 2025 Task Log documentation report revealed, in part, on 12/03/2025 at 11:54AM, S15CNA documented on Resident's #R6 performance regarding bed mobility, toilet use, bowel elimination, bladder elimination, and that Resident #R6 had eaten 51-75% of the 8:00AM meal. Review of Resident #R7's December 2025 Task Log documentation report revealed, in part, on 12/03/2024 at 11:53AM, S15CNA documented on Resident's #R7 performance regarding bed mobility, toilet use, bowel elimination, bladder elimination, and that Resident #R7 was turned and positioned. Further review revealed on 12/03/2025 at 11:52AM, S15CNA documented that Resident #R7 had eaten 51-75% of the 8:00AM meal. Review of Resident #R8's December 2025 Task Log documentation report task revealed, in part, on 12/03/2025 at 11:57AM, S15CNA documented on Resident's #R8 performance regarding bed mobility, and that Resident #R8 had eaten 76-100% of the 8:00AM meal Further review revealed on 12/03/2025 at 11:58AM, S15CNA documented on Resident #R8's performance regarding toilet use, bowel elimination, and bladder elimination. Review of Resident #R9's December 2025 Task Log documentation report revealed, in part, on 12/03/2025 at 12:02PM, S15CNA documented on Resident's #R9 performance regarding bed mobility, toilet use, bowel elimination, bladder elimination, that Resident #2 was turned and positioned, and that Resident #R9 had eaten 0-25% of the 8:00AM meal. In an interview on 12/03/2025 at 11:40AM, S10CNA indicated she was not the person who documented Resident #3 had a bath on 12/02/2025, because she did not take care of Resident #3 on 12/02/2025. S10CNA further indicated she had shared her electronic medical record (EMR) credentials with S11CNA, S12CNA, and S13CNA, and they had used her credentials to document on residents' activities of daily living (ADLs) on 12/02/2025. In an interview on 12/03/2025 at 11:52AM S11CNA indicated she used S14CNA's credentials to document residents' ADLs on 12/02/2025, and had used S10CNA's credentials to document residents' ADLs on 12/01/2025. In an interview 12/03/2025 at 12:03PM S13CNA confirmed she had given Resident #3 a bed bath on 12/02/2025, and she had used S10CNA's credentials to document Resident #3's bed bath in Resident #3's electronic medical record (EMR) on 12/02/2025. In an interview on 12/03/2025 at 12:38PM, S20CNA indicated she provided care to Resident #2, Resident #R6, Resident #R7, Resident #R8, and Resident #R9 on 12/03/2025. S20CNA further indicated while she received her new EMR credentials on 12/02/2025, she forgot them at home, so instead, had used S15CNA's credentials to document Resident #2, Resident #R6, Resident #R7, Resident #R8, and Resident #R9's ADLs on 12/03/2025. In an interview on 12/03/2025 at 12:09PM, S2Corporate Nurse indicated staff's EMR credentials should be confidential. S2Corporate Nurse further indicated staff should not share their credential information nor document in residents' EMRs using another CNA's credentials. In an interview on 12/03/2025 at 12:22PM, S4CNA Supervisor indicated the facility's CNAs should not use each other's credentials to document in residents' EMRs.</p>		