

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Metairie Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 Riverside Drive Metairie, LA 70003	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41461</p> <p>Based on record reviews and interviews, the facility failed to protect the resident's right to be free from resident to resident physical abuse for 1 (Resident #5) of 2 (Resident #5 and Resident #62) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of the facility's undated Abuse, Neglect, and Misappropriation of Funds Program revealed, in part, the facility was to ensure the safety and well-being of residents at all times, and the facility was committed to a zero tolerance of any form of abuse in our facility.</p> <p>Review of Resident #5's record revealed, in part, a Brief Interview for Mental Status score of 14, which indicated a cognitive mental status.</p> <p>Review of Resident #62's record revealed, in part, a Brief Interview for Mental Status score of 4, which indicated severe cognitive impairment.</p> <p>Review of Resident #5's progress note dated 11/28/2024 at 2:17 p.m. revealed, in part, Resident #5 stated another resident (Resident #62) went into her room and punched her (Resident #5) in the face while she was asleep.</p> <p>Review of Resident #62's progress note dated 11/28/2024 at 2:09 p.m. revealed, in part, Resident #62 went into another resident's (Resident #5) room, punched her in her face and, waking her up out of her sleep. Further review revealed, Resident #62 told Resident #5, Bitch get your yellow ass out my bed.</p> <p>Review of an undated Resident Incident Report revealed, in part, an incident between Resident #5 and Resident #62 was reported on 11/28/2024 at 2:25 p.m. Further review revealed Resident #62 propelled his wheelchair into Resident #5's room, and hit her in the face, and told Resident #5 to get out of his bed.</p> <p>In an interview on 12/18/2024 at 1:56 p.m., S6Assistant Director or Nursing (ADON) indicated on 11/28/2024 at 2:14 p.m., S18Licensed Practical Nurses (LPN) sent her a text message to inform her Resident #62 hit Resident #5 in the face.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 12/18/2024 at 2:06 p.m., S2Director of Nursing (DON) indicated on 11/28/2024 at 2:25 p.m. , S6ADON texted her that Resident #62 hit Resident #5. S2DON further indicated resident to resident abuse should not have occurred between Resident #5 and Resident #62.</p> <p>In an interview on 12/19/2024 at 11:32 a.m., S1Administrator indicated on 11/28/2024 about 1:30 p.m. S1Administrator received a text from S2DON that Resident #62 hit Resident #5. S1Administrator indicated resident to resident abuse should not have occurred between Resident #5 and Resident #62.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41461</p> <p>Based on interviews, record review and facility policy review, the facility failed to ensure an allegation of physical abuse was reported on the Statewide Incident Management System no later than 2 hours after an allegation for resident to resident physical abuse for 1 (Resident #62) of 2 residents (Resident #5 and Resident #62) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of the facility's undated Abuse, Neglect, and Misappropriation of Funds Program policy revealed, in part, if a determination of abuse occurred the incident would be reported by the Administrator to the Department of Health and Hospitals via the Statewide Incident Management System (SIMS).</p> <p>Review of Resident #5's progress note dated 11/28/2024 at 2:17 p.m., revealed, in part, Resident #5 stated another resident (Resident #62) came into her room and punched her (Resident #5) in the face while she was asleep.</p> <p>Review of Resident #62's progress note dated 11/28/2024 at 2:09 p.m., revealed, in part, Resident #62 went into another resident's (Resident #5) room, punched her in her face, waking her up out of her sleep. Further review revealed, Resident #62 told Resident #5, Bitch get your yellow ass out my bed.</p> <p>Review of an undated Resident Incident Report revealed, in part, an incident between Resident #5 and Resident #62 was reported on 11/28/2024 at 2:25 p.m. Further review revealed Resident #62 propelled his wheelchair into Resident #5's room, hit Resident #5 in the face, and told Resident #5 to get out of his bed.</p> <p>In an interview on 12/18/2024 at 2:06 p.m., S2Director of Nursing (DON) indicated on 11/28/2024 at 2:25 p.m., she received a text message from S6Assistant Director of Nursing (ADON) that Resident #62 hit Resident #5. S2DON further indicated she texted S1Administrator with this information immediately after receiving the information from S6ADON. S2DON further indicated S1Administratoer was the only staff who could input incidents into the SIMS system.</p> <p>In an interview on 12/19/2024 at 11:32 a.m., S1Administrator indicated on 11/28/2024 at approximately 1:30 p.m. he received a text from S2DON that Resident #62 hit Resident #5. S1Administrator further indicated there was no documented evidence and he could not produce documented evidence that a Statewide Incident Management System incident report or investigation was reported and it should have been.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>41461</p> <p>Based on record reviews and interviews, the facility failed to ensure:</p> <ol style="list-style-type: none"> a thorough investigation was completed following an allegation of abuse for 2 (Resident #5 and Resident #62) of 2 (Resident #5 and Resident #62) sampled residents was investigated for abuse; and increased supervision was provided after an allegation of resident to resident abuse for (Resident #62) of 2 sampled residents (Resident #5 and Resident #62) investigated for abuse. <p>Findings:</p> <p>Review of the facility's undated Abuse, Neglect, and Misappropriation of Funds Program policy revealed, in part, all incidents or suspected incidents of resident abuse would be investigated immediately. Further review of the facility's undated Abuse, Neglect, and Misappropriation of Funds Program policy revealed a thorough investigation of facts regarding the incident would be recorded and maintained by the administrator. Further review revealed in the instance of resident to resident abuse, the involved resident would be separated, monitored, and protected. Further review revealed the Description of Investigation shall include:</p> <ol style="list-style-type: none"> Date/time of incident; Statement that allegation was found to be valid or invalid; Signature of Director of Nursing or Administrator; and Identify of Resident. <p>Review of Resident #5's progress note dated 11/28/2024 at 2:17 p.m. revealed, in part, Resident #5 stated another resident (Resident #62) went into her room and punched her (Resident #5) in the face while Resident #5 was asleep.</p> <p>Review of Resident #62's progress note dated 11/28/2024 at 2:09 p.m., revealed, in part, Resident #62 went into another resident's (Resident #5) room, punched her in her face waking her up out of her sleep. Further review revealed, Resident #62 told Resident #5, Bitch get your yellow ass out my bed.</p> <p>Review of the facility's Resident Incident Report revealed, in part, no indication the allegation of resident to resident abuse was valid or invalid. Further review revealed no indication the Administrator or Director of Nursing investigated the incident on the date it occurred. Further review revealed no documentation of a 24 hour follow-up.</p> <p>Review of Resident #62's December 2024 Electronic Medication Administration Record revealed visual checks every 2 hours starting on 12/06/2024 at 4:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 12/18/2024 at 2:06 p.m., S2DON indicated on 11/28/2024 at 2:25 P.M., S6Assistant Director of Nursing (ADON) texted her Resident #62 hit Resident #5. She further indicated the was no documented evidence and she could produce documented evidence a thorough investigation on the incident of resident to resident abuse between Resident #5 and Resident #62 was completed. She further indicated there was no documented evidence and she could not produce documented evidence of increased supervision for Resident #62 immediately after the 11/28/2024 incident. She further indicted a more complete investigation should have been completed and increased supervision of Resident #62 should have been done.</p> <p>In an interview on 12/19/2024 at 11:32 a.m., S1Administrator indicated on 11/28/2024 at approximately 1:30 p.m. he received a text from S2DON that Resident #62 hit Resident #5. S1Administrator further indicated there was no documented evidence and he could not produce documented evidence that a thorough investigation of resident to resident abuse. S1Administrator further indicated there was no documented evidence and he could not produce documented evidence increased supervision for Resident #62 was provided after the incident occurred on 11/28/2024.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41461</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure residents, who had a history of unsafe smoking used a safety smoking device and was supervised while smoking for 3 (Resident #31, Resident #15 and Resident #53) of 3 (Resident #15, Resident #31, and Resident #53) sampled residents reviewed for unsafe smoking.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 12/16/2024 at 9:50 a.m. when Resident #31, a resident identified by the facility as an unsafe smoker with moderate cognitive impairment, was observed smoking without the use of a smoking apron (a safety device which provides protection against burns to clothing and/or skin) and without staff supervision. Resident #31's care plan, initiated on 10/02/2024, included Resident #31 was an unsafe smoker, was required to wear a smoking apron, and required staff supervision while smoking.</p> <p>S1Administrator was notified of the Immediate Jeopardy situation on 12/16/2024 at 5:52 p.m.</p> <p>This deficient practice had the likelihood to cause more than minimum harm to all 3 residents (Resident #15, Resident #31, and Resident #53) identified by the facility as unsafe smokers who required safety smoking devices and/or supervision while smoking.</p> <p>Findings:</p> <p>Review of the facility's policy titled Smoking Policy, updated 07/04/2024, revealed in part, residents that smoke would be assessed for the safety of smoking unattended and if determined unsafe, would not be allowed to have smoking paraphernalia in their possession, and would be care planned for the amount of supervision needed while smoking. Further review revealed the administrator was responsible for enforcing the designated smoking area, the nursing staff was responsible for keeping and distributing smoking paraphernalia for residents who were identified as unsafe smokers, and the ward clerk was responsible to monitor an active unsafe smoker list.</p> <p>Resident #31</p> <p>Review of the facility's smoking list revealed, in part, Resident #31 was identified by the facility as unsafe smoker.</p> <p>Review of Resident #31's medical record revealed, in part, Resident #31 was admitted to the facility on [DATE] with diagnoses of, in part, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting his right dominant side.</p> <p>Review of Resident #31's annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/10/2024 revealed, in part, Resident #31 had a Brief Interview of Mental Status (BIMS) score of 9, which indicated Resident #31 had moderate impaired cognition. Further review revealed Resident #31 was identified as a tobacco user.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #31's quarterly MDS with ARD of 05/10/2024 revealed, in part, Resident #31 had a BIMS score of 10 which indicated Resident #31 had moderate impaired cognition. Further review revealed Resident #31 was identified as a tobacco user.</p> <p>Review of Resident #31's Comprehensive Care Plan, with an initiation date of 10/02/2024 revealed, in part, Resident #31 was actively an unsafe smoker who was required to wear a smoker's apron, and required staff supervision while smoking.</p> <p>Review of Resident #31's physician orders with a start date of 07/01/2024 revealed, in part, Resident #31 was an unsafe smoker and was required to wear a smoker's apron at all times while smoking.</p> <p>Observation on 12/16/2024 at 9:00 a.m., revealed Resident #31 was sitting in his wheelchair in his room with two burn holes in his shirt, one unlit cigarette under his left leg, and a lighter attached to a retractable device on his jacket.</p> <p>Observation on 12/16/2024 at 11:07 a.m., revealed Resident #31 was rolling in his wheelchair down hall c, with two burn holes in his shirt and a lighter attached to a retractable device on his jacket.</p> <p>In an interview on 12/16/2024 at 11:08 a.m., Resident #31 indicated he does not need anyone to go outside with him to smoke.</p> <p>Observation on 12/16/2024 at 12:18 p.m., revealed Resident #31 wheeled himself down hall c, with two burn holes in his shirt, and a lighter attached to a retractable device on his jacket.</p> <p>In an interview on 12/16/2024 at 12:19 p.m., Resident #31 indicated he was going to smoke.</p> <p>Observation on 12/16/2024 at 12:24 p.m., revealed Resident #31 was outside on the facility's smoking patio, unsupervised and without a smoker's apron on. Further observation revealed Resident #31 removed a pack of cigarettes out of his jacket, removed the cigarette lighter attached to a retractable device on his jacket, and lit a cigarette using the lighter.</p> <p>Observation on 12/16/2024 at 12:39 p.m., S1Administrator witnessed and confirmed Resident #31 was identified as an unsafe smoker, was on the facility's smoking patio unsupervised, without a smoker's apron on, and was in possession of a cigarette and a lighter.</p> <p>There was no documented evidence and the facility could not provide any documented evidence there was a list of identified unsafe smokers located at the nurses' station.</p> <p>In an interview on 12/17/2024 at 9:03 a.m., S2Director of Nursing (DON) indicated Resident #31, an unsafe smoker, was observed smoking unsupervised, without a smoker's apron on, and in possession of smoking paraphernalia. S2DON further indicated administrative staff was aware of unsafe smokers smoking unsupervised, without a smoker's apron on and in possession of smoking paraphernalia.</p> <p>In an interview on 12/17/2024 at 10:35 a.m., S5CNA indicated she was not aware Resident #31 was an unsafe smoker who required a smoker's apron with supervision while smoking. S5CNA further indicated she had not been aware that Resident #31 had smoking paraphernalia in his possession.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #15</p> <p>Review of Resident #15's annual MDS with ARD of 06/11/2024 revealed, in part, Resident #15 was identified as a tobacco user.</p> <p>A review of the facility's smoking list revealed, in part, Resident #15 was identified by the facility as an unsafe smoker.</p> <p>Observation on 12/16/2024 at 3:30 p.m., revealed Resident #15 sitting in his wheelchair in hall c with an opened full pack of cigarettes between his legs.</p> <p>Review of Resident #15's care plan revealed Resident #15 was care planned for unsafe smoking. Further, safe smoking interventions revealed in part; Resident#15 is an unsafe smoker, must wear a smoker's apron while smoking, cigarettes and lighter must be locked in the nurse's cart and Resident #15 must be supervised while smoking in the designated smoking location.</p> <p>In an interview on 12/17/2024 at 9:56 a.m., S4CNA indicated she was unaware Resident #15 was an unsafe smoker and should not have smoking material in his possession.</p> <p>Resident #53</p> <p>Review of Resident #53's smoking assessment dated [DATE], revealed, in part, Resident #53 was an unsafe smoker.</p> <p>Review of Resident #53's annual MDS with an ARD date of 05/28/2024, revealed, in part, Resident #53 had a BIMS of 15 which indicated Resident #53 was cognitively intact and was identified as a tobacco user.</p> <p>Review of Resident #53's care plan, dated 10/24/2024, revealed, in part, Resident #53 should be supervised while smoking and should use a smoker's apron.</p> <p>In an interview on 12/16/2024 at 12:45 p.m., Resident #53 indicated he kept his cigarettes in his personal locked box and a lighter in his shirt pocket and he does not have to be supervised while smoking.</p> <p>Observation on 12/16/2024 at 12:45 p.m., revealed Resident #53 took a lighter out of his shirt pocket.</p> <p>In an interview on 12/16/2024 at 12:46 p.m., S8CNA indicated Resident #53 should not have smoking material in his room.</p> <p>In an interview on 12/16/2024 at 12:47 p.m., S4CNA indicated Resident #53 should not have smoking material in his room.</p> <p>In an interview on 12/16/2024 at 12:48 p.m., S11LPN, indicated Resident #53 should not have any smoking paraphernalia in his room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 12/16/2024 at 12:50 p.m., S2Director of Nursing (DON) indicated she was aware Resident #53 was identified as an unsafe smoker, Resident #53 had to be supervised while smoking, and Resident #53 had smoking material in his possession.</p> <p>In an interview on 12/17/2024 at 8:55 a.m., S1Administrator confirmed the administrative personnel is responsible for ensuring the facility's designated smoking areas are enforced, Residents who are identified as unsafe smokers do not have smoking paraphernalia available in their rooms or on their person, and there was a current list of identified unsafe smokers at the nursing station</p> <p>In an interview on 12/17/2024 at 9:45 a.m., S1Administrator indicated Resident #15 was an unsafe smoker and should not have had smoking material in his possession.</p> <p>The Immediate Jeopardy was removed on 12/17/2024 at 6:50 p.m., after it was verified through observations, interviews, and record review, the facility implemented an acceptable Plan of Removal, prior to the survey exit.</p> <p>A Plan of Removal was accepted on 12/17/2024 at 6:50 p.m., which included the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> 1.) On 12/16/2024, S2DON and S1Administrator inspected other identified unsafe smokers from a review of an updated smokers list in order to collect and store items on the nursing cart and to prevent other potential harm that could occur. 2.) On 12/16/2024, a review of the current smoker's policy was conducted by S1Administrator and S2DON immediately with no immediate changes made. 3.) On 12/16/2024, S2DON and S1Administerator inspected personal belongings of all unsafe smokers and any smoking material found in possession of residents and was confiscated to given to the assigned nurse on the medication cart. All materials collected by S1Administrator and S2DON were placed in a zip locked bag and labeled with the resident's name. 4.) On 12/16/2024, direct care staff were immediately in-serviced on the facility smoker's policy by S2DON, and made aware of who was currently deemed as an unsafe smoker and each resident's level of safety to smoke. 5.) Beginning on 12/16/2024, all direct care staff, CNAs and nurses, were notified and in-serviced by S2DON. All staff would assist with supervising smoking for unsafe smokers as well as ensuring smoker's aprons were worn. This was initiated with the staff who were present and would continue with each shift, prior to the provision of care. 6.) On 12/16/2024, nurses were told by S2DON that they would secure smoking items and would locate a smoking attendant that could assist with smoking activity each time a resident requested to go out and smoke. In-services would be ongoing. 7.) On 12/16/2024, an updated smoking list was provided by S2DON to the Minimum Data Set (MDS) nurses and placed at the desk for all staff to reference. <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48855</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure an enteral feeding bag (bag that contains a formula for the purpose of supplying nutrients directly into the stomach) was properly labeled to include the date and time of initiation, an expiration date, the name of the resident, and the rate of the infusion. This practice was identified for 1(Resident#1) of 1 (Resident #1) sampled residents investigated for enteral feeding.</p> <p>Findings:</p> <p>Review of Resident #14's rerecord revealed, in part, Resident #14 was readmitted to the facility on [DATE] with a diagnoses, in part, of dysphagia (difficulty swallowing food and/or liquids) and gastrostomy status (a surgical procedure that creates an opening in the abdomen and into the stomach to provide nutritional support).</p> <p>Review of the facility's undated Percutaneous Endoscopic Gastrostomy (PEG) policy and procedure revealed, in part, formula bottles and/or bags shall be labeled with the resident's name, date and time, and rate of administration.</p> <p>Review of Resident #14's December 2024 Physician Orders revealed, in part, an order with a start date of 09/03/2024 for enteral feed Jevity per PEG tube at 70 milliliters (mL) an hour continuously, with 200 mL free water flush every 6 hours.</p> <p>Review of Resident #14's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/2024 revealed, in part, Resident #14 received enteral feeds.</p> <p>Observation on 12/16/2024 at 10:25 a.m. revealed Resident #14's enteral feeding bag and free water flush bag was not labeled with the date and time administered, Resident #14's name, and an infusion rate.</p> <p>Observation on 12/17/2024 at 9:02 a.m. revealed Resident #14's enteral feeding bag and free water flush was not labeled with the date and time administered, Resident #14's name, and rate of administration.</p> <p>In an interview on 12/17/2024 at 9:10 a.m., S15Licensed Practical Nurse (LPN) confirmed Resident #14's enteral feeding bag and free water flush bag were not labeled with the date and time administered with Resident #14's name, and with an infusion rate for the enteral feed and the free water flush.</p> <p>In an interview on 12/17/2024 at 1:28 p.m., S2Director of Nursing (DON) indicated Resident #14's enteral feed and free water flush should have been labeled with the date and time administered, Resident #14's name, and an infusion rate for the enteral feed and the free water flush.</p> <p>Observation on 12/19/2024 at 8:49 a.m. revealed Resident #14's enteral feeding was not labeled with Resident #14's name.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 12/19/2024 at 8:49 a.m., S21LPN indicated Resident #14's enteral feed and free water flush should have included Resident #14's name.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33202</p> <p>Based on record reviews, interviews, and observations, the facility failed to ensure staff were able to demonstrate competency in skills necessary to assess for safe smoking for 3 (Resident #31, Resident #15 and Resident # 53) of 3 (Resident #31, Resident #15 and Resident #53) residents reviewed for unsafe smoking.</p> <p>Findings:</p> <p>Review of the facility's policy titled Smoking Policy, updated 07/04/2024, revealed in part, residents that smoke would be assessed for the safety of smoking unattended and if determined unsafe, would not be allowed to have smoking paraphernalia in their possession, and would be care planned for the amount of supervision needed while smoking. Further review revealed the administrator was responsible for enforcing the designated smoking area, the nursing staff was responsible for keeping and distributing smoking paraphernalia for residents who were identified as unsafe smokers, and the ward clerk was responsible for monitoring an active unsafe smoker list.</p> <p>Resident #31</p> <p>Review of the facility's smoking list revealed, in part, Resident #31 was identified by the facility as unsafe smoker.</p> <p>Review of Resident #31's medical record revealed, in part, Resident #31 was admitted to the facility on [DATE] with diagnoses, in part, of hemiplegia and hemiparesis following an unspecified cerebrovascular accident (stroke) affecting his right dominant side.</p> <p>Review of Resident #31's quarterly MDS with an ARD of 05/10/2024 revealed, in part, Resident #31 had a BIMS score of 10 which indicated Resident #31 had moderately impaired cognition. Further review revealed Resident #31 was identified as a tobacco user.</p> <p>Review of Resident #31's Comprehensive Care Plan, with an initiation date of 10/02/2024 revealed, in part, Resident #31 was an unsafe smoker who was required supervision and a smoker's apron while smoking.</p> <p>Review of Resident #31's physician orders with a start date of 07/01/2024 revealed, in part, Resident #31 was an unsafe smoker and was required to wear a smoker's apron at all times while smoking.</p> <p>Observation on 12/16/2024 at 9:00 a.m., revealed Resident #31 was sitting in his wheelchair in his room with two burn holes in his shirt, one unlit cigarette under his left leg, and a lighter attached to a retractable device on his jacket.</p> <p>Observation on 12/16/2024 at 11:07 a.m., revealed Resident #31 was rolling in his wheelchair down hall c, with two burn holes in his shirt and a lighter attached to a retractable device on his jacket.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation on 12/16/2024 at 12:18 p.m., revealed Resident #31 wheeled himself down hall c, with two burn holes in his shirt, and a lighter attached to a retractable device on his jacket.</p> <p>Observation on 12/16/2024 at 12:24 p.m., revealed Resident #31 was outside on the facility's smoking patio, unsupervised and without a smoker's apron on. Further observation revealed Resident #31 removed a pack of cigarettes out of his jacket, removed the cigarette lighter attached to a retractable device on his jacket, and lit a cigarette using the lighter that was attached to his jacket.</p> <p>Observation on 12/16/2024 at 12:39 p.m., S1Administrator confirmed Resident #31 was identified as an unsafe smoker, was on the facility's smoking patio unsupervised, without a smoker's apron on, and was in possession of a cigarette and a lighter.</p> <p>In an interview on 12/16/2024 at 12:40 p.m., S1 Administrator confirmed Resident #31 was identified as an unsafe smoker, was on the facility's smoking patio unsupervised, without a smoker's apron on, and was in possession of a cigarette and a lighter.</p> <p>There was no documented evidence and the facility could not provide any documented evidence there was a list of identified unsafe smokers located at the nurses' station.</p> <p>In an interview on 12/17/2024 at 8:40 a.m., S7Agency Certified Nursing Assistant (ACNA) indicated he had not received any training on safe and/or unsafe smoking policies.</p> <p>In an interview on 12/17/2024 at 9:03 a.m., S2Director of Nursing (DON) indicated prior to Resident #31's above mentioned observation on 12/16/2024 at 12:24 p.m., staff had not received education on the facility's smoking policy and there was no evidence presented that staff were educated on residents who were identified as unsafe smokers.</p> <p>In an interview on 12/17/2024 at 9:56 a.m., S4CNA indicated she did not know Resident #15 was an unsafe smoker and should not have had smoking material in his possession. S4CNA further indicated prior to 12/16/2024 she was not educated on residents considered to be unsafe smokers and interventions required for unsafe smokers.</p> <p>In an interview on 12/17/2024 at 10:35 a.m., S5CNA indicated she was not aware Resident #31 was an unsafe smoker, who required a smoker's apron with supervision while smoking.</p> <p>Resident #15</p> <p>Review of Resident #15's annual MDS with ARD of 06/11/2024 revealed, in part, Resident #15 was identified as a tobacco user.</p> <p>A review of the facility's smoking list revealed, in part, Resident #15 was identified by the facility as an unsafe smoker.</p> <p>Observation on 12/16/2024 at 3:30 p.m., revealed Resident #15 sitting in his wheelchair in hall c with an opened full pack of cigarettes between his legs.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #15's Comprehensive Care Plan revealed, in part, Resident #15 was an unsafe smoker. Further review revealed, interventions for Resident #15 included he must wear a smoker's apron while smoking, cigarettes and lighter must be locked in the nurse's cart and Resident #15 required supervision while smoking.</p> <p>In an interview on 12/17/2024 at 9:56 a.m., S4CNA indicated she was unaware Resident #15 was an unsafe smoker and should not have had smoking material in his possession.</p> <p>Resident #53</p> <p>Review of Resident #53's smoking assessment dated [DATE], revealed, in part, Resident #53 was an unsafe smoker.</p> <p>Review of Resident #53's annual MDS with an ARD date of 05/28/2024, revealed, in part, Resident #53 had a BIMS of 15 which indicated Resident #53 was cognitively intact and was identified as a tobacco user.</p> <p>Review of Resident #53's Comprehensive Care Plan, dated 10/24/2024, revealed, in part, Resident #53 required supervision and a smoker's apron while smoking.</p> <p>Observation on 12/16/2024 at 12:45 p.m., revealed Resident #53 received a lighter from his shirt pocket.</p> <p>In an interview on 12/17/2024 at 8:55 a.m., S1Administrator confirmed the administrative personnel was responsible for ensuring staff are educated and trained on unsafe smoking policy and procedures. Further, S1Administrator indicated staff training/education was not implemented and the policy was not enforced as required for unsafe smokers.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45877</p> <p>Based on record reviews and interviews, the facility failed to maintain a record of controlled drugs for 2 (Medication Cart a and Medication Cart b) of 2 (Medication Cart a and Medication Cart b) medication carts reviewed for the reconciliation of controlled drugs (the process of ensuring that the location and quantity of controlled drugs was accurate).</p> <p>Findings:</p> <p>Review of the facility's undated policy titled, Controlled Drug Policy and Procedure revealed, in part, controlled drugs are to be counted after every shift by the nurse reporting on duty and the nurse reporting off duty. Further review revealed the inventory of the controlled drugs must be recorded in the narcotic records and signed for correctness.</p> <p>Review of the facility's December 2024 Medication Cart a Controlled Drugs-Count Record revealed, in part, the following shifts had an incomplete reconciliation of controlled drugs by the nurse coming on duty and the nurse going off duty:</p> <ul style="list-style-type: none"> - 12/01/2024 on the 7:00 a.m. to 3:00 p.m. shift - 12/16/2024 on the 11:00 p.m. to 7:00 a.m. shift - 12/17/2024 on the 11:00 p.m. to 7:00 a.m. shift; and, - 12/18/2024 on the 7:00 a.m. to 3:00 p.m. shift <p>Review of the facility's December 2024 Medication Cart b Controlled Drugs-Count Record revealed, in part, the following shifts had an incomplete reconciliation of controlled drugs by the nurse coming on duty and the nurse going off duty:</p> <ul style="list-style-type: none"> - 12/17/2024 on the 11:00 p.m. to 7:00 a.m. shift. <p>In an interview on 12/18/2024 at 9:28 a.m., S16Licensed Practical Nurse (LPN) indicated the controlled drugs-count record should be signed by the off going and on coming nurse each shift. S16LPN further indicated the facility's December 2024 Controlled Drugs-Count Record for Medication Cart a had missing signatures on 12/01/2024, 12/16/2024, 12/17/2024, and 12/18/2024.</p> <p>In an interview on 12/18/2024 at 9:50 a.m., S2Director of Nursing confirmed the controlled drugs-count record should be signed by the off going and on coming nurse each shift. S2Director of Nursing acknowledged Medication Cart a had missing signatures on 12/01/2024, 12/16/2024, 12/17/2024, and 12/18/2024 and Medication Cart b had missing signatures on 12/17/2024.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</p> <p>Based on record reviews and interviews, the facility failed to monitor for behaviors and potential side effects of antidepressants and anti-anxiety medications for 1 (Resident #346) of 5 (Resident #10, Resident #43, Resident #53, Resident #79, and Resident #346) residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Resident #346's Electronic Medical Record (EMR) revealed, in part, Resident #346 was admitted to the facility on [DATE] with diagnoses, in part, of major depressive disorder and anxiety.</p> <p>Review of Resident #346's December 2024 Physician's Orders revealed the following orders:</p> <ul style="list-style-type: none"> - Prozac (a medication used to treat depression) Oral Capsule 20 milligrams (mg), give 1 capsule by mouth one time a day related to major depressive disorder beginning on 12/04/2024; and, - Buspirone (a medication used to treat anxiety) Hydrochloride Oral Tablet 5 MG, give 1 tablet by mouth two times a day related to anxiety disorder beginning on 12/04/2024. <p>Review of Resident #346's December 2024 Electronic Medication Administration Record revealed, in part, no documented evidence and the facility did not present any document evidence side-effect monitoring for antianxiety medication was completed on 12/09/2024 and 12/14/2024 on the night shifts. Further review revealed no documented evidence side-effect monitoring of antidepressants was completed on 12/09/2024 and 12/14/2024 on the night shifts.</p> <p>Review of Resident #346's EMR revealed, in part, no documented evidence and the facility did not present any documented evidence for behavior monitoring on 12/06/2024 for the night shift, 12/08/2024 for the night shift, 12/10/2024 for the morning shift, 12/11/2024 for the night shift, 12/12/2024 for the night shift, 12/13/2024 for the night shift, 12/14/2024 for the evening shift, 12/16/2024 for the evening shift and the night shift, 12/17/2024 for the morning shift and for the night shift, and 12/18/2024 for the evening shift and the night shift.</p> <p>In an interview on 12/19/2024 at 10:38 a.m., S19Assistant Director of Nursing confirmed Resident #346's EMR did not have any documented evidence of behavior monitoring or side effect monitoring for the above mentioned shifts.</p> <p>In an interview on 12/19/2024 at 11:10 a.m., S2Director of Nursing confirmed Resident #346's EMR did not have any documented evidence of behavior monitoring or side effect monitoring for the above mentioned shifts.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>41461</p> <p>Based on record review and interviews, the facility failed to ensure a sample for a urinalysis, a test for determining the presence of a urinary tract infection (UTI), was obtained and treatment for a UTI was initiated as ordered for 1 (Resident #62) of 1 (Resident #62) sampled residents investigated for urinary tract infections.</p> <p>Findings:</p> <p>Review of Resident #62's record revealed, in part, a physician's order dated 12/05/2024 for a urinalysis (UA) with a culture and sensitivity related to aggressive behavior.</p> <p>Review of Resident #62's record revealed, in part, on 12/05/2024 an order for a urinalysis with a culture and sensitivity.</p> <p>Review of a Resident #62's record revealed, in part, a laboratory report that indicated the urine sample was collected on 12/10/2024 and an approval date of 12/13/2024 that indicated a result of a urinary tract infection. Further review revealed a handwritten order for ampicillin (an antibiotic to treat infection) 500 milligrams (mg) three times a day (tid) for seven days written on the laboratory results.</p> <p>Review of Resident #62's December 2024 Electronic Medication Administration Record revealed, in part, Resident #62 received ampicillin 500 mg as ordered starting on 12/16/2024.</p> <p>In an interview on 12/19/2024 at 10:30 a.m. S2Director of Nursing (DON) indicated on 12/05/2024 during a Utilization Review meeting it was discussed, and the decision was made to obtain a UA from Resident #62 due to a history of aggressive behavior. S2DON further indicated the UA was obtained on 12/10/2024. S2DON further indicated she did not know why it took 5 days to obtain Resident #62's UA, but the urine sample should have been obtained on 12/05/2024. S2DON further indicated the culture results were received on 12/13/2024. She further indicated the physician should have been notified, orders received and antibiotics started on 12/13/2024 and they were not.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>40405</p> <p>Based on observation, record review, and interviews the facility failed to ensure food was palatable, and served at an appetizing temperature.</p> <p>Findings:</p> <p>Review of Resident #34's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/2024 revealed a Brief Interview for Mental Status (BIMS) of 10, which indicated moderate cognitive impairment.</p> <p>In an interview on 12/16/2024 at 10:41 a.m., Resident #34 indicated food served at the facility did not taste good, and the alternate meal was just as bad as the scheduled main meal.</p> <p>Observation on 12/18/2024 at 11:53 a.m. revealed an alternate meal lunch tray was provided to the survey team by S9Dietary Manager. Four surveyors tasted the food, and findings revealed the mashed potatoes and gravy were lukewarm to room temperature, the cod fish patty was thin and consisted mostly of breading, and the steamed broccoli was soft and mushy. Findings revealed, the sampled alternate meal was not palatable or at an appetizing temperature.</p> <p>In an interview on 12/18/2024 at 12:45 p.m., S9Dietary Manager acknowledged the facility's alternate lunch tray was not palatable and not served at an acceptable temperature.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41461</p> <p>Based on observations and interview the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure stored food had an open date for 8 food products; and 2. Ensure kitchen cooking equipment was kept in a clean and sanitary condition. <p>Findings:</p> <p>Review of the facility's undated policy titled Proper Labeling and Storage of Food revealed, in part, proper food preparation, storage, and handling practices are essential in preventing foodborne illness and unsafe food handling practice represented a potential source of pathogen exposure for those with weakened immune systems (e.g. elderly, young, immunocompromised). Further policy review revealed sanitary conditions and safe food handling are required in food service settings, and proper storage, and labeling of food in a commercial kitchen could help prevent foodborne illness. Policy review revealed label and date all foods with date prepared or opened, the use by date, and identify what the product is.</p> <p>Observations on 12/16/2024 at 10:00 a.m. revealed, in part,</p> <ul style="list-style-type: none"> - one opened container of jelly, with no open date; - one opened 5 pound container of peanut butter, with no open date; - one opened 11 ounce container of dry parsley flakes, with no open date; - one opened 24 ounce container of cinnamon spice, with no open date; - one opened 24 ounce container of nutmeg spice, with no open date; - one opened 24 ounce container of Italian seasoning, with no open date; - one opened 24 ounce container of oregano seasoning, with no open date; and - one opened 20 ounce container of mustard, with no open date. <p>Further observation revealed the standing fryer had a clear to yellow thick substance build up on the edges of the fryer.</p> <p>Further observations revealed the side of the stove next to the standing fryer and the side of the oven next to the standing fryer had thick clear to yellow substance on the sides of each of these equipment.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 12/16/2024 at 10:30 a.m., S9Dietary Manager indicated all the above listed containers should have had an open date, and they did not. She further indicated there was built up grease on the fryer, oven, and stove. S9Dietary Manager further indicated the fryer, oven, and stove should have been kept in a sanitary manner.</p> <p>48855</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>48855</p> <p>Based on interviews, observations, and policy review the administrative staff failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents by overseeing the effective implementation of the facility's smoking policy and procedure for monitoring and supervision for 3 (Resident #15, Resident #31, and Resident #53) of 3 (Resident #15, Resident #31, and Resident #53) residents identified as unsafe smokers.</p> <p>This lack of administrative oversight resulted in Immediate Jeopardy situation on 12/16/2024 at 9:50 a.m., when facility staff failed to ensure implementation of their smoking policy when an unsafe smoker (Resident #31) was observed smoking on the smoking patio, in possession of a cigarette and a lighter, alone, and without supervision.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 12/17/2024 at 3:58 p.m.</p> <p>This deficient practice had the likelihood to cause more than minimal harm to the 3 residents (Resident #15, Resident #31, and Resident #53) identified as unsafe smokers.</p> <p>Findings:</p> <p>Cross-Reference Findings at F-689</p> <p>Review of the facility's policy titled Smoking Policy, last updated 07/04/2024 revealed, in part, residents who continue to smoke will be assessed for the safety of smoking unattended. Further review revealed the administrator is responsible for seeing that the smoking designated areas are enforced. The nursing staff are responsible for keeping and distributing smoking paraphernalia for residents, and the ward clerk was responsible to monitor the active smoker list.</p> <p>In an interview on 12/16/2024 at 12:29 p.m., S1Administrator confirmed Resident #31 was on the unsafe smoker list. S1Administrator further indicated he observed Resident #31 smoking on the smoking patio, without a smoker's apron on, in possession of a cigarette and a lighter, alone, and without supervision.</p> <p>In an interview on 12/16/2024 at 3:58 p.m., S1Administrator indicated he is ultimately responsible to ensure the facility's smokers are safe and that the facility's policy and procedures for smoking is adhered to.</p> <p>In an interview on 12/17/2024 at 9:03 a.m., S2Director of Nursing (DON) indicated prior to the observation of Resident #31 smoking on the facility's smoking patio unsupervised, without a smoker's apron on, and in possession of smoking paraphernalia on 12/16/2024 at 12:24 p.m., the facility's staff was not educated on the facility's smoking policy.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Metairie Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 Riverside Drive Metairie, LA 70003	
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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 12/17/2024 at 3:30 p.m., S22Regional Administrator (RA) indicated he would provide in person oversight to S1Administrator and the administrative staff weekly beginning 12/17/2024. Further, S22RA would monitor the safe smoking areas of the facility on a weekly basis.</p> <p>In an interview on 12/17/2024 at 4:15 p.m., S22RA indicated in his absence, daily monitoring of the safe smoking areas of the facility will be done by S1Administrator. Further, S22RA indicated in the absence of S1Administrator, the daily monitoring of the safe smoking areas of the facility will be done by S2DON. In the absence of S2DON, the daily monitoring of safe smoking areas of the facility will be done by S6ADON. In the absence of S6ADON, the daily monitoring of the safe smoking areas of the facility will be done by the charge nurse on duty for that shift.</p> <p>The Immediate Jeopardy was removed on 12/18/2024 at 3:36 p.m., after it was determined through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal prior to the survey exit.</p> <p>A Plan of Removal was accepted on 12/18/2024 at 3:36 p.m., which included the following actions to correct the deficient practice:</p> <p>S22Regional Administrator will provider oversight as follows: in part;</p> <ol style="list-style-type: none"> 1.) On 12/17/2024, S22Regional Administrator (RA) provided in-person oversight to S1Administrator and administrative staff in the monitoring of unsafe smokers and the smoking areas on a weekly basis. 2.) On 12/17/2024, S22RA reviewed the Smoking Policy to ensure compliance with safe smoking 3.) On 12/17/2024, S22RA monitored unsafe smoking to ensure residents do not have smoking material on their person, are wearing smoker's aprons and are supervised. 4.) On 12/17/2024, S22RA quizzed direct care staff about the smoking policy and their role within. 5.) On 12/17/2024, S22RA reviewed the current smoking list to ensure it was updated. 6.) On 12/17/2024, S22RA reviewed all unsafe resident assessments and care plans to ensure all assessments and care plans were updated. <p>The likelihood of serious harm no longer existed for residents related to unsafe smoking on 12/18/2024 at 3:36 p.m.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41461</p> <p>Based on record reviews, observations, and interviews, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure staff performed hand hygiene between assisting residents (Resident #71 and Resident #411) with meals; and, 2. Ensure an indwelling urinary catheter tubing and collection bag was not on the floor for 1 (Resident #197) of 2 (Resident #62 and Resident #197) sampled residents investigated for urinary catheter and urinary tract infections (UTI), <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility's 2009 policy titled, Handwashing/Hand Hygiene revealed, in part, the facility considered hand hygiene the primary means to prevent the spread of infections. Further review revealed hand hygiene should be performed before and after assisting residents with meals. <p>Observation on 12/16/2024 at 11:49 a.m. revealed S19Certified Nursing Assistant (CNA) assisted Resident #71 with her meal without performing hand hygiene. Further observation revealed S19CNA then assisted Resident #411 with her meal without performing hand hygiene.</p> <p>In an interview on 12/16/2024 at 11:54 a.m., S19CNA confirmed she did not perform hand hygiene in between assisting Resident #71 and Resident #411 with their meals and she should have.</p> <p>In an interview on 12/16/2024 at 11:58 a.m., S20Licenced Practical Nurse confirmed hand hygiene should be performed between assisting residents with meals.</p> <p>In an interview on 12/18/2024 at 9:50 a.m., S2Director of Nursing confirmed hand hygiene should be performed between assisting residents with meals.</p> <ol style="list-style-type: none"> 2. Review of Resident #197's hospice admission orders dated 12/06/2024 revealed, in part, an order to insert a size 16 or 18 French Foley catheter for urinary retention or incontinence. <p>Observation on 12/16/2024 at 9:42 a.m. revealed Resident #197's urinary catheter tube was lying on the floor.</p> <p>Observation on 12/16/2024 at 2:35 p.m. revealed Resident #197 urinary catheter tube was lying on the floor.</p> <p>Observation on 12/17/2024 at 9:40 a.m revealed Resident #197's urinary catheter tubing and collection bag were observed lying on the floor under his bed.</p> <p>In an interview on 12/17/2024 at 9:45 a.m., S2Director of Nursing (DON) confirmed Resident #197's urinary catheter tubing and bag was lying on the floor at his bedside. S2DON further indicated Resident #197's urinary catheter tubing and collection bag should not have been lying on the floor.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 12/17/2024 at 9:50 a.m., S1Administrator confirmed Resident #197's urinary catheter tubing and bag was lying on the floor at his bedside. S1Administrator further indicated Resident #197's urinary catheter tubing and bag should not have been lying on the floor.</p> <p>45877</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>44336</p> <p>Based on interview and record review, it was determined that the facility failed ensure a pneumonia vaccine was administered for 1 (Resident #23) of 5 (Resident #10, Resident #23, Resident #41, Resident #42 and Resident #46) reviewed for vaccines.</p> <p>Findings:</p> <p>Review of Resident #23's medical record revealed the Responsible Party (RP) signed a consent on 01/10/2024 for Resident #23 to receive a pneumonia vaccine.</p> <p>There was no documented evidence that the pneumonia vaccine was administered as per the consent, and the facility could not provide documentation the pneumonia vaccine had been administered.</p> <p>In an interview on 12/17/2024 at 5:35 PM, S2Director of Nursing (DON) confirmed the pneumonia vaccine had not been administered to Resident #23 after the RP signed the consent on 01/10/2024.</p> <p>49753</p>