STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195279	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Mandeville	1820 W. Causeway Approach Mandeville, LA 70471

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on record review and interviews, the facility failed to ensure Minimum Data Set (MDS) assessments were completed and transmitted timely for 2 (#27 and #101) of a total of 31 sampled residents reviewed for Resident Assessment. Findings: Resident #27 Review of Resident #27's Clinical Record revealed he was admitted to the facility on [DATE]. On 10/07/2024, review of Resident #27's Quarterly MDS with an ARD of 09/03/2024 revealed the MDS assessment was incomplete and had a status of: In progress. On 10/08/2024, review of Resident #27's Quarterly MDS with an ARD of 09/03/2024 revealed a completion date of 10/08/2024, signed by S6MDS. Resident #101 Review of Resident #101's Clinical Record revealed he was admitted to the facility on [DATE]. Further review revealed Resident #101 was discharged to the hospital on 09/07/2024 and returned to the facility on [DATE]. On 10/07/2024, review of Resident #101's Discharge MDS with an ARD of 09/07/2024 revealed it was incomplete and had a status of: In progress. On 10/08/2024, review of Resident #101's Discharge MDS with an ARD of 09/07/2024 revealed a completion date of 10/08/2024, signed by S5MDS. On 10/08/2024 at 3:40 p.m., an interview was conducted with S5MDS and S6MDS. They reviewed the above MDS assessments and confirmed they were not completed within the required 14 days after the ARD date, and had not been transmitted to CMS. (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
	195279	A. Building B. Wing	10/09/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/2024 at 3:51 p.m., an interview was conducted with S4DON. She reviewed the above MDS assessments and confirmed they were not completed within the required 14 days after the ARD date, and had not been transmitted to CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195279	A. Building B. Wing	10/09/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on interviews and record reviews, the facility failed to ensure resident's MDS assessments accurately reflected the resident's status for 5 (#17, #22, #26, #99, and #114) out of 31 residents reviewed in the final sample. The facility failed to ensure: 1. Resident #17 and Resident #22 were accurately coded for PASRR (Pre-admission Screening and Resident Review); 2. Resident #26 was not coded for anticoagulant use; 3. Resident #99 was coded correctly for Diabetic foot ulcers; and 4. Resident #114 was coded correctly for discharge. Findings: 1. Resident #17 Review of Resident #17's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Anxiety Disorder, Unspecified Psychosis, and Major Depressive Disorder, Single Episode Mild. Review of Resident #17's 142 Form titled Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification dated 10/25/2023, revealed an approval for admission by the state Level II Authority for a temporary period effective 10/25/2023 through 10/23/2024. Review of Resident #17's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/14/2024 revealed Section A1500: Resident evaluated by PASRR was coded 0. No. Further review revealed section A1510: Serious Mental Illness was blank. Resident #22 Review of Resident #22's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis of Schizophrenia, Unspecified Dementia, Schizoaffective Disorder Bipolar Type, and Schizophreniform Disorder. Review of Resident #22's 142 Form titled Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification dated 11/05/2013 revealed a permanent approval for admission by the state Level II Authority on 11/12/2013. Review of Resident #22's Annual MDS with an ARD of 09/09/2024 revealed Section A1500: Resident evaluated by PASRR was coded as 0. No. Further review revealed Section A1510: Serious Mental Illness was blank. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/2024 at 3:45 p.m., an interview was conducted with S5MDS. She verified Resident #17's Form 142 indicated Resident #17 was approved for admission by the state Level II Authority for a temporary period effective 10/25/2023 through 10/23/2024. She reviewed Resident #17's Annual MDS assessment dated [DATE] and confirmed Section A1500 should have been coded as 1-Yes, and was not. On 10/09/2024 at 8:50 a.m., an interview was conducted with S6MDS. She verified Form 142 indicated Resident #22 was approved for permanent Level II on 11/12/2013. She reviewed Resident #22 Annual MDS assessment dated [DATE] and confirmed Section A1500 should have been coded as 1-Yes, and was not. On 10/09/2024 at 4:00 p.m., an interview was conducted with S4DON. She reviewed the aforementioned findings for Resident's #17 and #22. She confirmed the resident's Annual MDS assessments should have been coded correctly and were not. 2. Resident #26 Review of Resident #26's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #26's Quarterly MDS with an ARD of 06/20/2024 revealed Resident #26 was coded for anticoagulant use. Review of Resident #26's Physician Orders dated April 2024-October 2024 revealed no orders for anticoagulants. Review of Resident #26's MAR dated April 2024-October 2024 revealed the resident did not receive any anticoagulants. On 10/08/2024 at 3:40 p.m., an interview was conducted with S5MDS. She reviewed Resident #26's Quarterly MDS assessment with an ARD of 06/20/2024 then reviewed his MAR for that time. S5MDS confirmed Resident #26 was not taking anticoagulants at that time, and his 06/20/2024 MDS was coded for anticoagulant use and should not have been. On 10/08/2024 at 3:51 p.m., an interview was conducted with S4DON. She was notified of the aforementioned findings and confirmed Resident #26 should not have been coded for anticoagulant use. 3. Resident #99 Review of Resident #99's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes Mellitus with Other Skin Ulcer. Review of Resident #99's Admission MDS with an ARD of 08/23/2024 revealed Section M0300. A. Number of Stage 1 Pressure Injuries- 1, Section M1040. B. Diabetic Foot Ulcer(s) - No, and M1200. I. Application of dressings to feet (with or without topical medications) - Yes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #99's Physician's Orders revealed the following in part: Diabetic ulcer to left posterior ankle: cleanse with wound cleanser, pat dry, apply silver antibacterial gel, apply non-adherent pad, apply black foam, apply no sting skin prep to periwound, secure transparent drape tape to form air tight seal, attach wound vac at 125mmHg and continuous setting every Monday and Friday and as needed until resolved. Start date: 08/19/2024. End date: 08/28/2024. Stage 1 Pressure Injury to Sacrum: cleanse with wound cleanser, apply barrier cream daily and as needed until resolved, every day shift and every 24 hours as needed. Start date: 08/19/2024. End date: 09/17/2024. On 10/09/2024 at 2:40 p.m., an interview was conducted with S5MDS. She reviewed Resident #99's wounds and confirmed Resident #99 had a Stage 1 Pressure Ulcer to her sacrum as well as a Diabetic foot ulcer to her left ankle. She reviewed Resident #99's Admission MDS with an ARD of 08/23/2024. S5MDS confirmed section M1040. B. Diabetic Foot ulcer(s) was coded no, and should have been coded yes since Resident #99 had a Diabetic Foot Ulcer. On 10/09/2024 at 3:45 p.m., an interview was conducted with S4DON. She reviewed Resident #99's wounds and confirmed Resident #99 had a Stage 1 Pressure Ulcer to her sacrum as well as a Diabetic foot ulcer. She reviewed Resident #99's Admission MDS with an ARD of 08/23/2024. S4DON confirmed section M1040. B. Diabetic Foot ulcer(s) was coded no and should have been coded yes since Resident #99 had a Diabetic Foot Ulcer. 4. Resident #114 Review of Resident #114's Clinical Record revealed she was admitted to the facility on [DATE] and was discharged on [DATE]. Review of Resident #114's Discharge MDS with an ARD of 07/31/2024 revealed Section A2105 Discharge Status: Short Term General Hospital. Review of Resident #114's Discharge Summary dated 07/31/2024 revealed the resident was discharged to home/community. On 10/08/2024 at 3:40 p.m., an interview was conducted with S5MDS. She stated she was responsible for the MDS Assessments. S5MDS verified Resident #114 was discharged to home with family. She reviewed Resident #114's Discharge MDS and confirmed Section A2105 indicated the resident was discharged to the hospital, and should have been coded for discharged home with family. On 10/08/2024 at 3:51 p.m., an interview was conducted with S4DON. She verified Resident #114 was discharged home. She reviewed Resident #114's Discharge MDS and confirmed Section A2105 was coded for being discharged to the hospital and should have been coded for discharge to home. 47173 47191 (continued on next page)

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	195279	A. Building B. Wing	10/09/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49343

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	195279	A. Building B. Wing	10/09/2024

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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** 48184 Based on record reviews and interviews, the facility failed to ensure a resident identified with a qualified mental disorder was referred to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 1 (#48) of 5 (#17, #22, #30, #48 and #59) residents reviewed for PASARR. Findings: A review of Resident #48's medical record revealed she was admitted to the facility on [DATE]. Further review revealed Resident #48 received a new diagnosis of Psychotic Disorder with Delusions due to Known Physiological Condition on 06/07/2024. A review of Resident #48's Level 1 Pre-Admission Screening and Resident Review dated 06/04/2024 revealed Resident #48's new diagnosis of Psychotic Disorder with Delusions due to Known Physiological Condition was not included. Further review revealed no documented evidence a review had been submitted for a Level II evaluation and determination. On 10/08/2024 at 2:15 p.m., an interview was conducted with S4DON. She confirmed Resident #48 was diagnosed with Psychotic Disorder with Delusions on 06/07/2024. She stated a review to the appropriate state-designated authority for a Level II PASARR evaluation and determination was not completed after Resident #48's newly diagnosed condition on 06/07/2024 and should have been. On 10/08/2024 at 2:29 p.m., an interview was conducted with S8LPN. She confirmed she was responsible for submitting reviews to the appropriate state-designated authority when a resident had a new qualifying mental illness. S8LPN confirmed on 06/07/2024 Resident #48 had a new diagnosis of Psychotic Disorder with Delusions due to Known Physiological Condition, but she did not submit a review to the appropriate state-designated authority for a Level II PASARR evaluation and determination and should have.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872 Based on record review and interviews, the facility failed to ensure the resident's plan of care was revised when code status was changed from full code to Do Not Resuscitate (DNR) for 1 (#18) of 31 sampled residents reviewed for care plans. Findings: Review of Resident #18's clinical record revealed the resident was admitted to the facility on [DATE]. Review of Resident #18's care plan revealed the following, in part: Problem: Full code (09/22/2024). Intervention: Respect resident and family wishes. Review and update code status with resident and family as needed. Review of current physician orders for Resident #18 revealed the following, in part: Do Not Resuscitate (DNR). Order date-09/24/2024. An interview was conducted on 10/09/2024 at 8:15 a.m. with S5MDS. S5MDS stated the MDS (Minimum Data Set) nurses were responsible for revising resident care plans when there are changes in resident care. S5MDS stated the staff who completed the LaPOST (Louisiana Physician Orders for Scope of Treatment) document and had the resident/ responsible party sign the document were to notify the MDS nurse of the order change immediately, and did not. S5MDS reviewed Resident #18's current care plan and current physician orders, and confirmed the care plan should have been revised from full code to DNR and it was not. An interview was conducted on 10/09/2024 at 8:38 a.m. with S11SSD. S11SSD stated she completed Resident #18's LaPOST and had Resident #18's son sign the document. She confirmed she did not notify the MDS nurse of the code status change from full code to DNR. An interview was conducted on 10/09/2024 at 8:20 a.m. with S4DON. S4DON stated the process for a code status change was for the staff who had the LaPOST signed by the resident/responsible party to notify the MDS nurse immediately, and then the MDS nurse revised the resident's care plan. S4DON reviewed Resident #18's current care plan and current physician orders, and confirmed the care plan should have been revised from full code to DNR and it was not.

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	195279	A. Building B. Wing	10/09/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47173 Based on observations and interviews, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with accepted principles for 1 (Cart A) of 3 (Cart A, Cart B and Cart C) medication carts and 1(Medication Room A) of 1 medication room observed. The facility failed to ensure expired medications were not available for administration to residents. Findings: The following observations were made and verified by S8LPN on 10/08/2024 at 10:15 a.m. of Medication Room A: Two boxes of 5% Lidocaine Patches with an expiration date of July 2024. One box of 5% Lidocaine Patches with an expiration date of August 2024. The following observations were made and verified by S8LPN on 10/08/2024 at 11:00 p.m. of Medication Cart A: One box of 5% Lidocaine Patches with an expiration date of July 2024. On 10/08/2024 at 11:00 a.m. an interview was conducted with SS8LPN. SS8LPN stated she was responsible for checking the medication carts and the medication storage room monthly for expired medication. SS8LPN confirmed the above expired medications should have been discarded and not readily available for use. On 10/08/2024 at 11:40 a.m., an interview was conducted with S4DON. S4DON stated she was aware of the expired medication mentioned above. S4DON stated the medication carts and medication storage rooms were checked monthly for expired medications. S4DON confirmed the expired medications should not have been stored in the medication storage room or on Medication Cart A available for use.

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	195279	A. Building B. Wing	10/09/2024

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 47173 Based on interviews and record review, the facility failed to employ staff with appropriate competencies and skill sets to carry out the functions of the food and nutrition service by failing to have a certified dietary manager on staff. Findings: On 10/07/2024 at 8:15 a.m., an interview was conducted with S12DM. S12DM stated she did not have a current food service management and safety certification. On 10/07/2024 at 3:30 p.m., an interview was conducted with S3ADM. S3ADM stated he or any other staff in the facility did not have a certificate or degree for food service or dietary management.

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	195279	A. Building B. Wing	10/09/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47173 Based on observations, interviews and record reviews, the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety. The facility failed to: 1. Maintain documentation of daily temperature and chemical sanitation checks for the dishwasher; and 2. Maintain documentation of freezer and refrigerator temperatures checks. This deficient practice had the potential to affect 109 residents who were served meals from the facility's kitchen. Findings: Review of the Daily Department Temperature & Chemical Monitoring Log revealed the following: 10/01/2024- No opening and midday temperature checks documented for the Walk-in Refrigerator, Other Refrigerator 1-3 or the Walk-in Freezer. No daily wash/rinse cycle temperatures and chemical sanitation checks documented for the dish machine. 10/03/2024- No daily wash/rinse cycle temperatures and chemical sanitation checks documented for the dish machine. 10/04/2024- No opening and midday temperature checks documented for the Walk-in Refrigerator, Other Refrigerator 1-3 or the Walk-in Freezer. No daily wash/rinse cycle temperatures and chemical sanitation checks documented for the dish machine. 10/05/2024- No opening and midday temperature checks documented for the Walk-in Refrigerator, Other Refrigerator 1-3 or the Walk-in Freezer. No daily wash/rinse cycle temperatures and chemical sanitation checks documented for the dish machine. 10/06/2024- No opening and midday temperature checks documented for the Walk in Refrigerator, Other Refrigerator 1-3 or the Walk-in Freezer. No daily wash/rinse cycle temperatures and chemical sanitation checks documented for the dish machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/07/2024 at 8:15 a.m., an interview was conducted with S12DM. S12DM confirmed the above mentioned refrigerator/freezer/dish machine temperature checks and chemical sanitation checks had not been completed and recorded and should have been. On 10/07/2024 at 4:00 p.m., an interview was conducted with S3ADM. S3ADM was made aware of the above mentioned incomplete temperature checks and incomplete chemical sanitation checks. He confirmed refrigerator/freezer/dish machine temperature checks and chemical sanitation checks should be recorded.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on record review and interviews, the facility failed to ensure a resident's Medication Administration Record (MAR) was accurately documented for 1 (#69) of 1 (#69) sampled residents reviewed for compression stockings. Findings: Review of Resident #69's Clinical Record revealed Resident #69 was admitted to the facility on [DATE] with a diagnosis of Hypertension and Edema. Review of Resident #69's current Physician Orders revealed the following, in part: Apply compression stockings in the morning and remove at bedtime. Start date: 07/01/2024. Review of Resident #69's MAR dated October 2024 revealed S7LPN documented Resident #69 was wearing compression stockings on 10/08/2024 and 10/09/2024. On 10/08/2024 at 9:54 a.m., an observation was made of Resident #69. No compression stockings were observed to her bilateral lower extremities. On 10/08/2024 at 11:05 a.m., an observation was made of Resident #69. No compression stockings were observed to her bilateral lower extremities. On 10/08/2024 at 1:25 p.m., an observation was made of Resident #69. No compression stockings were observed to her bilateral lower extremities. On 10/09/2024 at 9:20 a.m., an observation was made of Resident #69. No compression stockings were observed to her bilateral lower extremities. On 10/09/2024 at 1:10 p.m., an observation was made of Resident #69. No compression stockings were observed to her bilateral lower extremities. On 10/09/2024 at 1:20 p.m., an interview was conducted with S7LPN. She stated Resident #69 had an order for compression stockings to be applied every morning. She was notified of the observations of Resident #69 not wearing the compression stockings on 10/08/2024 and 10/09/2024. She stated Resident #69 frequently refused for staff to apply the compression stockings to her bilateral lower extremities. She reviewed the resident's MAR and confirmed the MAR reflected the resident was wearing the compression stockings on 10/08/2024 and 10/09/2024. She stated when the resident refused to wear the compression stockings, she should have documented the refusal on the MAR. She confirmed the resident's MAR should not have reflected the resident was wearing compression stockings if she wasn't. (continued on next page)

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	195279	A. Building B. Wing	10/09/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/2024 at 3:29 p.m., an interview was conducted with S4DON. She was made aware of the above observations. She stated Resident #69 often refused to wear her compression stockings. She stated it was the nurse's responsibility to ensure the compression stockings were in place and to document it on the MAR. She stated if the resident refused to wear the compression stockings, the nurse should chart the refusal on the MAR. She reviewed Resident #69's MAR and confirmed the compression stockings were documented as being on the resident, and not as being refused by the resident. She confirmed when Resident #69 refused to wear the compression stockings, a refusal should have been documented on the MAR and was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195279	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Mandeville	1820 W. Causeway Approach Mandeville, LA 70471

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48184 Based on interviews and record review, the facility failed to implement appropriate plans of action to correct identified quality deficiencies for 2 (#27 and #101) of a total of 31 sampled residents reviewed for Resident Assessment. Findings: Review of the facility's Correction Action Plan dated 07/01/2024 revealed the following, in part: 1. Problem identified: Multiple MDSs are not being completed timely. Projected Completion Date: 10/01/2024. 2. Plan of action: Immediate action: approval to hire another assessment nurse for office; reviewed open MDS with Case Manager, educated on competing MDSs timely; Opened MDSs that are overdue to be completed. Audit of: opened MDSs that are overdue to be completed. In-service Provided: completing documentation per policy. Other: discussed the impact on the MDS office since starting central admission with ID team. 3. Monitoring (who, what, when): DON/CM/designee will monitor for timely completion of MDS'. DON/CM will continue to obtain education on completing MDS' correctly in the new system. 4. Follow-up for effectiveness: Current plan of action effective: No If no, new plan or action: 126 late MDS' completed. System created to prevent additional late MDS' and attempting to minimize the problem. Reached out to PRN and other facilities' assessment nurses to help. Review of QAPI Root Cause Analysis (RCA) for MDS Timeliness Correction dated 07/01/2024 revealed the following: Concern: MDSs are not being completed timely per CMS's guidelines. Why? Increased number of MDS's required d/t increased number of admits and discharged . Why? Facility attempting to increase census to a higher level as instructed per corporate and running a high re-hospitalization rate. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Root Causes: 1. Influx in the number of MDSs required. 2. High number of resident's being re-hospitalized . Possible solutions to concern based on Root Cause Analysis: 1. Increased staff (hired and trained new MDS nurse). 2. Increased hours devoted to completing MDS'. Review of the QA Tool revealed there were 42 resident's MDS assessments late upon surveyor entrance to facility. Resident #27 Review of Resident #27's Clinical Record revealed he was admitted to the facility on [DATE]. On 10/07/2024, review of Resident #27's Quarterly MDS with an ARD of 09/03/2024 revealed the MDS assessment was incomplete and had a status of: In progress. Resident #101 Review of Resident #101's Clinical Record revealed he was admitted to the facility on [DATE]. Further review revealed Resident #101 was discharged to the hospital on 09/07/2024 and returned to the facility on [DATE]. On 10/07/2024, review of Resident #101's Discharge MDS with an ARD of 09/07/2024 revealed it was incomplete and had a status of: In progress. On 10/08/2024 at 3:40 p.m., an interview was conducted with S5MDS. She reviewed and confirmed the Quarterly MDS with ARD of 09/03/2024 was not completed in the required 14 day timeframe. On 10/09/2024 at 3:20 p.m., an interview was conducted with S4DON. She stated the facility had an increase in admissions and re-hospitalization s. She stated the MDS staff could not keep up with completing and transmitting the MDS assessments. She verified there was a current QA open pertaining to the MDS assessments being completed timely and the QA completion date was 10/01/2024. She stated she was not able to close the QA on the projected date of 10/01/2024 due to the ongoing issue of MDS assessments not being completed timely. She confirmed the QA was not effective. On 10/09/2024 at 4:01 p.m., an interview was conducted with S4DON. She stated there was an open QA with audit tools for MDS assessments completion. S4DON confirmed they did not address the issues with the audit tools for MDS assessments completion and their QA was not effective.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on observation, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment to help prevent the development and transmission of infection for 1 (#57) of 6 (#57, #62, #65, #102, #108, and #315) residents reviewed for infection control. The facility failed to ensure staff wore proper Personal Protective Equipment (PPE) while providing peri-care to a resident who was on Enhanced Barrier Precautions (EBP). Findings: Review of the facility's policy titled Enhanced Barrier Precautions revised on 03/2024, revealed the following, in part: For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Changing briefs or assisting with toileting Review of Resident #57's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #57's current Physician Orders revealed the following, in part: Start date 09/14/2024: Enhanced Barrier Precautions-gown and gloves to be worn during high contact resident care activities due to wound. An observation was made on 10/08/2024 at 1:00 p.m., of the Enhanced Barrier Precautions sign posted on Resident #57's door and above the head of her bed revealed the following, in part: Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Changing briefs or assisting with toileting. An observation was made on 10/08/2024 at 1:07 p.m. of S9CNA providing peri-care to Resident #57. S9CNA did not wear a gown while changing Resident #57's brief and providing peri-care. An interview was conducted on 10/08/2024 at 1:25 p.m. with S9CNA. S9CNA verified Resident #57 was on EBPs due to the wounds on her legs. She confirmed she did not wear a gown when changing Resident #57's brief and should have. An interview was conducted on 10/09/2024 at 9:30 a.m. with S4DON. She was notified of the above observation on 10/08/2024. S4DON confirmed when a resident was on EBPs, staff should wear a gown while providing peri-care and changing briefs.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47173 Based on observation and interview, the facility failed to provide a safe, functional, and sanitary environment for residents and staff. The facility failed to ensure the walk-in cooler was free from pooling water. The facility had 109 residents who received meals out of the kitchen. Findings: On 10/07/2024 08:15 a.m., an initial tour of the kitchen was conducted with S12DM. An observation was made of a large amount of cloudy water pooled in the corner of the walk in cooler with a large saturated towel, in attempt to soak up the water. At this time, an interview was conducted with S12DM. S12DM stated she was aware of the pooling water and she had notified maintenance last week. S12DM confirmed the pooled water was unsanitary, unsafe and should not be on the floor of the cooler. On 10/07/2024 at 03:35 p.m., an interview was conducted with S13MD. S13MD stated he was notified last week of the pooling water in the walk in cooler. He stated last week he attempted to reseal the weather strip but it was unsuccessful. On 10/08/2024 at 12:57 p.m., an interview was conducted with S2AADM. S2AADM stated he was made aware of the pooling water in the walk in cooler two weeks ago. He confirmed pooling water should not be in the walk in cooler and was.