

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Pontchartrain Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Highway 190 Mandeville, LA 70448	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173</p> <p>Based on interviews and record review, the facility failed to ensure an allegation of physical abuse was reported to the state agency in the required time frame for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for abuse.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property with a revision date of 09/26/2017, revealed, in part, the following:</p> <p>Policy:</p> <p>Reporting/Response:</p> <ol style="list-style-type: none"> 1. Report all alleged violations of abuse to the state agency 2. Any employee who becomes aware of an alleged abuse shall report the incident to a supervisor, DON or Administrator immediately. 3. The facility will report all allegations of abuse to the state agency within 24 hours of discovery . <p>Review of the clinical record for Resident #1 revealed she was admitted to the facility on [DATE].</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/2024, revealed a Brief Interview for Mental Status (BIMS) of 00 which indicated Resident #1 was severely cognitively impaired.</p> <p>Review of the Incident Report for Resident #1, dated 02/04/2025 at 8:00 a.m., revealed S5LPN documented the following:</p> <p>Description: Care Partner reported bruise on resident. Upon entering the room, S5LPN noted bruising to left side of the forehead. Resident #1 was unable to give a description and the incident was not witnessed.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediate Action Taken: Reported to the Supervisor and the Nurse Practitioner.</p> <p>Review of the Nurse's Notes for Resident #1 dated 02/04/2025 at 8:00 a.m., revealed S5LPN noted a bruise to the left side of the forehead.</p> <p>On 03/05/2025 at 11:45 a.m., an interview was conducted with Resident #1's representative. He stated on 02/04/2025 he was notified by the facility Resident #1 had sustained a large bruise to her left forehead. He stated he visited Resident #1 after the incident and she stated to him, Don't hurt me, I'll do what you say. He stated he was concerned somebody hit Resident #1 due to the size and location of the bruise and her statement to him.</p> <p>On 03/05/2025 at 2:30 p.m., an interview was conducted with S5LPN. S5LPN stated she worked 7:00 a.m. to 7:00 p.m. on 02/04/2025. She stated shortly after the start of the shift the Certified Nursing Assistant told her Resident #1's left forehead was bruised. S5LPN stated she assessed Resident #1 and reported the bruise to S6QAN and Resident #1's representative. She stated Resident #1's representative came to the facility and told S4ADON he was concerned Resident #1 was hit by another resident.</p> <p>On 03/05/2025 at 1:54 p.m., an interview was conducted with S4ADON. She stated she was responsible for incident reports. She stated on 02/04/2025, S6QAN informed her Resident #1 had a bruise to her left forehead. She stated Resident #1's representative came to the facility and told her he was concerned Resident #1 was hit by another resident. She stated she started investigating the incident immediately. She stated she reviewed the video surveillance for the evening shift which took her all day. She stated S1ADM was notified of the alleged physical abuse and bruising to Resident #1's forehead.</p> <p>On 03/05/2025 at 3:39 p.m., an interview was conducted with S1ADM. She confirmed staff notified her on 02/04/2025 Resident #1 had a large bruise to her left forehead. She confirmed the incident was unwitnessed and unexplained. She stated Resident #1's representative voiced concerns of another resident hitting Resident #1 to her. She confirmed she did not report this allegation of physical abuse to the state agency because she thought she could investigate the incident herself and if she found no signs of physical abuse she did not have to report it.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173</p> <p>Based on interviews and record review, the facility failed to ensure a resident's comprehensive plan of care was implemented for 1(#1) of 3(#1, #2 and #3) residents reviewed in the sample. The facility failed to ensure Resident #1 had daily meal intake percentage documented.</p> <p>Findings:</p> <p>Review of the Clinical Record for Resident #1 revealed she was admitted to the facility on [DATE] with diagnoses, which included Non-Alzheimer's Dementia, Malnutrition and Dysphagia.</p> <p>Review of Care Plan for Resident #1 revealed the following, in part:</p> <p>09/24/2024- Potential for altered nutrition. I am fed by staff.</p> <p>Goal: I will have adequate nutrition.</p> <p>Intervention: Observed meal intake and document percentage.</p> <p>Review of Nutrition Intake for Resident #1 dated February 2025, revealed no percentage of meal intake documented on the following dates:</p> <p>02/02/2025, 02/09/2025, 02/10/2025, 02/12/2025, 02/13/2025, 02/14/2025, 02/15/2025, 02/16/2025, 02/21/2025, 02/22/2025, 02/24/2025 and 02/25/2025.</p> <p>On 03/05/2025 at 1:19 p.m., an interview was conducted with S2DON. She reviewed Resident #1's Nutrition Intake sheet for the month of February 2025. She confirmed the aforementioned dates were left blank for Resident #1's daily percentage meal intake and should not have been. She stated if the CNA did not chart the percentage of food intake consumed by Resident #1 than it was not implemented.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>46975</p> <p>Based on observations, and interviews the facility failed to ensure a safe, functional, sanitary and comfortable environment. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1.) Ceiling tiles were in good repair for Room b, Room c, Room d, Room f, and Hall b; 2.) The vent above the ice machine on Hall c was clean; 3.) The gutters of the building remained intact; and 4.) Hall a's bathroom toilet was maintained in a sanitary and functional condition. <p>This deficient practice had the potential to effect the 114 residents residing in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> On 03/03/2025 at 9:45 a.m., a tour of the facility was conducted. In Room b there were 2 ceiling tiles which had a brown substance on them. In Room c there were 18 sagging ceiling tiles, a tan substance on the ceiling tile above a resident's bed, and a tear in 1 ceiling tile. In room d there was a baseball sized brown substance on 1 ceiling tile. In room f there were 3 ceiling tiles with a brown substance on them. On Hall b there were 4 ceiling tiles with tears, and 2 ceiling tiles had a brown substance on them. 2. <ul style="list-style-type: none"> On 03/03/2025 at 10:00 a.m., an observation of the ice machine room on Hall c was conducted. The vent on the ceiling was completely covered in a gray fluffy substance. 3. <ul style="list-style-type: none"> On 03/03/2025 at 10:20 a.m., an observation of the exterior of the facility was conducted. There were 2 gutters to the right of the facility's entrance connected to a large PVC pipe going into the ground. The tops of the PVC pipes were broken off, leaving jagged edges exposed. 4. <ul style="list-style-type: none"> On 03/03/2025 at 12:20 p.m., a tour of the facility was conducted with S1ADM. She confirmed the above observations. She reviewed the maintenance binder and verified none of the above observations were entered into the maintenance binder and should have been. She stated as physical environment issues arise, they should be fixed. <p>On 03/03/2025 at 12:20 p.m., a tour was conducted of the Hall a shower room with S1ADM.</p> <p>(continued on next page)</p>

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