

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure it provided medications, as ordered by the prescriber, to meet the needs of 1 (#4) of 6 residents reviewed for medications. Findings: Review of the facility's policy titled Pharmacy Services Overview, with a revision date of 04/2019, revealed the following, in part:Policy StatementThe facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications.Policy Interpretation and Implementation4. Residents have sufficient supply of their prescribed medications and receive medications in a timely manner. Review of Resident #4's clinical record revealed she was admitted to the facility on [DATE]. Review of Resident #4's Significant Change MDS with an ARD of 05/19/2026 revealed she had a BIMS of 15, which indicated she was cognitively intact. Review of Resident #4's Current Physician Orders revealed the following, in part:Start date 07/08/2026. Mouthwash. Give 10 ml by mouth every 6 hours for mouth ulcers. Swish and spit for 7 Days. Magic mouthwash contents: viscous lidocaine 2%, diphenhydramine (2.5 mg/mL), and an antacid (Maalox). Status: On Hold. Reason for hold: pharmacy. Review of Resident #4's MAR dated July 2026 revealed the Magic Mouthwash had been on hold since 07/11/2026 at 7:00 p.m. On 07/14/2026 at 8:30 a.m., an interview was conducted with Resident #4. She stated mouthwash was ordered for her last week because she currently had sores in her mouth. She stated she had not received the mouthwash in days. She stated nursing staff told her they were waiting on pharmacy to send it. On 07/15/2026 at 11:42 a.m., an interview was conducted with S14LPN. She stated she was aware Resident #4 had mouthwash ordered, but the mouthwash was on hold because pharmacy had not sent it yet. She stated the mouthwash was not on her medication cart, Med Cart 2. She stated she had not called pharmacy to follow up on the medication. On 07/15/2026 at 12:15 p.m., an interview was conducted with a pharmacist from the pharmacy used by the facility. She stated Resident #4 had an order for Magic Mouthwash which was a combination of lidocaine, Benadryl, and Maalox. She stated the pharmacy received notification the facility needed a refill on Saturday 07/11/2026. She stated the pharmacy was out of lidocaine at that time and had to order it. She stated the lidocaine came in on Monday, 07/13/2026. She stated she reviewed pharmacy documentation and Resident #4's Magic Mouthwash was delivered to the facility Monday night. On 07/15/2026 at 12:32 p.m., an interview was conducted with S2DON. She reviewed Resident #4's MAR and verified the Magic Mouthwash had been on hold since Saturday 07/11/2026. At that time, an observation of Med Cart 2 was made with S2DON. S2DON opened Med Cart 2 and Resident #4's Magic Mouthwash was observed to be in the medication cart. Resident #4's Magic Mouthwash had a dispense date of 07/13/2026 which was verified by S2DON. S2DON confirmed the facility had Resident #4's mouthwash since 07/13/2026, and she should have been receiving it per physician orders.		

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interviews, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles. The facility failed to ensure 1 (Medication Cart #1) of 3 Medication Carts observed were kept locked when not under direct observation of authorized staff. Review of the facility's policy titled, Medication Labeling and Storage with a revised date of February 2026 revealed the following, in part: Medication Storage: 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications and biological are locked when not in use and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. On 07/14/2026 at 11:16 a.m., an observation was made of Med Cart #1 unlocked and unattended near resident rooms. On 07/14/2026 at 11:19 a.m., an interview was conducted with S6LPN. S6LPN stated she was responsible for Med Cart #1. S6LPN confirmed Med Cart #1 was left unattended, unlocked and not within her sight. S6LPN confirmed she should have locked the medication cart prior to leaving it unattended. On 07/14/2026 at 4:21 p.m., an interview was conducted with S2DON. S2DON confirmed all medication carts containing medications should be locked when unattended.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident status by failing to ensure a resident Minimum Data Set (MDS) was accurately coded for Pre-admission Screening and Resident Review (PASRR) for 1 (#102) of 3 sampled residents reviewed for PASRR. Findings: Review of Resident #102's Clinical Record revealed she was admitted to the facility on [DATE] with Form 142 Notification of Medical Certification approved by the state Level II Authority dated 08/27/2025 thru 08/26/2026. Review of Resident #102's Annual MDS with an ARD of 06/09/2026 revealed the following: Section A1500 PASRR was coded 0, which indicated the resident did not have a serious mental illness and/or mental retardation or a related condition. Section A1510 Level II PASRR conditions was blank. An interview was conducted with S15MDS on 07/15/2026 at 1:30 p.m. S15MDS verified Resident #102's Form 142 indicated approval by Level II PASRR authority effective 08/27/2025. She reviewed Resident #102's annual MDS assessment dated [DATE]. S2DON confirmed Section A1500 should have been coded as 1-Yes, and was not. An interview was conducted with S2DON on 07/15/2026 at 1:50 p.m. S2DON verified Resident #102's Form 142 indicated approval by Level II PASRR authority effective 08/27/2025. She reviewed Resident #102's annual MDS assessment dated [DATE]. S2DON confirmed Section A1500 should have been coded as 1-Yes, and was not.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding by failing to:1. Ensure free water bags were changed in appropriate timeframe for 1 (#2) of 2 residents reviewed for tube feedings; and2. Ensure free water flushes were administered per physician's orders for 1 (#59) of 2 residents reviewed for tube feedings. Findings: 1. Review of the Clinical Record for Resident #2 revealed she was admitted to the facility on [DATE] with diagnoses, which included Dysphagia Following Cerebral Infarction. Further review revealed a diagnosis of Encounter for Attention to Gastrostomy on 02/11/2026. Review of the current Physician Orders for Resident #2 revealed, in part, the following: Enteral Feed Order every day and night shift for tube feeding.Glucerna 1.5 at 55 ml/hr x22 hours water flush via pump at 40 mL/hr to meet protein and fluid needs. An observation was made on 07/14/2026 at 8:51 a.m., of Resident #2's tube feeding solution spiked and hanging in Resident #2's room currently infusing. Further observations revealed the free water bag was observed to have 400 mls of water in it and was dated 07/12/2026. Observed bag of free water label read: Do not use for greater than 24 hours. An observation was made on 07/14/2026 at 8:54 a.m., of Resident #2's tube feeding with S12LPN. She confirmed Resident #2's free water bag was dated 07/12/2026 and that the bag read Do not use for greater than 24 hours. She stated the free water bag and the tube feed container should be changed every 24 hours. An interview was conducted on 07/15/2026 at 11:50 a.m. with S2DON. She stated both the free water bag and the tube feeding bag should be changed every 24 hours. She was made aware of the above observation and confirmed the free water bag should have been changed on 07/13/2026. 2. Review of Resident #59's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Gastrostomy Status. Review of Resident #59's current physician orders revealed in part, the following: Flush PEG tube with 100mL of water every 4 hours. An interview was conducted on 07/13/2026 at 10:00 a.m. with S16LPN. She stated she had not performed the 10:00 a.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. An interview was conducted on 07/13/2026 at 11:20 a.m. with S16LPN. She stated she had not performed the (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:00 a.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. An interview was conducted on 07/13/2026 at 1:05 p.m. with S16LPN. She stated she had not performed the 10:00 a.m. or the 1:00 p.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. An interview was conducted on 07/13/2026 at 3:07 p.m. with S16LPN. She stated she had not performed the 10:00 a.m. or the 1:00 p.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. An interview was conducted on 07/14/2026 at 10:15 a.m. with S5LPN. She stated she had not performed the 10:00 a.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. An interview was conducted on 07/14/2026 at 12:15 p.m. with S5LPN. She stated she had not performed the 10:00 a.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. An interview was conducted on 07/14/2026 at 2:15 p.m. with S5LPN. She stated she had not performed the 10:00 a.m. nor the 1:00 p.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. An observation and interview was conducted on 07/14/2026 at 3:10 p.m. with S5LPN. She stated she had not performed the 10:00 a.m. nor the 1:00 p.m. PEG tube water flush for Resident #59 because he was out of his room. She stated Resident #59 had water flushes ordered every 4 hours to maintain his PEG tube. Observed S5LPN perform a 100mL PEG tube water flush for Resident #59. S5LPN stated this was the first time she had flushed Resident #59's PEG tube today. An interview was conducted on 07/15/2026 at 11:50 a.m. with S2DON. She stated she expected nursing staff to flush Resident #59's PEG tube as ordered every 4 hours. She stated nursing staff had a window of 1 hour before and 1 hour after the scheduled time to flush Resident #59's PEG tube.		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to provide fluids sufficient to maintain adequate hydration. The facility failed to provide a water pitcher or any fluid for hydration within reach for 1 (#3) of 2 residents reviewed for UTI's. Findings: Review of Resident #3's clinical record revealed she was admitted to the facility on [DATE], with diagnoses which included Dementia and UTI's. Review of Resident #3's Quarterly MDS with an ARD of 06/22/2026 revealed a BIMS of 3, which indicated she was severely cognitively impaired. Further review revealed Resident #3, the resident rarely had water or other fluids at her bedside. She stated if Resident #3 had water at the bedside, it was not within her reach. She stated Resident #3 was able to, and would, drink water independently if it was within her reach. She stated when she visited, she placed Resident #3's water on her bedside table in front of her, and she was able to grab it and drink it when she wanted to. On 07/14/2026 at 8:05 a.m., an observation was made of Resident #3. She was lying in bed with her eyes opened. A cup of water was observed sitting on the left corner of her dresser, which was out of her reach and line of sight. No other fluids were at the bedside. On 07/14/2026 from 10:38 a.m.-2:32 p.m., a continuous observation was made of Resident #3's ice water cup. Her water was observed sitting on the left corner of her dresser, out of her reach and out of her line of sight during this timeframe. No other fluids were kept at the bedside during this timeframe. On 07/14/2026 at 3:35 p.m., an observation was made of Resident #3. She was lying in bed with her eyes opened. A cup of water was observed sitting on the left corner of her dresser, which was out of her reach and out of her line of sight. No other fluids were at the bedside. On 07/15/2026 at 10:16 a.m., an observation was made of Resident #3. She was lying in bed with her eyes opened. Her bedside table was at the bottom of her bed, with no fluids on it. A cup of water was observed on her dresser, behind her head and out of her line of sight. On 07/15/2026 at 11:27 a.m., an interview was conducted with S13CNA. She stated Resident #3 could drink independently. She confirmed Resident #3's cup of water was behind her head, on her dresser, and no other hydration at her bedside. She stated Resident #3's family would put the water on her bedside table in front of her when they visited, but when the family left, staff would put the water back on the dresser. She stated staff kept Resident #3's water on her dresser because if they put it close to her, she would spill it in her bed. On 07/15/2026 at 11:35 a.m., an interview was conducted with Resident #3's family member, who was at Resident #3's bedside. The family member stated when she came in this morning, Resident #3's water was behind her head, on her dresser. The family member stated Resident #3 could not reach the water when it was on her dresser. The family member stated she moved Resident #3's bedside table close to her and placed the water on it. At this time, Resident #3's bedside table was observed over her torso and ice water was observed on the table. Resident #3 was observed to drink 4 ounces of the water independently. On 07/15/2026 at 11:45 a.m., an interview was conducted with S14LPN. She stated Resident #3 could drink independently. She stated if Resident #3 had water or other fluids at her bedside within reach, she would be able to grab it on her own to drink it. She confirmed residents should have hydration within (continued on next page)		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their reach throughout the day. On 07/15/2026 at 12:31 p.m., an interview was conducted with S2DON. She was notified of the above observations. She stated Resident #3 was able to drink independently and should have had hydration within her reach throughout the day.		

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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. Based on observation and interviews the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety by failing to ensure staff with facial hair wore a beard restraint. This deficient practice had the potential to affect any of the 98 residents who received nourishment from the facility's kitchen. On 07/13/2026 at 08:10 a.m. an observation of the facility's kitchen food preparation area was conducted with S4DM. An observation of two male employees both with beards and mustaches not wearing beard restraint while serving morning meal. On 07/14/2026 at 8:18 a.m., an interview was conducted with S4DM. S4DM confirmed S5DS and S6DS were not wearing a beard restraint over their facial hair and should have. On 07/14/25 at 8:18 a.m., an interview was conducted with S1ADM. S1ADM confirmed beard restraints should have been worn by anyone with a facial hair in the food preparation area.		