STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195303	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Nursing Home	506 West 5th Street Laplace, LA 70068

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 22609 Based on observation and interview, the facility failed to protect client confidentiality for 1 resident (Resident #8) of 32 sampled residents (Resident #1, Resident #3, Resident #8, Resident #11, Resident #15, Resident #25, Resident #21, Resident #24, Resident #28, Resident #29, Resident #40, Resident #43, Resident #47, Resident #53, Resident #54, Resident #56, Resident #57, Resident #60, Resident #6, Resident #67, Resident #68, Resident #70, Resident #73, Resident #78, Resident #80, Resident #88, Resident #86, Resident #87, Resident #89, Resident #340, Resident #34, and Resident #342). Findings: Observation on 08/06/2024 at 11:02 a.m. revealed Resident #8's closed exterior side of the door facing the hallway revealed written sign titled, Appointment Sheet. Further observation revealed, in part, Resident #8's written name with Tuesday, Thursday and Saturday goes to dialysis with a pick up time of 5:30 a.m. In an interview on 08/06/2024 at 12:15 p.m., S10Licensed Practical Nurse (LPN), after reading Resident #8's sign on exterior side of the door that was facing the hallway, indicated it would be a HIPPA violation, Health Insurance Portability and Accountability Act which protected the medical information in patients records and allowed for confidential communication between patients and medical professionals. S10 LPN further indicated people could figure out Resident #8 has end stage renal disease. In an interview on 08/06/2024 at 3:23 p.m., S4Director of Nursing indicated the sign on Resident #8's exterior door should not be posted.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877 Based on record reviews and interviews, the facility failed to ensure a Level 1 Pre-Admission Screening and Resident Review (PASARR) was completed correctly for 1 (Resident #56) of 1 (Resident #56) residents reviewed for PASARR. Findings: Resident #56 was admitted to the facility on [DATE] with diagnoses, in part, of Major Depressive Disorder, Anxiety, and Schizophrenia. Review of Resident #56's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/23/2024, revealed, in part, diagnosis of Major Depressive Disorder, Anxiety, and Schizophrenia. Further review revealed Resident #56 received antipsychotics on a daily basis. Review of Resident #56's record revealed a Level- 1 PASARR completed on 10/21/2021. Further review revealed Section 3: Mental Illness was marked yes. Further review revealed a referral was not made to appropriate state designated authority for Level II PASARR evaluation and determination. In an interview on 08/07/2024 at 2:05 p.m., S3Social Services indicated Resident #56's Level- 1 PASARR was completed incorrectly and a Level II PASARR should have been requested for Resident #56 due to her diagnosis of Major Depressive Disorder, Anxiety, and Schizophrenia.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877 Based on observation, interview, and record review, the facility failed to provide nail care for 2 (Resident #28 and Resident #40) of 6 (Resident #24, Resident #28, Resident #40, Resident #47, Resident #61, and Resident #78) sampled residents investigated for activities of daily living (ADLs). Findings: Resident #28 Resident #28 was admitted to the facility on [DATE] with diagnoses of hemiplegia affecting the right side. Review of Resident #28's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/16/2024 revealed she had impairment on one side of her upper and lower extremities. Review of Resident #28's Care Plan revealed Resident #28 required assistance with ADLs with a goal to be kept clean, dry and well-groomed. Observation on 08/06/2024 at 2:20 p.m. revealed Resident #28's toe nails extended past the tips of her toes. Observation on 08/07/2024 at 9:40 a.m. with S13Certified Nursing Assistant (CNA) and S6MedRecords/CNA Supervisor revealed Resident #28's bilateral toe nails and bilateral fingernails extended past the tips of the nailbeds. In an interview on 08/07/2024 at 9:42 a.m., S6MedRecords/CNA Supervisor indicated Resident #28's finger nails and toe nails needed to be trimmed. In an interview on 08/07/2024 at 9:50 a.m., S12Wound Care Nurse confirmed Resident #28's finger nails and toe nails needed to be trimmed. Resident #40 Resident #40 was admitted to the facility on [DATE] with diagnoses of right side hemiplegia (paralysis on one side of the body). Review of Resident #40's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/02/2024 revealed Resident #40 had impairment on one side of his upper and lower extremities. Review of Resident #40's Care Plan revealed Resident #40 had a self-care deficit related right side hemiplegia with goal to be kept clean, dry and well-groomed. Review of Resident #40's ADL record from 07/23/2024 through 08/06/2024 revealed no documented evidence Resident #40's nails were trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/06/2024 at 2:25 p.m. revealed Resident #40's nails extended past the tips of his fingers. Observation on 08/07/2024 at 12:27 p.m. revealed Resident #40's nails extended past the tips of his fingers. In an interview on 08/07/2024 at 12:30 p.m., S4Director of Nursing indicated Resident #40's nails needed to be trimmed.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 22609 Based on observations, record reviews, and interviews, the facility failed to develop a plan of care for 1 (Resident #3) of 1 resident (Resident #3) receiving respiratory care by nasal cannula. Findings: Observation on 08/05/2024 at 9:40 a.m. revealed Resident #3 received oxygen at 2 liters per minute (LPM) by nasal cannula. Review of Resident #3's Minimum Data Set (MDS) with an assessment reference date of 04/29/2024 revealed, in part, a brief interview mental status of 13 which indicated cognitively intact. Review of Resident #3's Physician Orders dated August 2024 revealed, in part, no orders for oxygen per nasal cannula. Review of Resident #3's Care Plan revealed, in part, most current target date listed for problems identified was dated 10/01/2024. Further review of the care plan revealed no plan of care was developed for oxygen care by nasal cannula. Observation on 08/06/2024 at 11:40 a.m. revealed Resident #3's received oxygen at 4 LPM per NC. In an interview on 08/06/2024 at 11:58 a.m., S10Licensed Practical Nurse (LPN) indicated Resident #3 received oxygen at 2 LPM by NC. S10LPN further indicated no physician's order for respiratory care for Resident #3. In an interview on 08/06/2024 at 12:30 p.m., S5Assistant Director of Nursing indicated they could not find a physician's order for Resident #3' oxygen care per NC. In an interview on 08/06/2024 at 3:49 p.m., S4Director of Nursing indicated there was no plan of care developed for Resident #3's oxygen care per NC.

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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. 41461 Based on record reviews and interviews, the facility failed to ensure the nursing staff signed a verification of an accurate medication count at the beginning and end of each shift for 2 [Medication Cart (a) and Medication Cart (b)] of 2 [Medication Cart (a) and Medication Cart (b)] Medication Carts (Med Cart) observed and reviewed for accurate dispensation of controlled medications. Findings: Review of the facility's undated Controlled Substances Policy revealed, in part, the nursing staff must count controlled drugs at the end of the shift with the nurse coming on duty and the nurse going off duty. Further review revealed the nurse coming on duty and the nurse going off duty must make the count together. Further review revealed the nursing staff must document and report any discrepancies to the Director of Nursing (DON) or designee immediately. Review of Med Cart (a)'s controlled substance binder dated 05/31/2024 to 08/07/2024 revealed, in part, no documentation of signatures of the nurse coming on duty and the nurse going off duty on the following dates and shifts: 06/03/2024 the 3:00 p.m. to 11:00 p.m. shift; 06/06/2024 the 7:00 a.m. to 3:00 p.m. shift; 06/11/2024 the 11:00 p.m. to 7:00 a.m. shift; 06/14/2024 the 11:00 p.m. to 7:00 a.m. shift; 06/23/2024 the 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shift; 06/30/2024 the 3:00 p.m. to 11:00 p.m. shift; 07/06/2024 the 11:00 p.m. to 7:00 a.m. shift; 07/11/2024 the 11:00 p.m. to 7:00 a.m. shift; 07/12/2024 the 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts; 07/14/2024 the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts; 07/17/2024 the 3:00 p.m. to 11:00 p.m. shift; 07/18/2024 the 3:00 p.m. to 11:00 p.m. shift; 07/19/2024 the 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. shifts; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/22/2024 the 11:00 p.m. to 7:00 a.m. shift; 07/24/2024 the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift; 07/25/2024 the 11:00 p.m. to 7:00 a.m. shift; 07/27/2024 the 3:00 p.m. to 11:00 p.m. shift; 07/29/2024 the 11:00 p.m. to 7:00 a.m. shift; 08/03/2024 the 7:00 a.m. to 3:00 p.m. shift; 08/06/2024 the 3:00 p.m. to 11:00 p.m. shift; and 08/07/2024 the 7:00 a.m. to 3:00 p.m. shift. In an interview on 08/07/2024 at 12:41 p.m., S8Licensed Practical Nurse (LPN) indicated she did not sign the narcotics book after the narcotics count on 08/07/2024 at 7:00 a.m. S8LPN further indicated she should have signed the narcotic book after she completed the narcotic count with the nurse going off duty. Review of Med Cart (b) 's controlled substance binder dated 05/22/2024 to 08/07/2024 revealed, in part, no documentation of signatures of the nurse coming on duty and the nurse going off duty on the following dates and shifts: 05/23/2024 the 7:00 a.m. to 3:00 p.m. shift; 05/27/2024 the 3:00 p.m. to 11:00 p.m. shift; 05/31/2024 3:00 p.m. to 11:00 p.m. shift; 07/05/2024 the 3:00 p.m. to 11:00 p.m. shift; 07/10/2024 11:00 p.m. to 7:00 a.m. shift; 07/14/2024 the 7:00 a.m. to 3:00 p.m. shift; 07/24/2024 the 7:00 a.m. to 3:00 p.m. shift; and 08/07/2024 the 7:00 a.m. to 3:00 p.m. shift. In an interview on 08/07/2024 at 1:08 p.m., S9LPN indicated she did not sign the narcotics book after the narcotics count on 08/07/2024 at 7:00 a.m. S9LPN further indicated she should have signed the narcotic book after she completed the narcotic count with the nurse going off duty. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/07/2024 at 1:15 p.m., S4Director of Nursing (DON) indicated all narcotic counts should be performed and documented in the narcotics book at the beginning and ending of each shift by the nurse coming on duty and the nurse going off duty. S4DON further indicated on the above mentioned dates narcotic counts were not documented as they should have been.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47081 Based on observation, record review, and interviews, the facility failed to ensure a resident was referred for dental services for 1 (Resident #25) of 3 (Resident #25, Resident #68, and Resident #21) sampled residents reviewed for dental services. Findings: Review of Resident #25's medical record revealed, in part, Resident #25 was admitted on [DATE]. Review of Resident #25's care plan with a goal date of 08/21/2024 revealed, in part, the potential for dental issues. Further review revealed care plan approaches to include arranging for dental appointments and periodic dental visits. Review of Resident #25's records revealed, in part, no documented evidence, and the provider could not provide any documented evidence, Resident #25 was evaluated for dental services. Review of Facility's resident dental treatment schedule dated 08/19/2024 revealed, in part, Resident #25 was not listed on the schedule for dental services. Observation on 08/05/2024 at 9:57 a.m. revealed Resident #25 did not have any upper teeth. Further observation revealed Resident #25 only had the front bottom teeth. Further observation revealed Resident #25's remaining bottom teeth were grey colored in the middle. In an interview on 08/05/2024 at 10:00 a.m., Resident #25 indicated she needed to see the dentist. Resident #25 further indicated she only had 6 teeth left and did not want to lose anymore. Resident #25 further indicated food was sometimes hard to chew. In an interview on 08/07/2024 at 12:17 p.m., S3SocialServices (SS) indicated she could not find any documentation Resident #25 was evaluated by dental services. S3SS further indicated Resident #25 was not on the dental services patient list. S3SS further indicated Resident #25 should have been evaluated for dental services. In an interview on 08/07/2024 at 12:32 p.m., S1Administrator confirmed Resident #25 should have been evaluated for dental services.

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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. 17453 Based on observations, interviews, and record reviews the facility failed to ensure: 1. Ensure clean items in the facility's laundry room were not kept in the contaminated laundry area, and 2. Ensure staff wore proper protective equipment and performed hand hygiene during incontinence care for 1 (Resident #24) of 6 (Resident #24, Resident #28, Resident #40, Resident #47, Resident #61, and Resident #78) residents investigated for activities of daily living. Findings: 1. Observation on 08/05/2024 at 9:15 a.m. revealed the facility's clean mop heads were hung on wall hooks directly over soiled linen barrels in the facility's contaminated laundry area. Observation on 08/06/2024 at 10:52 a.m. revealed 15 of the facility's clean mop heads were hung on wall hooks in the facility's contaminated laundry area. In an interview on 08/06/2024 at 10:52 a.m., S2Laundry Supervisor confirmed the facility's clean mop heads were stored on the wall of the contaminated area of the facility's laundry room. In an interview on 08/06/2024 at 10:53 a.m., S1Administrator confirmed the facility's clean mop heads were stored on the wall of the contaminated linen area of the facility's laundry room and should not have been. 2. Review of Facility's Handwashing/Hand Hygiene Policy and Procedure last revised August 2015 revealed, in part, hand hygiene was performed before and after removing gloves. Further review revealed staff should follow the handwashing/hand hygiene procedure to prevent the spread of infection. Review of Resident #24's Care Plan with a goal date of 09/03/2024 revealed, in part, Resident #24 was on Enhanced Barrier Precaution (EBP) for a right ankle diabetic ulcer. Further review revealed staff were to wear proper EBP and perform hand hygiene before and after providing incontinence care. Observation on 08/06/2024 at 8:27 a.m. revealed an EBP sign above Resident #24's bed indicating staff must wear PPE during incontinence care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/06/2024 at 1:50 p.m. revealed S7Certified Nursing Assistant (CNA) entered Resident #24's room to perform incontinence care without a gown on. Further observation revealed S7CNA had on gloves and cleansed Resident #24's vaginal area, removed her gloves, and did not perform hand hygiene. S7CNA then put new gloves on. Further observation revealed S7CNA cleansed Resident #24's buttocks, removed her gloves, and did not perform hand hygiene. S7CNA then put new gloves on, positioned Resident #24, put a new adult brief on, removed gloves, and then performed hand hygiene. In an interview on 08/06/2024 at 1:49 p.m., S7CNA indicated she should have performed hand hygiene in between glove changes and should have worn a gown when performing incontinence care to Resident #24. In an interview on 08/07/2024 at 11:00 a.m., S5Assistant Director of Nursing indicated S7CNA should have performed hand hygiene in between glove changes and should have worn a gown when performing incontinence care for Resident #24. 48855