STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195315	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaplan Healthcare Center	1300 W. Eighth Street Kaplan, LA 70548

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44269 Based on record review and interviews, the facility failed to notify the physician and/or NP (Nurse Practitioner) of a resident's invasive procdure for IVC (Inferior Vena Cava) filter removal for 1 (Resident #37) out of 1 (Resident #37) residents reviewed for notification of change in a final sample of 31 residents. Review of Resident #37's medical record revealed the following diagnoses, in part: Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant side, Acute Embolism and Thrombosis of Left Femoral Vein and Dysphagia following Cerebral Infarction. Review of progress note per S6ADON (Assistant Director of Nursing) on 07/29/2024 read in part: Resident left in stable condition via facility vehicle to HC1 (Hospital Center) for procedure. Review of the resident's Interventional Radiology Brief Post-procedure note revealed the date of service as 07/29/2024 at 1:54 p.m. Description of procedure: IVC filter removed without issue. On 11/05/2024 at 09:35 a.m., a phone interview was conducted with S4NP. She stated she was not made aware that Resident #37 had her IVC filter removed on 07/29/2024. S4NP explained nurses were to notify her of any change in the resident's condition and/or treatment. On 11/05/2024 at 10:16 a.m., a phone interview was conducted with S5MD. He stated was unaware the resident's IVC filter was removed on 07/29/2024. Review of the Resident #37's electronic health record failed to reveal evidence that S5MD (Medical Doctor) or S4NP were aware of the resident's IVC filter removal procedure.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269 Based on record review and interviews, the facility failed to report an alleged violation of its failure to provide care to a resident necessary to avoid physical harm to designated state agency for 1 (Resident #37) out of 31 residents reviewed in the sample. On 11/04/2024 at 10:12 a.m., a request was made to the facility for all incidents that had been reported to the state agency in the past 120 days. There were no reports recieved for Resident #37. A request was also made for a policy regarding reportable incidents, but no policy was received prior to survey exit. Review of Resident #37's medical record revealed an admitted [DATE] with the following diagnoses, in part: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Acute Embolism and Thrombosis of Left Femoral Vein and Paroxysmal Atrial Fibrillation. On 11/04/2024 at 1:56 p.m., a phone interview was conducted with Resident #37's Responsible Party (RP) who stated the resident had her IVC (Inferior Vena Cava) filter removed on 07/29/2024, and upon her return to the facility, a nurse discontinued the resident's Eliquis (blood thinner). Resident #37's RP explained that the resident was taken by ambulance on 09/06/2024 to Hospital A's emergency room (ER). Resident #37's RP stated when she arrived at Hospital A's ER, the ER nurse was reviewing the resident's current medications. At that time, it was identified that the resident had not been receiving Eliquis as prescribed since resident's IVC filter removal on 07/29/2024. Review of the resident's records and facility documents revealed on 07/29/2024, Resident #37 was transferred HC1 (Hospital Center) to remove her Inferior Vena Cava (IVC) filter. Resident #37 returned to the nursing home the same day as the procedure with an order to restart Eliquis 5 mg (milligrams) twice daily. S3LPN (Licensed Practical Nurse) failed to restart the resident's anticoagulant as ordered on 07/29/2024. The resident was not administered Eliquis for a total of 39 (78 doses) days from 7/29/2024 - 09/06/2024. On 09/06/2024 Resident #37's nurse noted in her notes that the appeared to be confused and lethargic, and noted with swelling to the left lower extremity. Resident #37 was sent out via ambulance to Hospital A's emergency room (ER). Upon admit to the ER, it was identified that Resident #37 had not resumed Eliquis (anticoagulant) since 07/29/2024, which resulted in an extensive left lower leg Deep Vein Thrombosis (DVT), and an extension of her previous stroke. On 11/05/2024 at 11:00 a.m., an interview was conducted with S1ADM (Administrator). She stated the facility followed the state agency's guidelines for reporting. S1ADM confirmed that Resident #37's daughter notified her in September 2024 that the resident's Eliquis was not resumed after her IVC filter was removed which subsequently caused the resident harm. S1ADM stated that she did not feel like this was a reportable incident because she completed an internal Incident/Accident Report for the medication error.

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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 - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47123 Based on record review and interview, the facility failed to accurately code the resident's Minimum Data Set (MDS) for antipsychotic use for 1 (Resident #42) out of 2 (Resident #42 and #53) residents reviewed for resident assessment discrepancy for antipsychotics. The final sample was 31 residents. Findings: Review of Resident #42's electronic revealed she was admitted to the facility on [DATE]. Review of the resident's quarterly MDS dated [DATE], Section N - Medications revealed the box for taking Antipsychotics was selected. Review of Resident #42's September 2024 physician orders failed to reveal an order for an antipsychotic. On 11/06/2024 at 9:50 a.m., an interview was conducted with S7RMDS (Regional Minimum Data Set). She confirmed that the resident had not received any antipsychotic medication. She stated she made an error in coding therefore the assessessment was inaccurate.

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269 Based on interviews, observations and record review, the facility failed to ensure the resident was provided nursing services and care that adhered to accepted standards of quality. Nursing staff failed to reconcile and administer the resident's prescribed anticoagulant medication for 39 days which jeopardized the resident's health and safety for 1 (#37) of 1 residents investigated for nursing services in a final sample of 31 residents. This deficient practice resulted in an Immediate Jeopardy for Resident #37 on 07/29/2024 when S3LPN (Licensed Practical Nurse) failed to resume the resident's anticoagulant Eliquis 5 mg (milligrams) twice daily after undergoing a same-day scheduled procedure at HC1 (Hospital Center) to remove an inferior vena cava (IVC) filter. On 09/06/2024, the nurse observed Resident #37 confused and lethargic with swelling to the left lower extremity. Resident #37 was transferred via ambulance to Hospital A's emergency room (ER) for evaluation on 09/06/2024 at 3:52 p.m. Upon admit to the ER, Hospital A identified that the facility's nurses failed to administer Resident #37's Eliquis from 07/29/2024 through 09/06/2024 (a total of 39 days and 78 missed doses). Hospital A's records revealed Resident #37 was diagnosed with extensive left lower leg Deep Vein Thrombosis (DVT), placed on a Heparin drip, then transferred to Hospital B for a higher level of care and further treatment. Hospital B's records dated 09/06/2024 at 8:26 p.m., revealed in part: Eliquis failure .MRI (magnetic resonance imaging) of the resident's brain revealed a large right MCA (Middle Cerebral Artery) ischemia. Resident #37 was hospitalized until 09/12/2024 at 5:22 p.m. The facility implemented an immediate corrective action plan on 09/07/2024 which was completed prior to the State Agency's investigation. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance on 09/09/2024. Findings: On 11/05/2024 at 9:30 a.m., a request was made for the facility's policy regarding resident medication reconciliation. S2DON (Interim Director of Nursing/ Infection Preventionist) stated the facility did not have such policy. Review of the medical records for Resident #37 revealed the resident had a history of Atrial Fibrillation and Cerebral Infarction due to Occlusion or Stenosis of the Right Anterior Cerebral Artery. Further review revealed the resident underwent a procedure for Inferior Vena Cava (IVC) filter placement to prevent blood clots on 01/29/2024. Resident #37 was admitted to the facility on [DATE], and was prescribed Eliquis 5 mg (milligrams) twice a day since 02/24/2024. On 11/04/2024 at 1:56 p.m., a phone interview was conducted with Resident #37's responsible party (RP) who stated the resident had her IVC filter removed on 07/29/2024, and a nurse at the facility had discontinued the resident's Eliquis. The RP explained that Resident #37 was taken by ambulance on 09/06/2024. When the RP arrived at Hospital A's ER, the ER nurse who reviewed the resident's current medications identified that the resident had not received Eliquis since the IVC filter had been removed on 07/29/2024. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #37's physician orders revealed Eliquis 5 mg tablet was held then discontinued by S3LPN on 07/25/2024. Review of the resident's medication administration record (MAR) and social services notes for July 2024 revealed Eliquis was held on 07/25/2024 to undergo a procedure at a local hospital (HC1) for IVC filter removal on 07/29/2024. Review of nursing progress notes dated 07/29/2024 at 5:30 a.m. per S6ADON (Assistant Director of Nursing) read: Resident left in stable condition via facility vehicle to HC1 for procedure. Review of the discharge orders dated 07/29/2024 from HC1 noted the resident should resume all previous medications. A listing of medication orders were attached which included Eliquis 5mg twice daily. Review of Resident #37's medication administration record (MAR) for July 2024 - September 2024 revealed the resident had not received Eliquis from 07/29/2024 - 09/06/2024. Review of nursing progress notes dated 09/06/2024 at 3:38 p.m. per S10LPNMDS (LPN Minimum Data Set Coordinator) revealed in part .at 2:40 p.m.Resident not responding to verbal stimuli .Left upper thigh swollen and warm to touch .at 2:50 p.m. S4NP (Nurse Practitioner) notified of Resident's condition and NON (New Order Noted) to send to ER for Eval (evaluation) .at 3:00 p.m. Ambulance notified of resident's condition and impending transfer .3:17 p.m. Resident left per stretcher . Review of Hospital A's medical records revealed in part, on 09/06/2024 at 3:52 p.m., Resident #37 arrived via ambulance, diverted en route to Hospital B for hypoxic episode (a period of time when the body's tissues are not getting enough oxygen). EMS (Emergency Medical Staff) reports 50% O2 (oxygen) sat (saturation), use of ambu (artificial manual breathing unit) bag. Resident arrived with 2L/NC (Liters of oxygen per Nasal Cannula) at 100%. Responsive to verbal stimuli, unable to answer questions, but does open eyes . Ultrasound of Left Lower Extremity Veins resulted on 09/06/2024 at 5:13 p.m. revealed in part, findings: Areas of mostly occlusive thrombus (blood clot) extending from the left common femoral vein through the calf. Thrombus also extends into the great saphenous vein (vein that runs from the foot to the upper thigh). The ER's note also revealed the MAR received from the nursing home did not show Eliquis was currently being given. Further review of Resident #37's medical records from Hospital A revealed on 09/06/2024 at 6:37 p.m., the ambulance called with update on transfer for higher level of care. The resident required a Heparin drip en route to Hospital B. Review of Resident #37's medical records from Hospital B revealed on 09/06/2024 at 8:26 p.m., Resident was transferred from Hospital A for DVT of LLE started on heparin drip .The resident is supposed to be on Eliquis, so this was reviewed as an Eliquis Failure Resident presented ill-appearing .significantly demented and unable to provide any meaningful history .left lower extremity with 3+ edema with mild erythema (reddening of the skin), firm to touch. Acute DVT of LLE complicated acute illness or injury with systemic systems that poses a threat to life or bodily .MRI of brain revealed a large right MCA (Middle Cerebral Artery) ischemia. Resident was hospitalized until 09/12/2024 at 5:22 p.m. and was discharged back to the nursing facility and restarted on Eliquis 5 mg twice daily. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Incident/Accident report by S6ADON (Assistant Director of Nursing) dated 09/09/2024 at 1:30 p.m. revealed in part: Medication Error .on 07/25, S3LPN received pre-op instructions to hold Eliquis for same procedure .Upon readmission to facility following procedure, S3LPN reviewed paperwork from hospital, read that there were no changes to medication, therefore did not reconcile and validate medications listed on hospital discharge paperwork with our eMAR (Electronic Medication Record). On 11/04/2024 at 2:00 p.m. and 3:50 p.m., attempts were made to contact S3LPN by phone, but no answer was received. On 11/04/2024 at 4:43 p.m., an interview was conducted with S2DON who verified the facility was made aware that Resident #37's anticoagulant had not been restarted since 07/29/2024 when Resident #37 was sent out to theER on [DATE]. S2DON stated a QA (Quality Assurance) report and improvement plan was started on 09/07/2024 after S1ADM and S2DON's investigation revealed Resident #37's Eliquis had been discontinued in error, and not restarted post IVC removal on 07/29/2024. On 11/05/2024 at 9:30 a.m., an attempt was made to interview Resident #37 who was laying in her bed but did not respond nor make eye contact. The resident was unable to be interviewed. On 11/05/2024 at 11:30 a.m., an interview was conducted with S1ADM who confirmed that Resident #37's Eliquis should have been restarted on 07/29/2024. She stated that S3LPN should have followed their medication reconciliation process. S1ADM stated a QA (quality assurance plan) was opened as soon as she was made aware that Resident #37's Eliquis had not been administered after the procedure on 07/29/2024. The facility implemented the following immediate corrective actions to correct the deficient practice which was completed prior to the State Agency's investigation. Review of the corrective action plan dated 09/07/2024 revealed: Admit/Re-admit Medication Reconciliation problem was identified when Resident #37 was sent to hospitalER on [DATE] and the ER nurse completed a medication reconciliation which revealed the resident had not received Eliquis since 07/29/2024. Plan of Corrective Action: 1. Immediately conducted internal review of Resident #37's electronic medical record and the discovery was made that when the resident returned from a same day procedure on 07/29/2024, S3LPN failed to restart the resident's Eliquis. 2. Monitored start-up reviewed of capturing all admit/re-admits from the hospital or with a change of medication orders with a final check completed by S11LPN. 3. Revised Care Plan conference objectives to include medications being reviewed during meetings with the resident and/or RP. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Implemented a change in the facility's medication reconciliation process. Any changes to any residents medications and/or readmitted will be first reconciled by the floor nurse caring for resident. Upon completion of reconciliation, nurses are to submit resident's paperwork for review to S6ADON and/or S11LPN. S6ADON will follow up the floor nurse to ensure the medication reconciliation is accurate. S11LPN to perform final review to ensure medication reconciliations are properly put in place within the MAR. 5. Resident in question MAR will be reviewed weekly to ensure her medication is administered as ordered. 6. Monitoring to begin ongoing for all new and readmit 09/09/2024 with all outcomes brought to the QAPI (Quality Assurance/Performance Improvement) committee on or before the next meeting as appropriate to ensure compliance. 09/09/2024- Nursing staff received verbal reeducation on properly reconciling a resident's medications to ensure accurate medications are being administered. On 11/04/2024 at 4:43 p.m., an interview was conducted with S2DON who explained care plan meetings were to now include medication review, monitoring of all new admit/readmits followed up for changes or new orders. S3LPN and the nursing department was re-educated on medication reconciliation on 09/09/2024. S1ADM explained when orders of any type are received, the new or discontinued orders must be reconciled with the eMAR to ensure the medications are accurate. S2DON stated she conducted the auditing of the newly admitted /readmitted residents as well as reviewed Resident #37's eMAR weekly to ensure medications were administered as ordered remotely. She stated the facility had not identified any recurring problems. On 11/05/2024 at 11:30 a.m., an interview was conducted with S1ADM who explained she conducted a verbal reeducation to S3LPN and to the other nurses on 09/09/2024. S1ADM further explained there new process was for S11LPN (Licensed Practical Nurse-Medical Records) to validate medication reconciliations are correct after admit and morning start-up meetings have been completed as a final check. On 11/04/2024 - 11/06/2024 throughout the days nursing staff interviewed were knowledgeable about the medication reconciliation process being done to ensure medications are administered accurately. S2DON's audits were reviewed and revealed all new admit/readmits residents orders were followed up to identify changes or new orders on 09/16/2024, 09/23/2024, 09/30/2024, 10/07/2024, 10/14/2024, 10/21/2024 and 10/28/2024. S2DON also completed review of Resident #37's eMAR weekly to ensure medication administered as ordered for four weeks: 09/16/2024, 09/23/2024x, 09/30/2024, 10/07/2024, 10/14/2024, 10/21/2024 and 10/28/2024. No concerns were identified with review of S2DON's audits. Twelve residents were identified as taking an anticoagulant. Review of those residents' orders and eMARs were done which revealed their anticoagulant medications were being administered as ordered for 11/01/2024- 11/04/2024; no issues were identified. Routine monitoring was conducted as appropriate with reported findings in the facility's QA/QAPI (Quality Assurance/Quality Assurance Performance Improvement) program. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance on 09/09/2024, thus it was determined to be a Past Noncompliance citation.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269 Based on interviews, observation and record review, the facility failed to ensure care and services were provided according to professional standards of practice resulting in harm for 1 (Resident #37) resident out of 31 final sampled residents. This deficient practice resulted in an Immediate Jeopardy for Resident #37 on 07/29/2024 when the facility's process for medication reconciliation failed as evidenced by: 1.S3LPN (Licensed Practical Nurse) failed to reconcile Resident #37's medications when the resident was readmitted to the facility following discharge from HC1 (Hospital Center) to remove an inferior vena cava (IVC) filter on 07/29/2024. The resident's discharge orders from HC1 included administration of the anticoagulant Eliquis 5 mg (milligrams) twice daily. -S6ADON and S11LPN further failed to follow the facility's standard of practice to conduct an additional review of Resident #37's medications reconciled by S3LPN. The resident's order for Eliquis 5 mg (milligrams) twice daily had not been resumed on 07/29/2024. -S4NP (Nurse Practitioner) failed to accurately verify Resident #37's medications when rounding on the resident on two different visits on 08/19/2024 and 09/04/2024. S4NP was therefore unaware whether or not nursing staff were administering Eliquis as ordered. The facility's failed process caused Resident #37 to go without the prescribed Eliquis from 07/29/2024 through 09/06/2024 (a total of 39 days and 78 missed doses) which resulted in serious harm for Resident #37. On 09/06/2024, the resident was transferred to Hospital A where she was diagnosed with an extensive left lower leg Deep Vein Thrombosis (DVT) requiring transfer to a higher level of care to Hospital B for further treatment. Hospital B's records dated 09/06/2024 at 8:26 p.m., revealed Resident #37 was admitted for treatment due to Eliquis failure and left lower extremity DVT. MRI (magnetic resonance imaging) of the resident's brain revealed she also suffered large right MCA (Middle Cerebral Artery) ischemia. Resident #37 remained hospitalized until 09/12/2024 at 5:22 p.m. 2. Resident #37 suffered a major cognitive decline as evident by the significant decrease in her BIMS (Brief Interview for Mental Status) score. Prior to the incident, the resident was assessed as having a BIMS score of 12 indicating intact cognition, whereas after the incident the resident's BIMS score was assessed as 00 indicating severe cognitive impairment. The facility implemented an immediate corrective action plan on 09/07/2024 which was completed prior to the State Agency's investigation. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance on 09/09/2024. Findings: 1. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/05/2024 at 9:30 a.m., a request was made for the facility's policy regarding resident medication reconciliation. S2DON (Interim Director of Nursing/ Infection Preventionist) stated the facility did not have such policy. Review of the medical records for Resident #37 revealed the resident had a history of Atrial Fibrillation and Cerebral Infraction due to Occlusion or Stenosis of the Right Anterior Cerebral Artery. Review of the resident's physician orders revealed an order dated 02/24/2024 Eliquis 5 mg (milligrams) twice a day. Review of the resident's electronic health record revealed Eliquis was held on 07/25/2024 to undergo a procedure at a local hospital (HC1) for IVC filter removal on 07/29/2024. Review of the discharge orders dated 07/29/2024 from HC1 noted the resident should resume all previous medications. A listing of medication orders were attached which included Eliquis 5mg twice daily. Review of Resident #37's July 2024, August 2024 and September 2024 eMARs (electronic Medication Administration Records) revealed Eliquis 5 mg twice daily was not administered from 07/29/2024-09/06/2024 for a total of 39 days (78 doses). Review of S4NP's (Nurse Practitioner) progress notes dated 08/19/2024 and 09/04/2024 revealed no documentation addressing the resident's IVC filter removal on 07/29/2024. The medication list in S4NP's treatment plan listed Eliquis 5mg. S4NP checked off that the Medication/Treatment Regimen had been reviewed. Review of Resident #37's nursing progress notes dated 09/06/2024 at 3:38 p.m. per S10LPNMDS (LPN Minimum Data Set Coordinator) revealed in part, at 2:40 p.m. Resident #37 was not responsive to verbal stimuli; her left upper thigh swollen and warm to touch. The resident was transferred to Hospital A for evaluation at 3:17 p.m. Review of Resident #37's medical records from Hospital A revealed in part, on 09/06/2024 at 3:52 p.m., Resident #37 arrived via ambulance, diverted en route to Hospital B for hypoxic episode (a period of time when the body's tissues are not getting enough oxygen). Ultrasound of Left Lower Extremity (LLE) Veins resulted on 09/06/2024 at 5:13 p.m. revealed in part: Areas of mostly occlusive thrombus (blood clot) extending from the left common femoral vein through the calf extending into the great saphenous vein (vein that runs from the foot to the upper thigh). Review of Resident #37's medical records from Hospital B revealed on 09/06/2024 at 8:26 p.m., an Eliquis Failure. Acute DVT of LLE complicated acute illness or injury with systemic systems that poses a threat to life or bodily functions .MRI of brain revealed a large right MCA (Middle Cerebral Artery) ischemia. Resident was hospitalized until 09/12/2024 at 5:22 p.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Incident/Accident report by S6ADON (Assistant Director of Nursing) dated 09/09/2024 at 13:30 (1:30 p.m.) revealed in part: a verbal phone order had been given to S8LPNSSD to place resident's Eliquis on hold for three days, 07/27/2024 - 07/30/2024, due to a procedure. This hold order was entered into Resident #37's electronic health record (EHR) on 07/18/2024 at 9:44 a.m. by S8LPNSSD. On 07/25/2024, S3LPN (Licensed Practical Nurse) floor nurse received pre-op instructions to hold Eliquis for a same day procedure. She attempted to place the hold order in the resident's EHR but was unable to do complete it and discontinued the Eliquis on 07/25/2024 at 2215 (10:15 p.m.). Upon readmission to facility following procedure, resident's charge nurse, S3LPN, reviewed paperwork from hospital, read that there were no changes to medication, therefore did not reconcile and validate medications listed on hospital discharge paperwork with Resident #37's eMAR (electronic Medication Administration Record). On 11/04/2024 at 2:00 p.m. and 3:50 p.m., attempts were made to contact S3LPN by phone, but no answer was received. On 11/05/2024 at 9:35 a.m., a phone interview was conducted with S4NP who stated she was not made aware that the resident had the IVC filter removed on 07/29/2024 until 09/13/2024. S4NP explained she had not reviewed the resident's eMAR when she rounded on the resident on 08/19/2024 and 09/04/2024. S4NP stated she assumed the nurses were giving Resident #37's Eliquis as ordered. On 11/05/2024 at 10:16 a.m., a phone interview was conducted with S5MD (Medical Doctor/Director). S5MD stated he was not notified when the resident's IVC filter was removed on 07/29/2024. S5MD stated he was made aware that the resident's Eliquis had not been given since 07/29/2024 when the facility started their investigation on 09/13/2024. S5MD confirmed the Eliquis failure placed the resident at an increased risk of thromboembolic events. S5MD confirmed S4NP should have made sure Resident #37's medications were correct. On 11/05/2024 at 11:00 a.m., a joint interview was conducted with S1ADM and S2DON. S1ADM stated she was aware that the nursing staff made a mistake when Resident #37's Eliquis had not been resumed post IVC filter removal on 07/29/2024. S1ADM explained the prior procedure that medications were first reconciled by the floor nurse receiving the resident returning to the facility and was expected to reconcile the medications with the resident's discharge instructions and current eMAR. Then the DON or ADON reconciled the meds to ensure accuracy and resolve any discrepancies. The final person was S11LPN (Medical records) to reconcile medications. S1ADM and S2DON agreed that prior to this incident, the three person medication reconciliation process should have been done, but had not. 2. Review of the resident's Significant Change Minimum Data Set (MDS) assessment dated [DATE] with an Assessment Reference Date (ARD) of 06/28/2024 revealed the following, in part: -BIMS (Brief Interview for Mental Status) score of 12, indicating intact cognition. - Functional Limitation in Range of Motion revealed Upper Extremity (shoulder, elbow, wrist, hand) and Lower Extremity (hip, knee, ankle, foot) = 1. Impairment on one side -Set up assistance required for ADLs (Activities of Daily Living) for eating (continued on next page)

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	195315	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaplan Healthcare Center	1300 W. Eighth Street Kaplan, LA 70548

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Partial/moderate assistance required for shower/bathing, personal hygiene, and upper body dressing -Substantial/maximum assistance required for ADLs of toileting hygiene, lower body dressing and bed mobility. Review of Resident #37's medical record revealed a note from a follow up appointment with her vascular neurologist on 09/18/2024 that revealed in part . Eliquis was never resumed and patient developed a large lower extremity DVT and a right MCA territory stroke. The new MCA territory stroke has rendered her with left-sided neglect, right gaze preference, left-sided hemiplegia was present even after her first stroke. Resident's daughter believes there is a rapid decline in her clinical status after her second stroke. Resident making minimal communication and does not voice her needs at all. Review of Resident #37's Quarterly MDS assessment dated [DATE] revealed the following, in part: -BIMS score of 00, indicating severely impaired cognition. - Functional Limitation in Range of Motion revealed Upper Extremity (shoulder, elbow, wrist, hand) and Lower Extremity (hip, knee, ankle, foot) = 2. Impairment on both sides. -Substantial/maximum assistance required for eating. -Dependent on staff for all ADLs of oral/personal hygiene, toileting, shower/bathing, dressing, bed mobility and all transfers. On 11/05/2024 at 9:30 a.m., an attempt was made to interview Resident #37 who was laying in her bed. She did not respond nor make eye contact. The resident was unable to be interviewed. On 11/04/2024 at 4:05 p.m., an interview was conducted with S8LPN/SSD (Licensed Practical Nurse/Social Services Director). S8LPN/SSD stated she was familiar with Resident #37 and verified that the resident had a decline after being hospitalized [DATE] to 09/12/2024. S8LPN/SSD further stated that prior to 09/06/2024, Resident #37 was able to speak and able to feed herself, but currently the resident was unable to speak and required staff to feed her. On 11/06/2024 at 12:25 p.m., an interview was conducted with S12ST (Speech Therapist). S12ST verified that when Resident #37 was admitted to the facility at the end of February 2024, the resident was receiving therapy services and had a PEG (Percutaneous Endoscopic Gastrostomy) tube feeding. The resident was able to safely consume pleasure feedings by mouth, was communicating appropriately and stated the resident was doing very well. S12ST explained that when Resident #37 returned to the facility, after being hospitalized in September 2024, the resident had regressed greatly. The resident was unable to follow simple commands, would only nod her head sometimes. Her eating skills had regressed so much that the resident's tube feedings were increased. Plan of Corrective Action: 1. Immediately conducted internal review of Resident #37's electronic medical record and the discovery was made that when the resident returned from a same day procedure on 07/29/2024, S3LPN failed to restart the resident's Eliquis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Monitored start-up reviewed of capturing all admit/re-admits from the hospital or with a change of medication orders with a final check completed by S11LPN. 3. Revised Care Plan conference objectives to include medications being reviewed during meetings with the resident and/or RP. 4. Implemented a change in the facility's medication reconciliation process. Any changes to any residents medications and/or readmitted will be first reconciled by the floor nurse caring for resident. Upon completion of reconciliation, nurses are to submit resident's paperwork for review to S6ADON and/or S11LPN. S6ADON will follow up the floor nurse to ensure the medication reconciliation is accurate. S11LPN to perform final review to ensure medication reconciliations are properly put in place within the MAR. 5. Resident in question MAR will be reviewed weekly to ensure her medication is administered as ordered. 6. Monitoring to begin ongoing for all new and readmit 09/09/2024 with all outcomes brought to the QAPI (Quality Assurance/Performance Improvement) committee on or before the next meeting as appropriate to ensure compliance. 7. S1ADM met with the contracted NP provider group to ensure the new protocol was understood. NP service will reference the actual EMAR for reconciliation of medications that residents receive. 09/09/2024- Nursing staff received verbal reeducation on properly reconciling a resident's medications to ensure accurate medications were being administered. On 11/04/2024 at 4:43 p.m., an interview was conducted with S2DON who explained care plan meetings were to now include medication review, monitoring of all new admit/readmits followed up for changes or new orders. S3LPN and the nursing department was re-educated on medication reconciliation on 09/09/2024. S1ADM explained when orders of any type are received, the new or discontinued orders must be reconciled with the eMAR to ensure the medications are accurate. S2DON stated she conducted the auditing of the newly admitted /readmitted residents as well as reviewed Resident #37's eMAR weekly to ensure medications were administered as ordered remotely. She stated the facility had not identified any recurring problems. On 11/05/2024 at 11:30 a.m., an interview was conducted with S1ADM who explained she conducted a verbal reeducation to S3LPN and to the other nurses on 09/09/2024. S1ADM further explained there new process was for S11LPN (Licensed Practical Nurse-Medical Records) to validate medication reconciliations are correct after admit and morning start-up meetings have been completed as a final check. On 11/06/2024 at 1:54 p.m., S1ADM stated the provider contacted S4NP and S13NPOwner (Nurse Practitioner Owner) of whom belong to the NP group contracted with the facility on 09/09/2024. The NP group implemented a systems change within their group's system to ensure the NPs reconcile resident medications accurately. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/06/2024 at 2:28 p.m., a phone interview was conducted with S13NPOwner who stated a new system was put into action by the NP group to ensure NPs accurately reconcile resident medications. The NP progress note form was revised to add wording that the medication list was to be used as reference only. NPs would now reference active orders in the resident's electronic health record and review the residents' MAR when reconciling medications for new admits/readmits or those with a significant change in condition. On 11/04/2024 - 11/06/2024 throughout the days nursing staff interviewed were knowledgeable about the medication reconciliation process being done to ensure medications are administered accurately. S4NP, S13NPOwner, and S5MD were knowledgeable about the new processes implemented by the NP group and actively involved in the facility's plan of corrective action for medication reconciliation medications.S2DON's audits were reviewed and revealed all new admit/readmits residents orders were followed up to identify changes or new orders on 09/16/2024, 09/23/2024, 09/30/2024, 10/07/2024, 10/14/2024, 10/21/2024 and 10/28/2024. S2DON also completed review of Resident #37's eMAR weekly to ensure medication administered as ordered for four weeks: 09/16/2024, 09/23/2024x, 09/30/2024, 10/07/2024, 10/14/2024, 10/21/2024 and 10/28/2024. No concerns were identified with review of S2DON's audits. Twelve residents were identified as taking an anticoagulant. Review of those residents' orders and eMARs were done which revealed their anticoagulant medications were being administered as ordered for 11/01/2024- 11/04/2024; no issues were identified. Routine monitoring was conducted as appropriate with reported findings in the facility's QA/QAPI (Quality Assurance/Quality Assurance Performance Improvement) program. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance on 09/09/2024, thus it was determined to be a Past Noncompliance citation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49176 Based on observations and interviews the facility failed to provide appropriate pharmaceutical services, by not properly disposing of a contaminated sharp, observed during medication administration. Findings: On 11/05/2024, a review of the facility's policy titled, Sharps Disposal, with a last revision date of January 2012, revealed in part: Policy Statement: This facility shall discard contaminated sharps into designated containers .1. Whoever uses contaminated sharps will discard them immediately, or as soon as feasible into designated containers . On 11/05/2024 at 11:01 a.m., an observation was made of S9LPN (Licensed Practical Nurse) perform a blood glucose test of a resident. After she performed the blood glucose test, she placed the used lancet in the palm of her gloved hand, and then removed her gloves. S9LPN returned to the medication cart, and placed her soiled gloves with the lancet inside into the trash receptacle of the medication cart. On 11/05/2024 at 11:09 a.m., an interview was conducted with S9LPN. S9LPN confirmed that she placed the used lancet inside her gloves then disposed of her soiled gloves and lancet in the trash receptacle of the medication cart. S9LPN stated she should have discarded the used lancet in the designated sharps container. On 11/06/2024 at 2:19 p.m., an interview was conducted with S2DON (Registered Nurse, Interim Director of Nursing, Infection Preventionist). S2DON confirmed that used lancets should be discarded into designated sharp containers.

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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. 49176 Based on observations and interviews, the facility failed to maintain an effective infection control and prevention program by failing to ensure staff performed hand hygiene when indicated according to accepted standards of practice during medication administration pass. Findings: On 11/05/2024, a review of the facility's policy titled Handwashing-Hand Hygiene Policy and Procedure, with a last reviewed date of 01/24/2024, revealed in part: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections .Policy Interpretation and Implementation: .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .b. Before and after direct contact with residents .i. After contact with a resident's intact skin .l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. On 11/05/2024 at 11:06 a.m., an observation was made of S9LPN (Licensed Practical Nurse) administering insulin to a resident. After administering the medication, she returned to the medication cart and began documenting on her computer. S9LPN did not sanitize her hands before returning to her work station. On 11/05/2024 at 11:09 a.m., an interview was conducted with S9LPN. S9LPN confirmed that she had not sanitized her hands after administering insulin, and before returning to her work station. S9LPN stated that she should have sanitized her hands before returning to her work station. On 11/06/2024 at 2:19 p.m., an interview was conducted with S2DON (Registered Nurse, Interim Director of Nursing, Infection Preventionist). S2DON confirmed that staff were supposed to sanitize their hands after completing a procedure/during medication pass, and before returning to their work station.