STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195342	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Pointe Healthcare and Rehabilitation	405 Milton Road Maurice, LA 70555

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47123 Based on interviews and record reviews, the facility failed to coordinate hospice care services for 4 (#1, #2, #3, and #R1) out of 4 (#1, #2, #3, and #R1) residents reviewed for hospice care. The facility failed to: 1. allow Residents #1, #2, #R1 and or their RP (Responsible Party) the choice of hospice provider. 2. obtain the initial certification and or most recent recertification of terminal illness and most recent hospice POC (plan of care) for Residents #1, #2, #3, and #R1, and 3. immediately notify the hospice agency when there was an incident of alleged abuse towards Resident #R1. Findings: On [DATE], a review of the facility's policy titled Hospice Care Policy and Procedure with a revision date of [DATE], read in part, Purpose to assure all disciplines are working together to provide quality care to the resident. Procedure 3. Hospice will maintain all documentation in the clinical record . On [DATE], a review of the facility's agreement with the contracted hospice agency dated [DATE], read in part, . 3.6 Abuse and Bereavement Hospice shall report all alleged violations involving mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of unknown source .within 24 hours of Hospice's actual notice of such alleged violations. V. Records (a) Nursing facility . shall prepare and maintain complete and detailed clinicals records . Each clinical record shall completely, promptly and accurately documents all services provided to, and events concerning each Residential Hospice Patient . Resident #1 Review of Resident #1's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] with diagnoses including, but not limited to, Alzheimer 's Disease, and Anxiety Disorder. Review of Resident #1's February 2024 physician's orders revealed an order dated [DATE] that read in part: Admit to . hospice dx (diagnosis): terminal e/s (end stage) Alzheimer's Disease. (continued on next page)

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #1's Quarterly MDS (Minimum Data Set) dated [DATE], revealed the Brief Interview for Mental Status (BIMS) of 1, indicating her cognition was severely impaired. Under Section O: Special Treatments, the resident was admitted to hospice. Further review of Resident #1's EHR failed to reveal a recent hospice care conference summary report (hospice plan of care), and the most recent recertification of terminal illness. Resident #2 Review of Resident #2's EHR revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Hemiplegia Following Cerebral Infarction, Other Speech/Language Deficits Following Cerebral Infarction and Unspecified Dementia Review of Resident #2's Quarterly MDS dated [DATE] revealed the BIMS of 4, indicating her cognition was severely impaired. Under Section O: Special Treatments the resident was admitted to hospice. Review of Resident #2's physician's orders revealed an order entry with a start date of [DATE] which read in part, Admit to Contracted Hospice for dx: End Stage Cerebral Infarction. Resident #3 Review of Resident #3's EHR revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Chronic Systolic (Congestive) Heart Failure and Shortness of Breath Review of Resident #3's physician's orders revealed an order entry with a start date of [DATE] which read in part, Admit to Contracted Hospice . dx: CHF (Congestive Heart Failure). Review of Resident #3's person-centered plan of care, revealed in part, a focus of I have chosen to receive hospice care with Contracted Hospice dx CHF. Review of Resident #3's hospice documents in the EHR revealed no evidence of an initial certification and or recertification of terminal illness and no hospice POC's. Resident #R1 Review of Resident #R1's EHR revealed he was admitted to the facility on [DATE] with diagnoses including, but not limited to, Cervical Disc Disorder with Myelopathy. Review of Resident #R1's [DATE] physician's orders revealed an order dated [DATE] which read in part: Admit to . hospice for terminal dx (diagnosis) of Cervical Disc Disorder with Myelopathy. Review of Resident #R1's Quarterly MDS dated [DATE] revealed the Brief Interview for Mental Status of 10, indicating his cognition was moderately impaired. Under Section O: Special Treatments, the resident was admitted to hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #R1's nurse's notes dated [DATE] revealed the following entry: Resident #R1 reported that his roommate punched him early this morning while he was in bed. I know I holler in my sleep sometimes, but I'm only human! He can't just beat me up. Resident #R1 stated he was punched on the arm, light bruising noted to left elbow. ROM (Range of Motion) to left arm WNL (Within Normal Limits). No other injuries noted. Afterward, staff assured that Resident #R1 and his roommate remain separated while investigation took place. Notified RP, DON (Director of Nursing) and Doctor. Further review of Resident #R1's EHR failed to reveal a recent hospice care conference summary report, most recent recertification of terminal illness, hospice initial visit, and hospice initial certification. On [DATE] at 9:21 a.m., the S2DON brought in a list of residents on hospice services along with the hospice contracts. S2DON stated the Contracted Facility was their primary hospice preferred provider. On [DATE] at 12:25 p.m., a phone interview was conducted with Resident #1's RP. She stated she did not pick the hospice company nor was she given a list in person or verbally with choices of different hospice companies of who the facility was contracted with. Resident #1's RP stated she was contacted by the Hospice Company directly and then met with them at the nursing home to sign the paperwork. On [DATE] at 2:00 p.m., a phone interview was conducted with Resident #R1'S RP. She stated the facility told them they work with Contracted Hospice, and that the Contracted Hospice is their preferred provider. Resident #R1's RP stated she was not informed of any other hospice companies the facility was in contract with. On [DATE] at 2:13 p.m., a phone interview was conducted with Resident #2's RP who confirmed that Resident #2 was receiving hospice services for a decline in her health. He stated while Resident #2 was admitted to the hospital, the facility reached out to the RP to inquire about hospice services for Resident #2. RP stated he agreed to hospice services for Resident #2. He further stated I did not receive a list of different hospice companies or different hospice pamphlets, I went with the contracted Hospice because that's what the facility told me they use. On [DATE] at 4:27 p.m. an interview and review of Resident #1, #2 #3 and #R1's hospice documents was conducted with S3ADON (Assistant Director of Nursing). S3ADON confirmed she was the designated team member for ensuring all hospice documents were current and scanned into the EHR. She stated the hospice documents are were only in the EHR and not in hospice binders or anywhere else. S3ADON, confirmed the last case conference summary for Resident #1 was done on [DATE] and stated it should have been done weekly, also and also confirmed the last recertification was expired on [DATE] and she did not have a current one in the chart. She confirmed Resident #2's last certification period that was scanned into the EHR was from [DATE] through [DATE] and the POC was from [DATE] through [DATE]. She was unable to verify a recertification or recent POC in the EHR. She confirmed Resident #3 did not have a certification, recertification or POC in the EHR. S3ADON confirmed there were no current certification and or recertification statements or hospice POC's for Residents #1, #2 #3, and #R1 and stated there should have been a current and updated certification and or recertification statement and POC's obtained from the residents' hospice agency and scanned into each resident's EHR. S3ADON stated she checked her emails and was unable to locate current certifications or recertifications and POC's for Residents #1, #2, #3, and #R1. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:53 a.m., a joint interview was conducted with S1ADM (Administrator), S2DON, and S3ADON. S1ADM stated the facility had two different hospice companies that they were in contract with. S2DON reviewed Resident #R1's EHR and stated the alleged abuse happened on [DATE] and could not locate documentation of Residents #R1's hospice company being notified. S1ADM, S2DON, and S3ADON, confirmed that the hospice company should have been notified of the alleged abuse incident with Resident #R1and were not. 47540